Homestead Homes Limited

# Alphington Lodge Residential Home

## Inspection report

1 St Michaels Close
Alphington
Exeter
Devon
EX2 8XH

Tel: 01392216352
Website: www.Alphingtonlodge.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection was unannounced and took place on 21 February 2017. The inspection was carried out by two inspectors. The service provides accommodation and personal care for up to 28 older people. At the time of this inspection there were 22 people living there.

There is a registered manager in post. At the time of this inspection the registered manager also managed another home another home owned by the providers and split their working week between the two homes. A trainee manager was employed on a full time basis to support the registered manager. 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 last inspection of the home took place on 12 and 15 January 2016 when the service was rated as 'requires improvement'. There was one breach of Regulation 12 of the Health and Social Care Act: Safe care and treatment. We found that risks to people's health and safety were not managed effectively, some aspects of medicine administration and recording were potentially unsafe, and daily reports did not always show that care had been carried out in accordance with each person's agreed plan. We also found that safe recruitment procedures had not always been followed. We recommended the provider looked at guidance and best practice in respect of quality monitoring and audits to ensure these were used effectively to improve the quality of care and support. At this inspection we found these issues had not been fully addressed. We also found further breaches of regulations.

Before this inspection we received concerns from a number of sources relating to various issues including low staffing numbers and allegations that incidents of abuse had been reported to a member of the management team but had not been investigated or acted upon. We passed these allegations of abuse to the local authority safeguarding team for investigation and we heard shortly afterwards that a member of staff had been dismissed for poor conduct during handover sessions. However, during this inspection we found that the provider had not carried out any further investigations into the alleged abuse to find out why the matters had not been taken seriously as soon as they had been reported. This meant the provider had failed identify failings in their safeguarding systems or take actions to improve them. The local authority safeguarding team also shared with us further concerns they had received and investigated, including concerns about end of life care, prevention of pressure sores, and the prevention and management of falls.

Before this inspection we had passed concerns relating to low staffing levels to the provider. We asked them to investigate the concerns and to provide evidence to show how they determined safe staffing levels, which they did promptly. They told us they had increased the staffing levels as a result of their findings. At the time of this inspection they were in the process of recruiting new staff. However, we found staff rotas had at times been poorly managed. Staff rotas for the week of our inspection showed unfilled shifts leaving short notice to obtain cover from agency staff or from the existing staff team. We heard of recent occasions when staff

had arrived on duty to find shifts had not been covered, leaving them short staffed. When this had occurred staff told us they had managed to complete all essential tasks, but it had been difficult.

Before the inspection some staff told us they did not always feel well supported. Staff meetings had been held in recent weeks to enable staff to raise concerns and issues and some staff told us they felt things were improving. However, professionals who visited the home regularly told us that communication systems were sometimes poor resulting in messages not always being passed on or acted upon.

While most medicines were stored, administered and recorded safely we found records of creams and lotions contained unexplained gaps. This meant there was insufficient evidence to show that staff had followed instructions issued by medical professionals for the prevention or treatment of skin problems such as pressure sores. At the time of this inspection one person was suffering from a pressure sore. After the inspection we received information to show they had taken prompt action to address this concern.

The provider had failed to fully address issues found at the last inspection relating to safe recruitment procedures. Their recruitment procedures had improved by ensuring Disclosure and Barring Service checks had been carried out before new staff began working in the service. This ensured the applicant did not have serious criminal convictions and had not been barred from working with vulnerable adults. However, they had failed to ensure they had received references that provided evidence of satisfactory previous employment conduct, or evidence of the applicant's trustworthiness, honesty or suitability for the post. We looked at three recruitment files and found that no references had been obtained for two members of staff, and in one instance the references had not been received until many weeks after they had begun working in the service. The provider amended their recruitment procedures during the inspection and gave us assurances that references will be obtained before new staff are employed in the future.

