Alverstoke House Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alverstoke House is a 'Nursing home'. People in nursing homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for 29 people. There were 25 people living at the home at the time of the inspection.

The home was based over two floors, connected by two stairwells. Bedrooms had en suite facilities and there were toilets and bathrooms available on each floor. There was a choice of communal spaces comprising of two communal lounges, a dining room and a conservatory where people were able to socialise.

The inspection was conducted on the 6 and 12 December 2018 and was unannounced. A registered manager was 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.

At this inspection we identified two breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified one breach of Care Quality Commission (Registration) Regulations 2009. You can see at the end of this report the action we have asked to provider to take.

Safeguarding issues were not dealt with effectively to ensure that people were protected from abuse. Where reports of abuse had been raised the provider and the registered manager had failed to take responsive action to investigate concerns.

The management team adapted a staff based culture which resulted in the views and feelings of the staff taking priority over the need to safeguard, protect and consider the needs of the people living at the home.

People were not always involved in the development of the service and their views were not always considered or acted on by the management team. The provider had arrangements in place to deal with complaints, however these arrangements were ineffective and complaints were not always acted on appropriately.

Systems and processes used to monitor the quality and safety of the service had not been fully effective in identifying and preventing the shortfalls found at this inspection.

Staff were not consistently supported in their roles. Systems in place to monitor staff training were ineffective in identifying training that had been received or when it was required to be updated.

Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). Capacity assessments had not been robustly completed for all people as required and those completed were not decision specific.

Individual and environmental risks to people were managed effectively. Risk assessments identified risks to people and provided clear guidance to staff on how risks should be managed and mitigated.

There were enough staff to meet people's needs in a timely way and staff were able to support people in a relaxed and unhurried way. Appropriate recruitment procedures were in place to help ensure only suitable staff were employed.

People received their medicines as prescribed. The home was clean and staff followed best practice guidance to control the risk and spread of infection.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food.

People were supported to maintain good health and had access to appropriate healthcare services when required. Staff were aware of people's health needs understood how people's medical conditions impacted their abilities. There were clear procedures in place to help ensure that people received consistent support when they moved between services.

People were supported to use technology and specialist equipment to meet their care needs and to support their independence where appropriate.

People received personal care in line with their personal preferences. Care files contained detailed information to enable staff to provide care and support in a personalised way. Care and support was planned in partnership with people, their families and healthcare professionals where appropriate.

People received mental and physical stimulation and had access to a range of activities. Staff supported people to meet their cultural and religious needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safeguarding issues were not dealt with effectively to ensure that people were protected from abuse and improper treatment.

Individual and environmental risks to people were managed effectively.

There were enough staff to meet people's needs and recruiting practices helped ensure that all appropriate checks had been completed.

Arrangements were in place for the safe management of medicines and people received their medicines as prescribed.

There were appropriate systems in place to protect people by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not follow legislation designed to protect people's rights and freedom.

Staff were not consistently supported in their roles. Systems in place did not identify where staff had received training or required training updates.

People were supported to eat and drink enough and had access to health professionals and specialists when needed.

When people were transferred to hospital, staff ensured key information accompanied them to help ensure they received ongoing healthcare support.

Some adaptations had been made to make the building supportive of people's needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and told us they were treated with dignity and respect.

Staff understood the importance of respecting people's privacy. Confidential information was kept securely.

Staff supported people to maintain relationships that were important to them.

People's cultural and diversity needs were explored and respected.

Is the service responsive?

Good

The service was responsive.

The provider had arrangements in place to deal with complaints, however these arrangements were ineffective and complaints were not always acted on appropriately.

People received personal care in line with their personal preferences. Care files contained detailed information to enable staff to provide care and support in a personalised way.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate.

Staff responded promptly when people's needs or preferences changed. Staff were kept up to date on people's changing needs.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and the provider had failed to identify allegations of abusive care practice and had not notified CQC of these concerns.

People were not always involved in the development of the service and their views were not always considered or acted on

by the management team.

The systems and processes in place to monitor the quality and safety of the service were not always robust.

There was a management structure in place and staff understood the roles and responsibilities of each person within the team structure.

The service worked in partnership with the local authority, healthcare professionals and social services to help ensure that people received effective care.

