MPS (Investments) Limited

Alston View Nursing and Residential Home

Inspection report

Fell Brow
Longridge
Preston
PR3 3NT
01772 782010

Date of inspection visit: 15, 17, 20 21 July 2015 and 30 September 2015
Date of publication: 13/11/2015

Ratings

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

Overall summary

Alston View is registered to provide accommodation, nursing and personal care for up to 49 people and is owned by MPS (Investments) Limited. At the time of our inspection on 30 September 2015 there were 37people living at the home: 21 people requiring nursing care and 16 requiring residential care. The home is located in the village of Longridge where access to local facilities are within walking distance. Alston View is a modern home with accommodation on three floors. All of the bedrooms are en-suite with the exception of two single rooms. A small car park is available for visitors. Accommodation is provided over three floors (including the ground floor) with lift access between the floors. There are communal lounges and a dining room as well as toilets and bathroom facilities. A kitchen and laundry are located on the ground floor.

We previously inspected the home in May 2015, and found the home required improvement in the following areas. People who used the service did not have their

Summary of findings

medicines well managed and that the infection control measures were not consistently adequate to protect people from the spread on infection. Staff training and supervision was not always carried out in a timely manner to ensure staff were properly supported to undertake their work. Staff were not confident in their knowledge and use of the Mental Capacity Act 2005. In some instances, care records and assessment were very narrowly based on clinical issues, and not focused on the whole person. People were not always supported to take part in a range of activities whilst staying at the home. Quality assurance and governance systems were in place; however they were not always followed and implemented. The staff communication systems were sometimes ineffectual. Staff were found to be caring, but some were not given support to reflect on practice through appropriate supervision.

We carried out a series of unannounced inspection visits in July 2015. On 15 July 2015, our inspection was undertaken as part of a joint visit with representatives from Lancashire County Council Social Services Department and the Police Public Protection Unit. Our visits were made after Social Services were alerted to the death of a service user, who had been found to be gravely ill when attended to by a visiting healthcare professional. We undertook subsequent inspection visits on 17, 21 and 22 July 2015 in order to collect further evidence of how the service was operating.

In July 2015 we found that that people were not kept safe from harm as staff had not received up to date training in safeguarding and allegations of abuse were not always recognised or reported. There was a lack of meaningful activities for people, although people told us they enjoyed the outside entertainers who visited. People's care was not always planned or delivered in a way that met their individual needs and preferences: care records were not robust and people's needs had not been comprehensively assessed. Medicines were not managed safely and properly: stock balances did not reconcile.

Staff had not received training in, and lacked understanding of, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Feedback from staff and information held within the records showed that the registered provider had not provided appropriate and sufficient support, training, professional development, supervision and appraisal to enable all staff members to carry out the duties. Care and treatment was not provided by suitably qualified, competent, skilled and experienced staff: the home relied on nursing care from registered mental nurses (RMNs), when clinical input from registered general nurses (RGNs) would have been more appropriate.

The data relating to the number of deaths at the home in the past 12 months differed across a number of agencies: CQC, the Local Authority and the Clinical Commissioning Group were all found to hold a different number. It was clear that the service provider had not correctly notified external agencies as required to do so. There was a lack of quality assurance systems and those that were in place were ineffective and had been used to effectively identify service deficits such as concerns around staff training, staff qualifications, care assessment and planning activities and notifications.

We revisited the home on 30 September 2015, and found that some improvements had been made. The care records were found to be well organised, making information easy to find. We were pleased to note that RGNs had now been appointed, rather than relying purely on the clinical input from RMNs. The RGNs had more suitable qualifications, experience, skills and knowledge to provide the care and treatment for those who required a higher level of nursing intervention. Staff spoken with were able to discuss the needs of those who lived at the home well.

The area manager advised that some progress had been made in recruiting new staff and that this was on-going. This meant the service were able to reduce their use of agency staff, which had previously been an issue, which was noted on the staff rotas.

Alston View is required to have a registered manager. At the time of our inspection there was an acting manager in place. A registered manager is a person who has registered with the Care Quality Commission 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. The service provider has given the Commission assurances that the acting manager will applied to be registered.

Summary of findings

We found errors in the way medicines were administered and managed. These issues were similar to those found in May 2015 and July 2015, and this put the care and welfare of people living at the risk. Medicine audits were not effective. Not all the staff had received appropriate fire safety training. Incidents and accidents were not properly monitored, and when these needed to reported to external agencies, we found that this had not always taken place.

Some areas of the home were found to be in need of a deep clean, and the home did not have a staff member who took overall responsibility of infection control measures. We have made a recommendation about this.