People's legal rights were not fully respected and protected. Staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) but did not fully understand how this should be applied. Care records contained some evidence that people's capacity to make decisions had been considered. However, the records did not show that the service had assessed people's capacity to make specific decisions in line with the mental capacity act or that a best interest process had been followed

Before this inspection we received concerns relating to poor end of life care. During the inspection we found that staff had not received training on end of life care. There had been poor communication with the local community nursing team which meant that guidance provided by the community nursing team had not always been followed or acted upon promptly.

The provider and registered manager carried out checks and audits to make sure the service was running smoothly. Where they had identified problems they had taken measures to improve the service However, these measures had not been fully effective and had failed to ensure that issues found at the last inspection had been fully addressed.

During our inspection we saw that people were relaxed with staff and enjoyed some laughter and banter. Comments included, "I'm quite happy. The staff are excellent. They always help if they can and are kind, but they've got a lot to see to." "They [staff] always ask if there's anything they can do to help". "A lot of them are really caring, I think they do treat me with respect". A relative told us "We are very happy with (the service)".

We found three breaches of the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been

concluded.

## 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 fully safe.

People were not fully protected from being looked after by unsuitable staff because safe recruitment procedures were not always followed.

Medicines were stored and administered safely.

Staff rotas were poorly managed, which meant there was a risk that at times there may be insufficient staff on duty to meet people's care and support needs.

Risk assessments were completed to ensure people were looked after safely and staff were protected from harm in the work place.

### Is the service effective?

**Requires Improvement**

The service was not fully effective.

People's legal rights were not fully respected and protected because people's capacity to make decisions was not fully assessed.

People received care and support from staff who were well trained, although some staff did not receive regular supervision from senior staff.

People received care and support from staff who understood their personal needs and abilities.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People could not be fully confident they would receive compassionate care at the end of their lives because staff did not have the knowledge or skills needed to meet their needs fully.

People received support from staff who were kind, compassionate and respected people's personal likes and dislikes.

People's privacy and dignity was not always respected. Staff were conscious of the need to maintain confidentiality

People were involved in making decisions about their care and the support they received.

## Is the service responsive?

**Requires Improvement**

The service was not fully responsive.

People's needs were assessed and plans were in place to explain how staff would support them. However, care plan documents were not always detailed, accurate or easy to follow.

People were supported to follow a range of hobbies and activities, although opportunities to go out for a walk or into the community were limited.

People received care and support which was personal to them and took account of their preferences.

Arrangements were in place to deal with people's concerns and complaints

## Is the service well-led?

**Inadequate**

The service was not fully well led.

Management systems were not fully effective. Tasks such as management of staff rotas and monitoring of creams administration records were not always carried out in a timely or efficient way.

Staff did not receive adequate supervision or support from the management team.

There were systems in place to monitor the quality of the service but these had failed to identify or adequately address issues found during this inspection, for example safeguarding processes

# Alphington Lodge Residential Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 21 February 2017 and was unannounced. It was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider also sent us a range of documents and information relating to their recording and monitoring processes and how they monitored the quality of the service.

During the inspection we spoke with the provider, registered manager, deputy manager and six members of staff including the cook and activities organiser. We also spoke with six people using the service and observed lunch in both dining rooms. After the inspection we spoke with one relative and also a number of health and social care professionals and  local authority commissioners.

We looked at records relating to the care of people living in the home including four care plans, medicine administration records, staff recruitment and staff training records. We also looked at records relating to the safety and maintenance of the home including fire safety records.

Requires Improvement

# Is the service safe?

## Our findings

We previously inspected the home on 12 and 15 January 2016 when we found the service was not fully safe. We rated the safety of the service as 'requires improvement'. We found a breach of Regulation 12: Safe care and treatment. This related to inadequate risk assessments, daily records not reflecting the care given to people, and unsafe medicine administration and recording. We found during this inspection improvements had been made to some daily records. There were also some improvements relating to risk assessment records. Medicine audits had been completed; however the provider and registered manager had not identified issues with the recording of application of creams and lotions.