The providers were fully engaged in running the service and their vision and values were clear and understood by staff.

Alverstoke House Nursing Home

Detailed findings

Background to this inspection

We carried out this comprehensive 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by safeguarding concerns that had been shared with us by anonymous sources.

This inspection took place on 6 and 12 December 2018 and was unannounced. Day one of the inspection was completed by two inspectors, two specialist advisors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was completed by two inspectors.

Before the inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with ten people living at the home and four family members. We observed care and support being delivered in communal areas of the home. We spoke with the service provider, the registered manager, the deputy manager, two registered nurses, five care staff, the chef, the activities co-ordinator and a member of the housekeeping team.

We looked at care plans and associated records for 12 people, staff duty records, five staff recruitments records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in November 2017 when it was rated as 'Good'.

Requires Improvement

Is the service safe?

Our findings

Safeguarding issues were not dealt with effectively to ensure that people were protected from abuse. For example, the registered manger had received three separate concerns about named members of staff's conduct which included staff shouting at people, people being fearful of some staff members and two staff members' forcibly changing a person's clothes without the person's consent leading to the person becoming distressed and fearful. These issues were discussed with the registered manager, who told us that when the issues were raised with them directly, they spoke with staff member's the allegations were made against. The registered manager confirmed that from their discussions with these staff members, it was clarified that a staff member 'may have been a bit short with the person' and that staff did change the person's clothes without consent. However, the registered manager was unable to provide us with any records of investigations they had completed in relation to the allegations made, or evidence that actions had been taken to prevent this type of abuse reoccurring. The registered manager had also failed to report these issues to CQC or local safeguarding team. Therefore, the management team and staff had failed to ensure people were protected from receiving improper treatment.

Additionally, not all staff had received safeguarding training or had this training updated in a timely way. On discussing safeguarding with staff; three lacked knowledge and awareness of actions to take if they suspected abuse. These staff were also unaware of external organisations, including CQC and the Local Authority, whom they could go to for additional support. We notified the local safeguarding team about our concerns.

The failure to protect people from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People told us and indicated they felt safe. One person said, "Yes, of course it's safe here. If it wasn't I wouldn't be here." Another person said, "Yes, I feel safe because there's always somebody around and I can ask if I need help." A family member told us, "Most definitely I know he's safe here because I've been watching them for a year. I've watched the way they handle [name]."

Individual risks to people were managed effectively. Risk assessments had been completed and identified possible triggers and actions staff needed to take to reduce the risks. For example, where people may behave in a way that might present a risk to the person or others, the behaviours and triggers had been identified and these were clearly understood by staff. People who were at risk of malnutrition and dehydration had clear and up to date information within their risk assessment of how this should be monitored and managed by staff. This included information about their likes and dislikes of certain food and the implementation of food and fluid charts, so that their intake could be closely monitored. Where people were at risk of falling, this was clearly documented in their care plan and risk assessment. Other risks were monitored and managed and risk assessments in place included moving and positioning, skin integrity, medicines management, the use of oxygen therapy and the risk posed by the use of catheters.

There were safe recruitment procedures in place, which included seeking references, obtaining a full

employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed appropriately before new staff started working with people.

People and their families told us that there were sufficient staff to meet their needs. They said that when they needed staff, they were able to get help quickly. One person said, "They're about on a level. If you want anything you just have to press the button and usually it's only a matter of minutes before someone comes along." Another person told us, "It depends on what times of day it is. Sometimes they shoot in when I press the bell and are here in less than a minute, sometimes it's five or 10 minutes – let's see what happens when I press it." This person then pressed their call bell and were attended to by a staff member within approximately 40 seconds. A family member said, "Some days the numbers are down but on the whole they tread the fine line well. There's never been a time that the care the patients get has suffered." Another family member told us, "They sometimes seem a little thin on the ground but I've certainly not seen any lack of care. The call bells are usually very quick, or probably no more than 10 minutes."

We found that staffing levels in the home were sufficient to meet the needs of the people and provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, bank staff and agency staff.