We did not have assurances that staff members had adequate knowledge to undertake their work, as many had not received sufficient training and supervision in order to perform their work effectively, although we noted that the home had an action plan to tackle this issue, and were working through the plan. Some areas of the home were in need of repair, and needed to be properly maintained.

Although people's needs were being met, and these were reflected in their improved care records, staff were sometimes slow to respond to people's requests for support, and the home did not always provide appropriate social activities.

Management record keeping was poor, and the governance systems operated within the home were not robust or effective, although we noted that some improvements to the systems had taken place. Systems and processes to record, assess, analyse and mitigate risks and promote people's well-being were not being followed.

We found five breaches of the HSCA 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred Care, Safe Medicines Management, Safe Care and Treatment, Staff Training and Supervision', Safeguarding, Safe Premises and Good Governance.

We found two breaches of the (Registration) Regulations 2009 in relation to notifications of deaths and notifications of other incidents.

We recommend that the service provider consults and implements best practice guidance on injection control measures.

We identified a number of breaches in regulations and the Care Quality Commission is considering the most appropriate regulatory response to resolve the problems we identified. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

You can see what action we took at the end of this report

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.

Improvements in the way the medicines were managed were needed: poor recording systems meant we could not be sure about the quantities of medicines held at the home. The way in which medicines were managed put people at risk.

The ways the service responded to, and reported safeguarding concerns were not robust.

Infection control measures and cleaning routines needed to be reviewed in order to ensure that home was kept clean and free from infection. We recommend that the service provider consults and implements best practice guidance on injection control measures.

Is the service effective?

Requires improvement

The service was not effective.

Arrangements for supporting staff did not develop their skills and knowledge in order for them to meet the complex needs of people living at the home. People told us staff knew their needs; however, we found staff training was not up to date.

Not all staff had not received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. As a result their understanding on these subjects was limited and potentially could have a negative impact of people living at the home.

Access to health care services were in place but there have been instances when this was not always sought in a timely way.

Is the service caring?

Good

The service was caring.

People praised the staff and we saw staff interactions which were warm and friendly. People were involved in their own care and support arrangements depending on their ability.

Staff understood the need to protect people's confidentiality.

Staff had considered people's end of life care needs.

Is the service responsive?

Requires improvement

The service was not responsive.

People at the home were not supported by planned activities based on their needs and preferences.

Summary of findings

The care and treatment provided by the service was always person-centred.

Care planning was up to date and provided staff with the information they required to meet people's needs.

Is the service well-led?

Inadequate

The service was not well led.

Processes were not followed to ensure effective assessment, monitoring and mitigation of risks to people's health, safety and welfare. People were not protected because the provider did not have effective systems in place to monitor and assess the quality of the services provided.

Important records had not been properly maintained. Notifications regarding events in the home such as deaths and incidents were not routinely sent to CQC and other external agencies.

The service provider made it clear that he was unhappy to have inspectors on site, and later apologised for the way in which he expressed his unhappiness.

Alston View Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this unannounced 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 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.

An inspection took place on 15, 17, 21 and 22 July 2015, and was unannounced. The inspection was carried out by the lead adult social care inspector for the service and a second adult social care inspector. At the time of the inspection, police officers from the Public Protection Unit and staff from Social Services were also on site. The inspection was in response to concerns raised by the Local Authority following the death of a service user at the home, who had been found to be gravely ill when attended to by a visiting healthcare professional. Following these inspection visits, during which concerns were found relating to the care, treatment and welfare of people living at the home, Lancashire County Council Social Services convened a multidisciplinary strategy meeting to discuss the joint findings, and all the stakeholders agreed that the home should be monitored through the Quality Improvement Planning (QIP) process. The service was asked to complete an action plan to show how it would bring about improvements to the service. The action plan was closely monitored by staff the Commission, Lancashire County Council Social Services (LCCSS) and the local Clinical Commissioning Group (CCG).

Whilst monitoring the action plan provided by the service provider, the Commission made the decision that prior to publication of these findings, to revisit the service in order to determine what improvements had been made since the previous inspection. We revisited the home on 30 September 2015, and found that some improvements had been made; however, further improvements were still required. The inspection was undertaken by the lead adult social care inspector for the service, four additional adult social care inspectors and an expert by experience with an interest in the care and support of older people.

During our series of visits in July 2015 we spoke to eleven people who lived at the home. We reviewed three people's care records held at the home and spoke to five members of the staff team (nurses and carers). We reviewed a selection of the management records, and staff personnel and training files. We also spent time talking to the registered provider, operations manager and area manager regarding the operation of the home. We spoke to six relatives who visited the home, and two visiting healthcare professionals. We observed the way that the staff team interacted with the people living at the home, and how people engaged with each other. We reviewed the medication system operated within the home.