At the last inspection we found the service had not always followed safe procedures when recruiting new staff. The service had failed to carry out Disclosure and Barring Service (DBS) checks before new staff began working there. DBS checks provide evidence that applicants for jobs have not been placed on a national barring list preventing them from working with vulnerable adults. At this inspection we looked at the recruitment files of three staff recruited since the last inspection. We found evidence that DBS checks had been carried out on each new member of staff. However, although references had been applied for, in two instances no references had been received, and for one member of staff the references had been received several weeks after they had begun working in the home. This meant that staff had been employed and were working in the home without references having been received for them. There was no evidence to show that the reference applications had been followed up, or alternative references applied for. They did not have evidence of the applicant's previous work record including any disciplinary procedures that the applicants may have been subject to. It also meant they did not have evidence of the applicant's character or suitability for the posts they had applied for.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed

During the inspection the provider amended their recruitment procedures to ensure adequate references and checks are obtained before new staff began working with people in future.

At the last inspection we found there were some areas of medicine administration that required improvements. Records of medicines administered were not always completed accurately and therefore we could not be confident the medicines had been administered correctly in accordance with the prescriber's instructions. During this inspection we found records of tablets and oral medications were well maintained with no unexplained gaps. However, records of creams and lotions contained unexplained gaps. We also found that creams administration charts did not include body maps to identify the areas where creams should be used. At the time of this inspection two people were suffering from pressure sores. After the inspection we heard from professionals including community nurses and social workers who were concerned that poor communication systems between the senior management team and the community nurses had meant that instructions on changes in creams and equipment such as pressure relieving mattresses had not been acted on promptly. They had also found that creams and lotions had been poorly recorded, which indicated they may not have been applied in accordance with the prescriber's instructions.

After this inspection the local authority safeguarding team carried out a whole service safeguarding review into the care and management of services people received. The areas specifically covered by the investigation included management of risk of falls, managing service users' needs in relation to administration of creams, the management structure of the home, staffing levels, staff training and support, and documentation of care needs. The outcome of the safeguarding review found that actions were being taken to improve systems. This included improvements to the management and recording of creams. While we remained concerned that the provider's quality monitoring systems had failed to identify and address risks relating to administration of creams when this occurred (see Well-led section), information from the safeguarding team showed that these concerns have now been addressed.

Before this inspection we received concerns that not all night staff had received adequate training on administration of medicines. Some people were prescribed medicines that required administration at night. We passed the concerns to the provider who investigated and gave us assurances that in future there would always be at least one member of staff on duty who has received training in safe administration of medicines at all times of the day and night. We were given assurances that all night staff had received training on medicine administration. The provider's recruitment and training policy had been amended to say, 'After (around) one month in the home, carers will be placed on medication training – see in-house medication administration training. This should occur sooner if it is a requirement for work (e.g. night carers)'. Records of staff training provided at the time of this inspection showed that all senior staff and night staff had received training on safe administration of medicines.

Safe systems were in place for the storage and administration of controlled drugs. Where people had been prescribed medicines at the end of their life, to be administered when needed by community nurses, these had been opened and recorded in the controlled drugs book in accordance with current good practice guidance.

People told us staff were "pretty good at giving them their tablets. We observed the senior carer giving people their medicines, and waiting until they had taken them.

A few weeks before this inspection took place we received a number of concerns about insufficient staffing levels both during the day and overnight. Some of the concerns we received included, "The home is under staffed for the majority of the time, some staff having worked 24 hour shifts. Not only is this unacceptable it is also dangerous" and "We are badly short staffed which means residents are not receiving the care they require as we have 4-5 service users who require two staff at all times and it's very difficult to do this when you are short staffed. Staff are also being made to do 18-24 hour shifts and if they say no they are made to feel really bad." We spoke with the provider and the registered manager who agreed to carry out checks and investigations. When their investigations were completed they gave us evidence of their findings and details of the actions they had decided to take. They found that staff were managing to complete tasks, but were often rushed. They told us they would increase the number of care staff in the mornings to four, and from late morning to mid-afternoon there would be three care staff. In the evenings they would increase the number of care staff to four, and overnight they would continue to provide two care staff. On weekdays either the trainee manager or registered manager were on duty. No members of the management team were on duty in the home at weekends, although a member of the management team was available on call. Other staff employed in the home included a cook, a kitchen assistant, two cleaners and an activities person. Ancillary staffing levels were lower at weekends.