People received their medicines safely. People told us they were happy with the way their medicines were managed. A person said, "The nurse does it [provide medicine] and that's the way I want it." Another person told us, "The nurse helps me with my eye drops and puts those in twice a day." A family member told us how their relative had been supported by staff to get their medicines in liquid form due to their reluctance to take their medicine and their difficulty in swallowing tablets.

Medicines were administered by staff who had received appropriate training and had their competence to safely administer medicines assessed. We observed medicines to be administered in a safe, dignified and respectful way to people. A medicines profile had been completed for each person. This showed any allergies to medicines and the person's preference in taking their medicines. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR chart no gaps were identified, this indicated that people received their medicines appropriately.

There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely. Full stock checks of medicines were completed monthly to help ensure they were always available to people. Controlled drugs were stored in accordance with legal requirements and there were auditing systems in place to ensure that all medicines were given as prescribed and managed safely. Safe systems were in place for people who had been prescribed topical creams.

The home was clean and systems were in place to ensure that all areas and equipment were cleaned on a regular basis. Cleaning schedules were in place for each area of the home and staff completed check sheets to show they had undertaken cleaning in accordance with the schedules, which we saw were up to date.

People and their family members also confirmed that the home was clean. Comments included, "It's very clean and tidy. They do a very good laundry service, very quick turnaround", "I've no complaints. My room is done every day", "It's the first thing I noticed when I came in here – no smell – and how clean it all is" and "It's very clean, everywhere. I've not really smelt any odours that hang around for long."

There were processes in place to manage the risk of infection and personal protective equipment (PPE) was available throughout all areas of the home. Staff were seen to be wearing gloves and aprons when appropriate. The laundry room was clean, organised and measures had been taken to ensure the risk of infection was minimised. For example, there was a dirty to clean flow for laundry, which helped to prevent cross contamination. We looked at records of infection control audits which were completed regularly by the registered manager. However, we found that where a reoccurring concern had been noted within these audits, actions taken by the registered manager and provider in relation to this had failed to mitigate these ongoing concern. This was discussed with the registered manager and provider on day one of the inspection. By day two of the inspection, the provider and registered manager informed us that action had now been taking that fully addressed these concerns.

Equipment such as hoists and lifts were serviced and checked regularly. Environmental risk assessments and general audit checks of the building were done regularly and health and safety audits were completed. There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff did not always follow the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We found that some people living at the home had a cognitive impairment and were not able to give valid consent for certain decisions. However, capacity assessments had not been robustly completed for all people when required and those completed were not decision specific or consistent. Additionally, detailed records of best interest decisions made were not in place to demonstrate why, how, or when the decision had been made, who had been involved in making the decision and what else had been considered. This was discussed with the registered manager on day one of the inspection. By day two, we found that capacity assessments had been fully completed for all people, and the registered manager was in the process of ensuring that best interest decisions were made following the legal requirements of the MCA. The registered manager also advised that going forward, MCA assessments and best interest decisions would be recorded in the same manner to ensure consistency and minimise confusion.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and where appropriate, DoLS applications had been made.

Staff had not always received an effective induction into their role. Staff inductions were not always completed consistently. Inductions are necessary to enable staff to meet the needs of the people they support and to provide new staff the opportunity to compete any essential training required. Staff did not always follow the provider's induction process. Therefore, the provider could not be assured that staff had the skills and knowledge to meet people's needs. By day two of the inspection, we found that the induction process had been reviewed; inductions were being completed where required and new induction packs had been formulated for different staff roles, including housekeeping staff.

People told us they felt staff were competent and well trained. People's comments included, "They know what they're doing", "They definitely know what they're doing. There's lots of training going on" and "The nurses will always answer medical questions. I think they know what they're doing and are experienced." Staff also felt they received appropriate training. A staff member told us, "I'm taking on extra training courses. I asked [trainer] if I could do them all, which she provided me with. She sat down with me and went through all of the ones that were available."

The provider had an electronic system in place to record the training that staff had completed. This included essential training, such as medicines management, safeguarding adults, fire safety, infection control,

moving and handling, MCA and DoLS and first aid. On viewing staff's individual training records, gaps were identified which demonstrated that not all staff had received training or training updates in a timely way. In addition, the system used to record training needs of staff was not robust and did not allow training requirements to be easily identified. These concerns were discussed with the registered manager on day one of the inspection. By day two of the inspection, additional training had been arranged as required.