During our September visit we spoke to twelve people. We reviewed a four people's care records held at the home and spoke to seven members of the staff team (nurses and carers). We reviewed a selection of the management records, and staff personnel and training files. We also spent time talking to the registered provider, operations manager and area manager regarding the operation of the home. We spoke to seven relatives who visited the home, and two visiting healthcare professionals. We observed the

Detailed findings

way that the staff team interacted with the people living at the home, and how people engaged with each other. We reviewed the medication system operated within the home.

Inadequate

Is the service safe?

Our findings

During our previous inspection visit in May 2015 we found that the arrangements for the safe management of people's medicines were not consistently effective. During this inspection we found this situation had not improved and that people were at risk because their medicines were not always managed in a safe manner.

During our inspection visits on 15, 17, 21 and 22 July 2015 we found a number of areas of concern that related to staff training in safeguarding, errors in the way medicines were managed, staffing levels and staff competency, the incident and accident recording systems, risk assessments and the plans that needed to be in place to show how people should be evacuated in the event of a fire.

During our visit on 30 September 2015 people we spoke with told us they felt safe in the home. One person said, "I know I'm safe – I can't fault it here." A visitor told us, "My family member was in another place before this and it was awful. Here is so much better." Another said, "I like it here. I get on with people and although it's not my home, it feels homely and nice. I feel safe".

Our findings during this inspection did not always support these comments. Medicines including refrigerated lines and controlled drugs were generally stored in a safe and appropriate manner. However, we found two tablets which had been put in a pot and were loose within a medicines trolley. There was no information as to who these tablets belonged to and the nurse on duty was not able to confirm this information.

We checked the stocks of seven people's medicines against the records of receipt and administration. In five examples, the numbers of tablets in stock did not tally with the records and we found there were too many tablets left over. The Medication Administration Records (MAR) for one person showed that 28 tablets had been received and commenced on 7/9/15. The MAR showed that it had been administered 23 times. The stock check held by the home showed that there were seven tablets in the box. Staff who were spoken to could not account for the two extra tablets. This indicated that staff had signed to say they had administered this person's medicine but had not given them.

Some medication administration records (MARs) were unclear, which increased the risk of mistakes being made. For example, we viewed the records of one person who was prescribed a medicine at a variable dose. The records were very confusing and the correct dose was not clear to staff. In another example, we found that staff had failed to follow instructions properly. This person was prescribed a medicine to be given as four tablets, one day each week. We found that on one occasion a staff member had signed to confirm they had administered it on the wrong day. On this and another occasion, only one tablet had been given. This meant the person only received a quarter of their prescribed dose.

Some people who used the service were prescribed medicines on an 'as required' basis. We found there was clear information in place for staff about when these medicines should be given, known as PRN protocols. However, we found one example where a person's PRN protocol had not been followed. This was a medicine prescribed for agitation but we found evidence it had been administered on a number of occasions when the person's daily records stated they had been settled and well. This was of particular concern as the medicine had side effects that made the person drowsy, and increased the person's already high risk of falling.

There were processes in place to carry out regular audits and counts of stock. However, we found evidence these were not carried out effectively. We found several examples of counts which had been completed by staff which should have indicated an error had been made. However, as people's MARs were not always carefully checked when carrying out the counts the potential errors were not always identified.

We were advised by the area manager, that all staff who administered medicines were required to undergo a competency check on a periodic basis. However, when we asked for the most recent competency checks for two senior care workers responsible for administering medicines, we were advised these had not yet been carried out. Staff involved in the administration of medicines had not received either up to date or refresher training in the safe administration of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not

Inadequate

Is the service safe?

provided in a safe way for service users because medicines were not managed safely and properly, and not all staff had received appropriate competency checks.

We carried out a tour of the home and checked the equipment that was used. All equipment viewed, including lifting equipment such as hoists, had been serviced within recommended timescales to help ensure it was safe for use. We found two areas that were potentially unsafe, which had not been locked. Both were out of use bathrooms which were being refurbished. One had some building material in it and the other was being used for storage of various items, which included a broken wardrobe. The light in this room was not working, which added to the potential hazards.

The service had policies and procedures in place in relation to safeguarding people from abuse. The procedures included information about how to identify signs of abuse and clear reporting protocols. However, through reviewing information with other agencies we were aware that the procedures were not always followed in practice. There had been recent occasions where staff had failed to identify circumstances where safeguarding referrals should have been made, and reports had not been made to the relevant authorities. Reports were only made after staff from Lancashire County Council identified issues and requested that these issues were reported.

Information held within the staff personnel and training records showed that staff had received training in safeguarding. However, half the staff team had not received update or refresher training.