During this inspection we looked to see if the actions taken by the provider had resulted in safe staffing levels. On arrival the registered manager was present plus four care staff in the morning. During the day we saw staff were able to respond to call bells promptly and people's needs were met in a timely way. Therefore

we were satisfied that the staffing levels determined by the provider (four care staff am, three care staff late morning to mid-afternoon and four care staff evenings) were sufficient to meet people's needs at the time of this inspection. However, when we looked at the staff rota for the current week we saw that on five nights over the coming week there was only one member of staff allocated, including the day of our inspection. We were concerned that arrangements to cover unfilled shifts had not been carried out in a timely way. This meant there was a risk that cover may not be obtained at short notice. The registered manager told us they were in the process of trying to arrange agency staff to cover the unfilled shifts and by the end of our inspection we were assured that agency staff had been arranged. They were in the process of recruiting new staff.

During the inspection we heard from some staff who were concerned about the way staff rotas were managed. One member of staff told us, "They (a member of the management team) don't get things sorted out properly. For example when they do the rotas they leave us short. It's not acceptable". We heard that on the previous Sunday there had been one senior member of staff, one permanent care staff and one agency staff on duty. This meant staffing levels had been below the agreed number of staff and staff had struggled to carry out all required care tasks. We heard that the use of agency staff caused additional pressures because the permanent staff had to spend time instructing the agency staff on the tasks they were expected to carry out. Staff faced additional pressures at weekends because there was no management presence in the home at weekends. During the inspection the provider told us there was a management 'on-call' system in place. However, on the previous Sunday the senior member of staff on duty had been unable to contact a member of the management team promptly. We discussed the management of staff rotas with the provider who told us that most shifts had been covered, often by permanent members of the staff team who had willingly worked additional hours at short notice. This meant that staffing levels had recently improved and people could be confident there were usually enough staff on duty to meet their needs safely. However, failure to organise staff rotas in a timely way meant there was a risk that some shifts may not always be fully covered, or alternatively that some staff may find themselves working longer shifts at very short notice.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

Staffing levels had been discussed in a staff meeting held in January 2017 and the registered manager told us staff had been positive about the proposed improvements in staffing levels. During the inspection one member of staff told us things were improving, "There are enough staff 99% of the time. We all try and help each other. If one's off sick we will cover. We sometimes use agency staff". Another member of staff said, "Staffing levels have been quite trying in the past". They thought there were now enough staff to keep people safe and meet their needs, although, "It can be quite hard to get it all done. Sometimes at lunchtimes there are two staff and a senior, and mealtimes can be a struggle. I think it's improving now". Another member of staff told us the staff could get everything done when there were enough of them, although sometimes this could be difficult. "You are doing your job to the best of your ability. You can't rush older people".

Most people told us they felt safe. Comments included, "I do feel safe. The staff are nice and most of them are respectful". Another person, new to the home said, "I do feel safe. I've used the call bell quite a bit. They kept checking I was ok, and said if there's anything you want, just ring the bell". However, one person told us, "The night staff don't treat me very well. They call me a liar." Another person told us the previous day they had witnessed a member of staff ignoring a person who had asked them for assistance. We spoke with the registered manager and provider who agreed to investigate these concerns. After the inspection they told us they found no evidence to support these concerns. However, a few weeks before this inspection the provider and registered manager had been aware of some concerns regarding the attitude of one member

of staff during handover sessions. The staff member had resigned after an investigation had been carried out into their conduct during handover sessions.