Staff said that they felt well supported by the registered manager and told us that they received one-to-one sessions of supervision. Supervision sessions should provide an opportunity for a manager to meet with staff, discuss their training needs, identify any concerns, and offer support. However, on viewing staff supervision records, we found that issues discussed during supervisions was very limited; mainly focused on staff conflicts and did not always show that discussions about staff performance and training needs or interests were discussed. The registered manager acknowledged that more information was needed to help ensure staff support and development needs were identified and met effectively, and agreed to look into a more structured approach to supervisions. Staff who had worked at the home for over a year had also received an annual appraisal with one of the management team, to assess their performance.

People were complementary about the food provided. One person described the food as; "Marvellous, lovely." This person also told us that when they had to attend a hospital appointment they were given a bag meal to take with them; they said, "I couldn't believe that they would do that." Another person told us, "On the whole I find it [food] very good." A family member said, "The food is amazing." Another family member told us, "The food is alright. We're allowed to bring food in, [name] likes mature cheddar cheese so I bring that in and it goes in the fridge in the kitchen."

People were given a choice between three set options at meal times and alternative snacks such as soups and sandwiches were also available on request. Mealtimes were a social experience and people were able to eat in the dining room or their bedroom, depending on their needs and preferences. Where people required assistance to eat or cut up their food, this was provided promptly in a patient and supportive way. Some people had also been supported to use special cutlery and crockery to aid their independence at mealtimes. Throughout the inspection, we saw that people were offered hot and cold drinks and staff prompted people to drink regularly. People confirmed that they were able to have drinks and snacks in the evening or night if they wished. One person said, "There's plenty of food, the portions are very generous. They're always coming around with tea, biscuits, fruit and cake." Another person told us, "I think everybody puts on weight when they come in here. There's no way I would ever be hungry."

When new people moved into the service, important information such as people's allergies was passed to the chef, in addition to people's likes or dislikes. For example, we saw information in the kitchen about whether people liked any extras with their meals or whether they preferred white or brown bread. Where people had been identified as having particular dietary requirements, including soft textured diets, this was clearly documented in people's care plans and on a noticeboard within the kitchen to remind staff. We spoke with a chef who was aware of people's individual dietary requirements and explained what action they would take if people were losing weight.

Staff recorded people's food and fluid intake for those who were at risk of malnutrition and dehydration. We found that these records were fully completed and reviewed to ensure that people had received adequate amounts of food and fluids. We saw that action had been taken when people were identified as suffering from unplanned weight loss.

Information in relation to people's health needs and how these should be managed was clearly documented within people's care plans. People's general health was monitored and they were referred to

doctors and other healthcare specialists when required. Nursing and care staff described how they supported people, which reflected the information in people's care plans and risk assessments. People were seen regularly by doctors, opticians and chiropodists as required. Alverstoke House had equipment suited to the needs of people living there. This included individual equipment where necessary such as hoists, mobility equipment and equipment to provide oxygen therapy. A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate people's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess a person's risk of developing pressure injuries and to monitor their bowel movements.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. The registered manager told us that they used the 'Red Bag Pathway.' The Red Bag Pathway helps ensure that all standardised paperwork, medication and personal belongings are kept together throughout a person's hospital stay and are returned home with them. The standardised paperwork ensured that everyone involved in the care for the person had the necessary information about their general health, current concerns, social information, abilities and level of assistance required. This allowed person centred care to be provided consistently.

Staff made appropriate use of technology to support people. Staff could view people's care plans on hand-held computers, on which they also recorded the care and support they delivered. This helped ensure people's records were up to date. Special pressure-relieving mattresses had been provided to support people at risk of pressure injuries and a system was in place to help ensure they remained at the right setting. In addition, an electronic call bell system allowed people to call for assistance when needed.

Some adaptions had been made to the home to support the needs of the people living there. A passenger lift gave access to the first floor and most bedrooms had en-suite facilities. There were toilets and bathrooms available on each floor. There was a choice of communal spaces comprising of two communal lounges, a dining room and a conservatory where people were able to socialise. Bedrooms were decorated with people's personal possessions and photos. There were handrails available in most communal areas of the home. However, one communal corridor had no handrails in place and handrails that were in place were not of contrasting colours to walls. This meant that these did not stand out and could result in people with mobility needs and sight impairments failing to identify or use these for support. This was discussed with the registered manager who agreed to raise this with the provider, so that actions could be taken to ensure that handrails stood out.