We spoke to two staff during our inspection of 30 September 2015 about their understanding of safeguarding, and the service's safeguarding procedure, and found they had very limited understanding. Although the staff were able to correctly identify safeguarding issues such as sexual, physical and financial abuse, they were unclear about issues such as acts of omission or the inability to respond to people's changing needs. When asked about how they would report suspected abuse, the staff we spoke with said they would make a record of the issue, and/or report it to more senior staff such as a nurse, senior carer or the manager. When asked what their understanding of an act of omission was, the staff were unsure: when asked if the failure to provide medical care and support to people when needed would constitute an act of omission, the staff were unsure. Their answers showed a limited understanding of the issues, and as a result, safeguarding issues such as acts of omission, or an inadequate response to people's circumstances, could have been overlooked and not properly reported.

This was a breach of Regulation 13 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided by way of proper safeguarding training for staff, and the proper operation and scrutiny of safeguarding policies and procedures when meeting needs of the people using the service.

During our inspection in July 2015, we found that despite providing services to people with significant healthcare needs, most nursing staff held qualifications in mental health. Due to the high level of clinical care required by people living at the home, this raised significant concerns, as the nursing staff were not suitability qualified to meet people's needs. During our visit on 30 September 2015, we found that four registered general nurses had been employed by the service provider. One of these had taken on the role of clinical lead for the service. This meant that people in need of clinical input were now better supported through the provision of appropriately qualified staff. Nurses spoke with said that having a clinical lead meant that they were "better placed to ensure the delivery of a high standard of care as we are a team, with a person who provides us with clear guidance and support."

Risk assessments were completed as part of the service's care planning procedures. We saw risk assessments were carried out which covered areas such as falling, developing pressure sores and mental health. Those we viewed were up to date and had been reviewed as required. Where risks were identified there was guidance for staff about how to keep people safe.

The area manager advised that some progress had been made in recruiting new staff and that this was on-going. This meant the service were able to reduce their use of agency staff, which was noted on the staff rotas. Less use of agency staff meant that people who used the service received their care from a consistent staff team who they were familiar with.

Staff rotas showed that the home was consistently staffed in line with the assessed establishment hours. We were advised by the area manager that the establishment hours

Inadequate

Is the service safe?

were determined in line with the needs of people who used the service and kept under constant review. During our July and September visits, we observed that ample numbers of staff were on duty to meet people's needs and we noted people were provided with support when they required it.

On 30 September 2015, we looked at four staff personnel files to assess the processes used to recruit new staff. We found that recruitment practices were inconsistent. We looked at the file of one person and noted this only contained an employment history for the last six months. There was no record on the person's interview notes that the gaps in their employment history had been discussed. The person's most recent employer had not provided a reference and the one other employment reference obtained, only confirmed the dates the person had worked for them. This meant there was no information about the person's conduct or performance in previous employment. There was also no confirmation that the person's nursing registration had been verified.

We looked at the file of another recently recruited staff member who had been subject to some disciplinary investigations in their most recent social care employment. There was no evidence that this issue had been thoroughly investigated by the acting manager prior to the person being offered employment at Alston View. All personnel files viewed confirmed that DBS checks had been carried out. The inconsistent recruitment practices with particularly reference to the way information was recorded, did not promote the safety and wellbeing of people who used the service or help to ensure that people had the correct skills to carry out their role.

During our tour we noted a number of visibly unclean areas. These were discussed with the area manager who advised us she was in the process of reviewing cleaning schedules. We were advised that the service did not have a person appointed as the lead in infection control. However the area manager had identified the need for this and was in the process of making suitable arrangements. We were also advised that all staff at the service were in the process of doing training in infection control to help ensure they were aware of safe practice.

We recommend that the service provider consults and implements best practice guidance on injection control measures such as "Prevention and control of infection in care homes" – an information resource produced by The Department of Health.

Requires improvement

Is the service effective?

Our findings

During our inspection visits on 15, 17, 21 and 22 July 2015 we found a number of areas of concern that related to staff training, supervision and appraisal, healthcare and the implementation of the Mental Capacity Act (MCA).

On 30 September 2015, we asked people if they thought they were cared for by staff who knew what they were doing. Without exception, people told us they felt the staff were very good, and they knew what they were doing. One person said, "The staff seem to know what they are doing. I've never had a problem with them." People said they got on well with staff and that staff provided 'excellent support' that they liked. Relatives we spoke with told us they had confidence in the skill and knowledge of the staff that supported their loved ones. Comments from relatives included, "The staff are really good. Some are more experienced than others, but they appear to work well together."