There were systems in place to manage risks to people's health, safety and well-being and keep people safe. Care plans contained risk assessments which supported staff to recognise people's individual risks and take the action necessary to minimise them and keep people safe. These included mobility and falls, skin integrity, nutrition and hydration. Bowel, food and fluid and turning charts were kept in a file, which staff told us they were conscientious about completing. The senior carer checked they had been completed at the staff handover meeting. Where potential risk of choking had been identified for one person guidance had been sought from speech and language therapists on safe food preparation. Where people required assistance to move using equipment such as hoists, a moving and handling assessment was in place explaining how staff should use the equipment to help the person move safely.

One member of staff told us over the previous 12 months, "More things have been put in place so it's safer for everyone. People will have a pressure mat in their rooms if they need one, and one person now has a call bell watch. It's getting better and better all the time". Another member of staff said "They have put a lot of things in place. There are cameras in the communal areas, although not in bedrooms. There is a screen in the lounge. They can also work to our benefit as it means we can find staff if we don't know where they are". A person told us, "The living conditions are lovely, there's a lot of good in it. There are just a few oddments".

Staff were aware of the service's whistleblowing policy and told us they would feel confident to use it. They knew how to recognise if people were vulnerable to abuse and the action to take to safeguard them.

Staff had a good understanding of the policy and procedures related to managing an accident or incident, telling us they would respond to the emergency bell, calling the senior staff who would call an ambulance if necessary. They would fill in the details in the accident book and complete a risk assessment form. They told us there was a clear policy.

There were systems in place to make sure the premises and equipment were safe for people. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations. The fire log folder contained an evacuation plan, fire maps, fire extinguisher list and a weekly fire maintenance check list last completed on a regular basis. The records also contained a fire safety risk assessment and an up to date personal evacuation plan (PEEP) for each person. Radiators had been covered in bedrooms although not all radiators in communal areas had been covered. The provider agreed to review their risk assessments to consider if covers were necessary in communal areas. Emergency plans, information and contact numbers were in an easily accessible file for staff to use.

All areas of the home appeared clean and well maintained. Checks were carried out regularly by the management team to ensure all maintenance was up to date and all areas were safe. Kitchen staff were up to date with food hygiene and infection prevention training. The latest rating by the Environmental Health department showed the home met all required standards and had been awarded the highest rating.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection of the service on 12 and 15 January 2016 we found people received effective care. This section was rated as 'good'. At this inspection we found some aspects of the care were not fully effective and required improvement.

We found that staff did not have a good understanding of Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) and the best interest process, although they understood the importance of supporting people to make choices and asking for consent before providing support.

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 made on their behalf must be in their best interests and as least restrictive as possible. Care records contained some evidence that people's capacity to make decisions had been considered. However, they did not show that the service had assessed people's capacity to make specific decisions in line with the mental capacity act or that a best interest process had been followed, even when a person's care records described them as having a 'cognitive impairment which affected their memory and ability to weigh up and retain information for complex decisions. This meant there was a risk staff may make decisions for people without knowing if it was in their best interests. During the inspection we spoke with the provider about local resources for mental capacity assessment training, tools, advice and guidance.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

People received care and support from staff who received induction training at the start of their employment to ensure they had the basic skills and understanding to meet the needs of people living in the home. The provider's recruitment and training policy stated that new staff would receive a range of training including induction training at the start of their employment. This included a period of shadowing experienced staff. All new staff were monitored during the first few months of their employment and the probationary period was reviewed after nine months. Those staff who had not previously worked in a care setting received training to enable them to achieve the Care Certificate. This is a nationally accredited induction standard which ensures all new staff achieve a basic comprehensive knowledge and competence in care. We spoke to a member of staff who told us this was their first experience of working in this setting, and they had learnt a lot from shadowing and being mentored by more experienced staff. They had good knowledge of the needs of the people they were supporting, although would have found it helpful to have had more time to read through people's care plans. We discussed this with the provider and registered manager who agreed to facilitate this by ensuring new staff had dedicated time for this task.