Good

Is the service caring?

Our findings

Most people and their families spoke highly of the staff and described them as kind and caring. A person said, "The staff are great. Very punctual, kind, and they really do care. I get on with them very well. They call me by my name and are always asking me if I'm alright or if I need anything." Another person told us, "The staff are all wonderful and really helpful." A family member said, "The staff are just wonderful. They just go the extra mile."

Throughout the inspection we saw people being treated with dignity and respect. Staff spoke with people in a kind and caring way. For example, when a staff member answered a person's call bell, we heard them say; "It's okay, I'm here, what's wrong [name]?" The staff member then lowered himself down, gave a light touch on the hand of the person and said; "Just as long as you're okay, that's fine." We observed another staff member support a person to eat; the staff member and the person were chatting away like old friends about families and the trials of bringing up children. On a third occasion, a staff member brought a meal to a person and said; ''Here we are, lunch, chicken chasseur, what do you think?" The person asked the staff member what chicken chasseur was and they replied, "It's French for something, chicken stew to you and me" and we saw the person had a good laugh.

People told us that their privacy was respected when they were supported with personal care. A person said, "Nobody comes into my room without knocking first." They added, "They [staff] sort the bath out for me and help me get in, then they go away and let me have a soak and wash myself and I press the button and they'll help me out." Another person told us, "I'm happy with the way I'm treated." Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. A staff member told us, "I would always make sure the person is covered. I would explain what I am doing and also ask them if they would like me to wait outside the room while they are doing specific personal tasks." We observed staff knocking on doors, and asking people's permission before entering their bedrooms.

Confidential information in relation to people living at the home; such as care records, were kept in the manager's office and only accessed by staff authorised to view it. Before the inspection, concerns had been raised in relation to the storing of confidential staff information and this was discussed with the registered manager and provider. The provider acknowledged that these concerns had been highlighted to them prior to the inspection and explained that new storage arrangements for confidential staff information had been implemented. Any information which was kept on the computer was also secure and password protected.

People were supported to maintain friendships and important relationships; their care records included details of the people who were important to them. People told us how their friends and family visited them at the home and were made to feel welcome. A family member said, "They make visitors very welcome. I've been told 'Make the kitchen your own' because I'm in almost every day." Another family member told us, "I've been here a few times and I've always been made to feel very welcome."

The registered manager explored people's cultural and diversity needs during pre-admission assessments

and in casual conversations as they got to know the person. People's specific needs were recorded in their care plans. This included people's faith needs and whether they preferred male or female staff to support them with personal care. Further information gave staff an insight into the person's interests, background and relationships that were important to them.

Good

Is the service responsive?

Our findings

The provider had arrangements in place to deal with complaints. The provider told us they had received two formal complaints since the last inspection; one from a family member and one from a member of staff. However, on reviewing the complaint records, we found that the issues and concerns raised by the staff member were not fully investigated and the complaint was not taken seriously. This complaint noted concerns about some staff members' conduct and safeguarding concerns; yet no formal investigations had been completed. Additionally, a response from a person in relation to complaints within the resident's survey completed in September 2018 said, 'I feel that my complaint is not taken correctly and the [management] side with the staff.' The management of complaints was discussed with the registered manager and the provider who acknowledged that past actions taken had not been robust and agreed to review their complaints procedure.

People's care plans contained person-centred information about their individual needs and how people wanted their needs to be met. Information within care plans included detailed guidance for staff as to how best to support people. This included, people's personal history; likes and dislikes, and hobbies and interests. The care plans were divided into sections for each area of care, along with an action plan to meet people's needs. For example, one section describing a person's night care needs stated, 'I usually like to settle for the night at approximately 8:30 after a hot drink.' Another person's behaviour care plan stated, 'If [person] is agitated, allow them time and space.' These records helped to ensure that people received the care they required in line with their needs, wishes and preferences. During the inspection we saw that care was provided in line with this information. People's care plans were reviewed regularly by the registered manager or deputy manager, or a member of the nursing staff to ensure that information remained relevant and correct.