On 30 September 2015, we looked to see how the systems in place for the training and supervision of staff were implemented within the home, and found that these systems did not support the safe and effective operation of the home. Information held within the staff personnel files showed that although inductions took place for new starters, these were not always complete. Mandatory training had not been completed. The staffing training records showed that those who required their training to be updated or refreshed had not attended the relevant training course or learning sessions. Staff told us that they were reliant on DVD based training, and work books that were completed and either sent away to a training provider for marking, or marked by the training coordinator at the home. The home's training matrix dated August 2015 showed that there were gaps in the training or refresher training for staff in the areas of manual handling, adult safeguarding, infection control, fire safety and evacuation, and the Mental Capacity Act (MCA). According to the matrix, only one staff member had received training in first aid. We spoke to two staff members about the training they had received regarding the new Fundamental Standards that regulate care services and the Duty of Candour on service providers and staff. Both said that they had not received any training on these subjects.

On 30 September 2015, we found that staff were not in receipt of regular support by way of appropriate supervision. We viewed two staff personnel files. Neither contained any evidence of supervisions that had taken place. We spoke to two staff who said that supervision was not regularly provided. One said, "If we need to talk to a senior staff member, then we can do this on a day to day basis, but we hardly ever get formal supervision on a one to one basis." We looked to see if staff received an annual appraisal, and in two cases, this had not taken place. We spoke with two other staff members who confirmed that despite working at the home for some time, they had not received an appraisal for over a year. We spoke with the service provider who explained that following an assessment of personnel files, a rolling programme of supervision and appraisals will be implemented and followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider had not provided appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff members to carry out the duties they were employed to perform.

We found the building to be large and spacious, its design and layout was appropriate to the meet the needs of the people living there. Reasonable steps had been taken to ensure that premises were accessible to all those who needed to use them. Although the premises and grounds appeared to be well maintained, we noted that there was very little outdoor space for people to use, apart from that at the front door in the car park. One person told us in July 2015, that they had not been outside for nearly three years. On 30 September 2015, we noted that the flagging at rear of property that is not regularly used by service users, was found to be in a poor state of repair. There were several cracked and raised flags which could pose a trip hazard for both staff and service users. The service provider agreed that this area of the home needed to be assessed to ensure that any potential hazards were identified and remedied.

This was a breach of Regulation 15 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must make sure that the premises and equipment are properly maintained.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards.

Requires improvement

Is the service effective?

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the acting manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

Staff told us of one person who lived at the home who from time to time became agitated and distressed, which they thought to be linked to their diagnosis of dementia. The person had been heard to say from time to time that they wanted to go home, not remembering that they now lived at Alston View. The staff explained that from time to time, the person spent time trying to open the front door which had a key pad lock on. They explained that when the person behaved in this way, staff tried to calm the person down, and then usually told the nursing staff of the issue. The staff said, " The nurses have medication that that help the person to relax. They explained that the home needs to continue to use the key code on the door so that the person did not go out as they would be unsafe if unaccompanied. We found that a DOLS application had been made for this person. The service had also made applications for three other people at the home for similar reasons.

In all the care files we looked at we noted that mental capacity assessments had been conducted to determine if people had the capacity to make decisions in specific areas. These were in conjunction with each plan of care. However, we noted that they were identical within each care record for each person, and therefore we were unsure if people were actually assessed as having capacity to make separate specific decisions. We did see evidence that multi-disciplinary meetings were held in some instances, with the least restrictive options being considered so that best interest decisions could be made on behalf of individuals. We did not see any DoLS applications made for people whose records we examined, as their liberty was not being restricted.

We looked to see how food and hydration was provided and made available in sufficient quantities and on a regular basis. People told us, "The food is always very good, and we always get enough to eat." We found there to be a choice of food and drink that took account of people's individual preferences. We observed staff offered support to enable people to eat and drink when necessary. We found documentary evidence to show that on-going assessment, planning and monitoring of nutritional and hydration needs and intake took place.

Fluid intake charts were used for people, and these charts were now routinely used or accurately completed. This was not the case when we inspected in July 2015. One staff member said, "We sometimes didn't have time to complete the charts when they were on the computer system, but now we have moved to paper documents, we can fill the forms in when people eat or drink." We found that weight monitoring and the action taken by the staff when changes were noted, was now taking place. This meant that people's healthcare in relation to weight loss or gain was now more closely monitored.

We looked to see how the service provided supported people to access external healthcare services and professionals, and found that these systems had improved since our visits in July 2015. Referrals to external services had taken place when people's needs had changed. Previously we found that assessments and referral processes were inconsistent, with one person not having their pressure sores correctly assessed. A tissue viability nurse visited the home at that time, found the person to be in a very poorly state of health; their wound was septic; had been incorrectly assessed and the referral should have been marked as urgent, but wasn't. Discussions with the nursing staff at the home found that they were now more aware of the need to correctly assess people's healthcare needs, and ensure referrals were made when required.