A training matrix supplied to us by the provider showed staff had received training on topics including infection control, control of hazardous substances, health and safety, moving and handling, first aid, fire safety, Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS), medication, safeguarding, food

hygiene and food safety. A member of staff we spoke with confirmed they had received training including hoist training, fire safety, first aid and these had been refreshed every 12 months. Training was delivered in a variety of ways including e-learning and in-house training. The in-house training included the use of workbooks, shadowing and observations. Staff were paid for their completion of training and given deadlines for the completion of topics.

Staff had not received training in end of life care. This meant that people could not be confident that staff had the knowledge or skills to meet their needs at the end of their lives. The provider told us they would seek suitable training for staff on this topic.

A member of staff told us they had done a lot of training. They told us people had come in to deliver it and recently there had been a dementia training workshop for staff which "helped our understanding of dementia. All of it refreshes your mind. I've been doing this job for 30 years and it's always good to be refreshed". Another member of staff said the dementia training had been a "real eye opener." It had made them aware of the importance of good communication when supporting people to make choices.

The provider and registered manager told us they aimed to provide one-to-one supervision to staff every six months. However, staff told us they did not have regular documented supervision. Although most felt well supported, some said they would appreciate the opportunity to have formal supervision and feedback. One member of staff said, "All the staff know we can go to the registered manager, even though we don't have regular slots. They talk to us individually and ask if things are OK. I had an appraisal a couple of months ago". They told us they had monthly staff meetings where managers, "ask us how we think things are going and if there are any problems they come out". The provider told us all staff had received an annual appraisal after working for the service for a year.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. People were very positive about the standard of meals provided. Comments included; "It's good food. I'm not fussy. I never leave anything. We have our meals together. It's a sociable time", "I always ask for a small [meal] and I get a small one" and, "The food is beautiful, the chef is marvellous. They always make such beautiful gravy; it's worth stopping here for the food!"

People were offered one main meal at lunchtime with two alternative choices. On the day of the inspection it was beef stew and vegetables. People were complementary about the meal and commented on how tender and easy to eat the meat was. Staff asked people in the morning what their preference would be for lunch. The cook had information displayed in the kitchen recording people's dietary needs, any allergies, likes and dislikes, preferred meal size and whether a high calorie diet is needed. The menus were on a five week rota and discussed with residents during residents' meetings. In addition the service reviewed the menus by distributing questionnaires every six months asking people the foods they liked and disliked and using their responses to develop the next menu.

Any specific dietary needs were understood and catered for, for example, a soft diet or diabetic diet. Care plans showed that people who were nutritionally vulnerable had their weight regularly monitored and there was guidance about the support they needed with food and fluids. For example one person without teeth required a soft diet. People could choose where they wanted to eat their meal, for example in the dining room or in their room. Most people chose to have breakfast in their room.

Everyone in the dining rooms was able to eat independently. Staff were responsive to people's needs, noticing when they needed support, for example asking, "Did you want me to cut up your meat for you?"

People received treatment and advice from health professionals when needed. Care records showed that people had been referred to external health professionals when required. This included a referral to a Community Psychiatric Nurse, who had provided information and strategies about how to safely and effectively support a person with mental health needs. One person had required an assessment from the speech and language therapy team in the past and records showed that advice had been obtained and the person's dietary needs were being met.

Before this inspection community nurses had raised concerns about communication systems in the home. We spoke with the registered manager and provider who told us there was a diary for nurses to record any instructions or requests. There had been an agreement that the diary should be checked daily by the deputy manager or a senior carer and all instructions actioned promptly. However, the nurses had been unable to locate the diary for a number of weeks.  At the time of this inspection the diary had been located by the nurses and was once again being used as a communication tool to ensure staff were aware of any changes in treatment or care.