Staff demonstrated a good awareness of the individual support needs of each person living at the home. For example, people who needed to be encouraged to drink, the support each person needed with their continence and where people liked to spend their day.

Staff promoted choice and respected people's autonomy by empowering them to be independent. We heard people being offered choices throughout the inspection. For example, we heard a staff member asking a person if they would like some assistance to eat and waited for them to consent before providing support in a relaxed way." A staff member told us, "One resident is a little unsteady on her feet, so I assist her to the washbasin where she is happy to wash herself once she's there. I stay in the room so she has nothing to worry about." This staff member added, "When I help another person wash, they always like to do their hands and face, so I encourage them to keep doing that." A person told us, "I do what I can for myself." We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their own pace.

The service was responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals. People's care plans also contained detailed information for staff about what actions were required if people's needs changed. Staff

were kept up to date on people's changing needs through verbal handover meetings, which were held in between shifts. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

The service had considered people's individual communication needs to ensure they received information in a way that they understood. People had a 'communication care plan' in place to guide staff on the best way to speak with people or present them with information. For example, one person's care plan contained clear information for staff about a condition which affected the person's ability to communicate and how this impacted on their day to day life. Another care plan stated, 'When communicating with [person] staff are to ensure they are looking at [person] and to minimise background noise.' The registered manager told us that when required, written information would be made available to people in an easy read or pictorial format, or arrangements were made to read important information to a person.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate. The registered manager and deputy manager completed assessments of people's needs before they moved into the home, to ensure they could be appropriately met. People and their family members told us that they were involved in their or their relatives care. A family member told us, "I have Power of Attorney so am fully involved in reviews of care." Family members also confirmed that they were kept informed of any changes in their loved one's needs, both face to face or via telephone contact.

People were provided with a wide range of activities to ensure appropriate mental and physical stimulation. There was an activities co-ordinator employed by the service, who was responsible for organising activities and events. A weekly timetable of activities was on display in a communal area of the service and this included activities such as games, music, baking, exercises and crafts. A family member told us, "Since [name of activities coordinator] took over the activities there are all sorts of things going on now." People were also encouraged to take part in a range of events within the local community. For example, during the inspection, some people were supported to attend a local Christmas festival in the community. The service had also made links with local schools and churches in the community and the activities co-ordinator spoke with us about a mother and baby group they had started to host within the service. They told us, "I really want to promote intergenerational interaction. It is amazing to see how they engage with each other." The service had worked hard to organise and hold regular 'theme days' throughout the year. For example, we looked at pictures of a past 'summer seaside' theme day, where people's relatives and friends had been invited to join.

At the time of the inspection no one living at Alverstoke House was receiving end of life care. However, the registered manager and staff were able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Some staff had received training in end of life care and demonstrated that they understood this. Some people's care plans contained information about people's individual end of life wishes. This included information about where the person wanted to be at the time of their death and how they wished their body to be cared for.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at Alverstoke House and felt it was well run. One person said, "I think it is well run, the manager is good." Another person told us, "I think she [the registered manager] is very effective."

Although people were happy at the home, we found that the provider and registered manager did not have effective systems and processes in place to ensure that people were safe and well cared for. For example, where allegations of abuse to people were made against two staff members, effective and appropriate action was not taken. Additionally, the registered manager and provider had not reported the allegations to appropriate organisations.

People were not always involved in the development of the service and their views were not always considered or acted on by the management team. For example, feedback from people was gained through the use of residents' questionnaires which were sent six monthly, however we found that action was not always taken in relation to responses. The last questionnaire completed in September 2018 highlighted that of the nine responses received; three people felt that they were not involved in decisions about the home and two people felt they were not getting appropriate food. The provider had noted most of these concerns, but no action had been taken to address them. Furthermore, for the questionnaire completed prior to the one in September; the three people who completed this all said that they felt that they were not involved in decisions about the home. At the time of the inspection, the provider confirmed that no action had been taken following these responses. Following the inspection, information was received which showed that all areas highlighted within the feedback surveys had been acted on. Additionally, a plan had been put in place to have regular resident meetings and for a member of the management team to talk to people on a one to one basis once a month, to gain their views and concerns.