Good

Is the service caring?

Our findings

In both July and September 2015, the feedback from people about the attitude and nature of staff was positive. Comments included, "The staff are always positive and caring, ready to listen and give you time if you need it." "Staff work in a dignified way, and I always feel special and well cared for."

In September 2015, the interactions we observed between staff members and those who lived at the home were all pleasant, polite and friendly. Staff expressed their genuine concern about individual people when talking with us. People we met spoke positively about the staff and described them as 'nice' and 'lovely'. One person said, "It's a nice place to be." Other comments included, "The staff are marvellous." And, "The staff are nice and friendly."

People recognised care workers and responded to them with smiles which showed they felt comfortable with them. We saw some interactions between staff and people were warm and friendly, however we noted conversations were mainly confined to discussions about care tasks. On one occasion we observed a person wanting help from staff to use the toilet, but they had to wait for some time before staff responded to their requests. This was a one off event, and our observations led us to believe that this was not a common occurrence.

We asked two carers what arrangements were in place for people to access advocacy services if they required them. They explained that information relating to advocacy services was available in the home in the form of leaflets. They also confirmed that information was displayed within the home, and on touring the home we confirmed this.

The staff we spoke with said that they had received training in the need to respect people's confidentiality. One staff member explained that this aspect of their work had been covered during their induction, but added that they had not received any further training on the subject, adding, "I think we need to be reminded of things life confidentially. You can find yourself publicly talking about a person in the lounge when really you should go into the office, and talk privately."

People's bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home. We observed care workers knocked on people's doors before entering rooms and staff took time to talk with people or assist them to undertake activities. Care workers used people's preferred names and we saw warmth and affection being shown to people.

We looked at the way the home supported people at the end of their life and found the systems now assisted with the care of those reaching the end of their life. Care plans and profiles reflected the needs of people with particular reference to end of life concerns. Staff explained that improvements had been made in recent weeks to the way the care plans were put together.

Requires improvement

Is the service responsive?

Our findings

During our inspection visits on 15, 17, 21 and 22 July 2015 we found a number of areas of concern that related to how care and treatment was provided in a safe and person centred manner, and the type and quality of activities on offer to people in the home.

On 30 September 2015, we looked to see how people were supported through meaningful and individualised activities, and found that the systems in place did not support people's health, quality of life and welfare. We were told the activities co-ordinator was not on duty on that particular day. We looked at the programme of leisure activities, which included topics, such as bingo, play your cards right, hair day, family day, dominoes and baking. On the day of our inspection the activity theme was, 'Free and easy'. We were told that a barge trip had been arranged for those who wished to participate. The area manager confirmed that the scope of activities could be improved. People we spoke with felt that there was a need to improve the way of activities were provided. Some people told us there were was not a lot to do, and as a result they spent a lot of time watching TV. Others told us that when activities do take place, they didn't last long enough.

On 30 September 2015, we saw a person trying to attract staff attention for almost five minutes, but no-one went to them. We went over and spoke with the person who said they wanted to use the toilet. We asked a staff member to assist, but they said they were a cleaner. They went to find the care staff and returned telling the person staff would be with them in two minutes. Almost 14 minutes later, a staff member came but was called away by another person. We then informed a nurse, who personally assisted the individual but by this time the person had been waiting a considerable time.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider had not ensured that each person received appropriate person-centered care and treatment.

The service provider confirmed that following our inspection visits on 15, 17, 21 and 22 July, the care records had been transferred from a computerised system to a paper format. During the inspection on 30 September 2015, a visiting professional explained that recommendations relating to the care and treatment of people's needs were now being followed, and when referrals were needed, these were being made. This was seen to be an improvement that had taken place in the previous month. We noted some significant improvement in the content of those files we examined. We 'pathway tracked' the care of four people who lived at the home. Three of these individuals required nursing care, whilst the other person needed support with personal care only.

The care records were found to be well organised, making information easy to find. We were pleased to note that nursing staff had been appointed, who had more suitable qualifications, experience, skills and knowledge to provide the care and treatment for those who required a higher level of nursing intervention. Staff spoken with were able to discuss the needs of those who lived at the home well.

Records showed that a wide range of external professionals had been involved in the care and treatment of those who lived at Alston View, such as GP's, dieticians, speech and language therapists, community nurses and opticians. Records showed that any advice or instructions from community professionals had been accurately transcribed within the plans of care. For example, a speech and language therapist (SALT) had provided some very clear instructions for staff about how one person should be supported with eating, in order to maintain good nutrition and to reduce the possibility of choking. We noted that these directions were being followed in day to day practice.

We saw that care charts were clearly recorded and up to date. These documented positional changes, dietary intake and fluid balance. This helped to ensure people's health care needs were being appropriately met. At the time of our inspection there was an occupational therapist, physiotherapist and nurse practitioner on site. We were told that the nurse practitioner visited the home each week to see those residents, who required medical advice, which was pleasing to note.

An assessment of people's needs had been conducted before a placement was arranged. We found a significant improvement in the plans of care. They were well written, informative and, in general person centred. They incorporated people's likes, dislikes, preferences, medical history, allergies and current needs well and provided staff with clear guidance about how individual requirements were to be best met. However, occasional vague

Requires improvement

Is the service responsive?

statements were used, such as "arrange chiropody and hair dressing regularly". We would expect to find a specific date or timescale linked to events or appointments. This allows the care and support provided to people to be measured effectively.

Each person who went to stay at Alston View was asked which gender of staff they preferred to assist them with personal care, which promoted choice, as well as privacy and dignity. Records showed the plans of care had been developed with those who used the service or their relative and people we spoke with confirmed they had been involved with the planning of their care or that of their relative.

It was difficult to establish if the care plans had been reviewed on a regular basis, because the current methods of recording information had been very recently implemented. However, systems were in place for regular reviews and we did see changes in one person's needs had been recorded well. Records showed that family members had been consulted about when they would like to be informed if their relative had a fall, for example, during the day or night time. Risk assessments had been conducted in a variety of areas, such as tissue viability, moving and handling, nutrition and falls. These identified any potential hazards, which may have affected peoples' health, safety and well-being.

During our tour of the premises on 30 September 2015we noted that specialised nursing equipment was provided for those who required it, such as profile beds, air flow mattresses and mechanical hoists. This helped to ensure appropriate care was being delivered. We saw a notice displayed at the nurses' station that explained which reminded staff to ensure anyone receiving not receiving nursing care from nurses employed by home, who had any skin damage, was to be referred to the district nurses for assessment and treatment. The records of one person showed that the district nurse attended regularly to renew the individual's wound dressings. When we spoke to staff about the involvement of district nurses, they confirmed that there were good systems in place to record issues when people needed their input, and that they were clear when to make referrals.

A complaints policy was in place at Alston View, which outlined the procedure to follow should people wish to make a complaint. This identified who would deal with their complaint and timescales for expected responses. This policy was incorporated in to the service users' guide, so that people could refer to it whenever they wished to do so. However, it was not displayed within the home to allow those who did not have a copy of the service users' guide to easily access the relevant information. The area manager gave us assurances that this would be displayed.

Inadequate

Is the service well-led?

Our findings

During our first series of visits on 15, 17, 21 and 22 July 2015 we found a number of areas of concern that related to the quality assurance systems operated within the home, and the systems in place to ensure external agencies, such as the Care Quality Commission (CQC), were notified of events such as deaths, and accidents and incidents that adversely affect people's well-being.

The service did not have a registered manager. There was an acting manager in place, who had been appointed in September 2015, and the service provider has given the CQC assurances that in order to fulfil their conditions of registration, the acting manager will be put forward to be registered with the CQC.

When we arrived at the home on 30 September 2015, the area manager welcomed us into the home. The area manager then informed the Registered Provider that we were on site. This is usual practice when unannounced inspections take place. The lead inspector for the service was then asked to speak to the Registered Provider over the telephone regarding our visit. The Registered Provider expressed his unhappiness about our presence at the home. He indicated that he would set off from his home in order to come to Alston View, saying, " When I get there you will be leaving the building. I want to speak to your supervisor. I am very unhappy." The Registered Provider was given the contact details for the CQC compliance manager. Following a conversation with the CQC compliance manager, the Managing Director for the company that operates Alston View, contacted the home, and explained that he was happy for the inspection to go ahead. During the feedback session given to the Managing Director at the end of the inspection on 30 September 2015, the lead inspector for the home was given a verbal apology regarding the behaviour of the Registered Provider earlier in the day. The lead inspector reminded the Managing Director that to intentionally obstruct a person authorised by CQC in course of their duties, to enter and inspect premises is an offence under the Health and Social care Act 2008 under which the commission could take action.

During the visit of 30 September 2015 staff working at the home said that leadership within the service had improved in recent weeks. One person said, "I think the management team was very weak and inconsistent previously, but changes have been made and I feel a lot more supported by the (acting) manager and nursing staff. Staff sickness and absence has decreased and the staff team aren't under as much pressure anymore." Staff told us that communication across the service had improved in recent weeks. They confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that the quality of these handovers had improved and that handovers were now not dependant on the staff on duty as they were in July 2015. This was because the record keeping had improved, and staff were clearly about why handovers were needed. This meant that staff were in a better position to obtain up to date and accurate information about people's on going needs, any new risks and any new ways in which people needed to be supported so as to keep them safe and comfortable.