The management team adopted a staff focused culture which resulted in the views and feelings of some staff taking priority over the need to safeguard, protect and consider the needs of the people living at the home. For example, when concerns had been raised about staff practices by other staff members and people, these were often dismissed by the management team. When we discussed this with the registered manager, they defended the staff members that concerns had been raised about and said, "They have worked here for years, they are very good; I don't believe they would shout at people." This further evidenced that where people raised concerns with management, these were not always taken seriously.

The provider had a programme of audits and quality checks in place which were completed by the provider and registered manager. Regular audits had been completed of the environment, medicines, health and safety and infection control. Where concerns were identified action plans were produced. However, we found that effective action was not always taken in a timely way. For example, as highlighted within the safe domain; infection control audits continued to highlight the same issues as actions implemented to address this were ineffective. Additionally, there was no clear auditing process in place to ensure that staff received appropriate supervision; training record audits had failed to identify the gaps in staff training and the lack of information within people's records in relation to MCA assessments and best interest decisions had not

been identified. These issues were discussed with registered manager and provider who acknowledged the shortfalls in these areas and agreed to review and update the current documentation and processes. Following the inspection information was received from the provider which highlighted that actions for the above issues were underway.

The failure to effectively assess, monitor and improve the quality and safety of services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered 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 and associated Regulations about how the service is run. At the time of the inspection, the management structure of the home consisted of the provider, a registered manager, a deputy manager, head of care, registered nurses and senior care staff. Staff understood the role each member played within this structure.

People and family members spoke positively about the management team. A person said, "[Name of manager] is a very good manager. Nothing is too much trouble. She always has time to speak if I need to." A family member told us, "The manager is very warm and compassionate. She has told me her door is always open if I need to speak to her."

During the inspection staff members spoken with were also positive about the registered manager. A staff member told us, "She's a good boss. I've never had an issue that I haven't been able to go to her for." Another staff member said, "She is really approachable. She is always welcoming to have a chat." A third staff member said, "She does well for the amount of pressure she's under." When staff were asked about teamworking, their comments included; "We work well as a team. For the most part we all get along with everyone. When it comes to the residents, you would never know if there was a problem between us [staff]", "The registered manager tries her hardest to deal with it [conflict between staff], certain staff don't want to listen, but it's not through a lack of her trying" and "In an all-female environment, it doesn't always run smoothly, but the registered manager sorts it." When we discussed the staff conflicts with the registered manager and the provider, and how this could impact on the care provided to people, they confirmed that there had been some longstanding issues in relation to this. They further commented they had implemented more regular staff meetings and spot checks to try and address these issues.

The provider was engaged in running the service and their vision and values centred on, 'Providing people with a happy, homely environment to live in where they received individualised, effective care.' Staff were aware of the provider's vision and values and how this related to their work. Staff meetings provided the opportunity for the provider and registered manager to engage with staff and reinforce the vision and values. The provider visited the home throughout the week to oversee the running of the service.

The service worked in partnership with the local authority, healthcare professionals and social services to help ensure that people received effective care. The registered manager also told us that they made active attempts to involve people in the local community. For example, during the inspection, some people were supported to attend a local Christmas tree festival in the local church and the home had participated in this by showcasing a tree decorated by the people living at the home.

The registered manager reviewed accidents and incidents that occurred in the home weekly to identify any patterns or trends and they described the action they would take if a common theme emerged. The homes fall audit had highlighted that one person had experienced an increased number of falls; this had resulted in staff considering preventative measures, which were implemented and a referral to healthcare professionals

had been made to help establish the reason for the falls.

Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The registered manager was able to describe to us their responsibilities as a registered person and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. However, this had not happened in the case of the the three safeguarding concerns raised as highlighted within the safe domain of this report. We discussed the failure to notify the CQC of these events and the registered manager recognised that this should have happened. The rating from the previous inspection report was displayed in the home and on the provider's website.

The failure to notify CQC of incidents which occur whilst services are being provided was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission about statutorily notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager failed to protect people from abuse and improper treatment.

The enforcement action we took:

We have told the provider they must make improvements.