In July 2015, we found that management record keeping was poor, inconsistent and sometimes not completed. In September 2015, we that that some improvements had been made. However, within the office, information was difficult to find and filing systems and records management systems were ineffective. When information was requested it was obvious that staff were unsure how to locate files, forms and other information.

On 30 September 2015, we found an accident file in place in the office that contained details of the accidents and incidents in the home for 2014. The forms were poorly filled in and it was unclear if any actions were taken as a result of many of the accidents. For example, the forms asked the question, 'Was the accident preventable' and one stated, 'Not really'. One form described an unwitnessed fall which had resulted in several injuries to a person. There were no details of an investigation, any actions taken or outcomes or references to other investigations. We asked where accident and incidents for 2015 were kept and were told there was a new book being used. We found a number of accident and incident forms on top of a filing cabinet in the office. Again there were no actions noted on most of the forms and we saw that different forms were being used so there was an inconsistent approach to how accidents were recorded. We could not find a matrix or index to evidence how accidents or incidents were tracked and dealt with.

On 30 September 2015, we saw evidence that some audits had taken place but some where several years old. For example the last kitchen audit was dated August 2014. The

Is the service well-led?

area manager told us that the kitchen did form part of the infection control audit and we saw that the home had a top rating of five from their latest Food Hygiene review from the local council in February 2015. We were given the latest Infection Control Audit dated 19 July 2015 which was discussed at the previous week's Quality Improvement Planning meeting (QIP) meeting (chaired by the Local Authority) as this was an area which was seen as needing to improve. The audit was comprehensive and contained a detailed action plan with timescales and who was responsible for carrying out each action.

We saw the latest 'Registered Manager Monthly Quality Audit' dated 1/7/15 which was completed by the former acting manager. The audit covered a number of areas such as notifiable events, falls and accidents and recruitment but the information was very limited. The audit highlighted issues but there was no detail or timescales set to resolve the issues brought up by the audit.

Within the office there were three care plan audit sheets on the notice board which showed that three care files had been audited on 17/8/15. None of the care plans were deemed to be adequate and scored 14%, 29% and 30% respectively. The audits only highlighted issues and did not contain remedial actions or timescales.

There was no evidence that legionella testing had been carried out which we questioned with the area manager. We were told that several water samples had been sent off by the maintenance worker and results were being sent back to the home. We queried this with the area manager and proprietor as this method was seen to be unusual. We were told this would be looked into.

These shortfalls showed that the systems in place, in terms of governance to monitor and improve the service provision, were not effective and amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In providing care and treatment of service users the registered provider had not ensured that appropriate governance systems were in place, that could be used to assess, monitor and improve the quality and safety of the service.

The systems used to identify accidents and incidents that then need to be reported to external agencies were not robust. For example, the data relating to the number of deaths at the home in the past 12 months differed across a number of agencies: The CQC, the Local Authority and the Clinical Commissioning Group were all found to hold a different number. It was clear that the service provider had not correctly notified external agencies as required to do so.

This constitutes a breach of Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. The service provider had failed to notify CQC of all the deaths of people who used the service, and of accident and incidents that adversely affected their health and welfare.

The home had an external quality accreditation in place via 'Investors In People' (IIP). The latest IIP certificate was dated 7/4/14.

We saw that there was a relative's notice board in the entrance/reception area of the home which displayed the last relative's meeting notes from 3/9/15, as well as notices asking for volunteers to join a resident and relative committee. There was also a notice letting people know and there were three scheduled visits from a senior member of staff from MPS Care Ltd to discuss any concerns or issues people may have.

The home had a servicing file in place. This was seen to contain up to date servicing certification across a number of areas such as the passenger lift, PAT testing, Fire extinguisher maintenance and hoisting equipment.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **In providing care and treatment of service users the registered provider had not ensured that each person received appropriate person-centered care and treatment. More appropriate individualized activities must be provided.**

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Care and treatment was not provided by way of proper safeguarding training for staff, and the proper operation and scrutiny of safeguarding policies and procedures when meeting needs of the people using the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **In providing care and treatment of service users the registered provider had not provided appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff members to carry out the duties they were employed to perform.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider must make sure that the premises and equipment are properly maintained.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **In providing care and treatment of service users the registered provider had not ensured that appropriate governance systems were in place, that could be used to assess, monitor and improve the quality and safety of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The service provider had failed to notify CQC of all the deaths of people who used the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The service provider had failed to notify CQC of all accident and incidents that adversely affected their health and welfare.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way for service users because medicines were not managed safely and properly.**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.