Requires Improvement

# Is the service caring?

## Our findings

We heard varying opinions about the caring attitude of staff. Most people living in the home and their relatives praised the staff for their caring manner. However, health and social care professionals told us they sometimes witnessed uncaring practice. At times staff were task-focussed, especially when the number of staff on duty was low. Health and social care professionals we spoke with after the inspection said that some staff were very caring, but not all. They said some staff failed to respect people's privacy and dignity, for example by entering rooms without knocking and waiting for the person to respond.

During our inspection we saw that people were relaxed with staff and enjoyed some laughter and banter. Comments included, "I'm quite happy. The staff are excellent. They always help if they can and are kind, but they've got a lot to see to." "They [staff] always ask if there's anything they can do to help". "A lot of them are really caring, I think they do treat me with respect". However, one person told us staff treated them with respect, "more or less. It depends on how you treat them".

A relative we spoke with after the inspection said the staff were always caring. They said the care staff "Have a bit of a 'soft spot' for (the person)" and went on to say "They staff are very friendly, very nice. People are happy and well cared-for."

Staff we spoke with had a caring attitude. One member of staff told us, "This is my first care assistant job. I like helping people, I love it". A relatively new member of staff told us they had worked with different people rather than the same people since they had been there, which meant they could get to know them and how they wanted their support needs to be met. They told us this was important because, "You can recognise if there are changes in the person, and if they're not feeling themselves". They told us it was important to build a trusting relationship with people so that they feel comfortable and can ask for what they want. "This is their home from home".

Staff were respectful, understanding and patient when assisting people. For example, we observed staff helping people to the dinner table. They were gentle and gave clear instructions, supporting people to move independently at their own pace. They recognised when a person was unhappy because a new resident was sitting in their usual chair at the dining table, and offered explanation and reassured the person they could sit in their usual chair at tea time.

Staff were committed to promoting people's independence and supporting them to make choices, and people told us their choices and preferences were respected. For example, one person told us. "I don't go to the lounge or dining room. I don't really join in. I prefer my own company". Another person asked a member of staff if they could find them a large print book to read. They weren't interested in the subject matter of the books the staff member came back with so the member of staff went back to find a more suitable book for the person. A member of staff told us, "I offer a choice of what they'd like to wear. I talk through the routine, don't just take it for granted that they know what I'm doing. I do it that way for everybody, whether they have dementia or not". Care plans described the impact of any cognitive impairment on people's decision making, for example one person was unable to make complex decisions about where and how they wanted

their support provided, but "was able to make daily choices presented to them throughout the day".

Relatives and friends were encouraged to visit and keep in touch with people. One person told us their relatives visited two or three times a week. They told us they were always made to feel welcome and given a cup of tea. Another person told us, "Oh my god they make my family feel so welcome! They have a good laugh. It's hilarious!"

Requires Improvement

# Is the service responsive?

## Our findings

People's social needs were not fully met, although was beginning to improve due to the recent employment of an activities organiser. A 'This is me' document provided information about the person's preferences, cultural and family background and significant events, places and people in their lives. This document should have supported staff to provide person-centred care in accordance with the person's individual wishes and needs, even if the person was unable to verbalise this themselves. People were offered a range of activities, although these did not always suit their interests and preferences. Information gathered in the 'This is me' documents had not been used to help the staff support people to participate in activities of their choice. An activities organiser had been recently been employed to provide activities at the home for two hours in the afternoon, four days a week. The activities programme was displayed in communal areas and included the hairdresser, tuck shop, hoopla, musical bingo, quizzes and art. During the inspection people were enjoying a singing session. The activities organiser also visited people in their rooms if they were unable to come down to the lounge, and spent time with them doing a range of activities including reading, chatting or looking through a 'reminiscence book' which contained 'snapshots from history'. One person enjoyed singing hymns or reading the gospel. The activities organiser told us, "The activities are very individual".

The activity programme referred to daily walks, but these were not taking place, and several people told us they wished they could go out. One person said, "I'd like to go out more. I don't go out at all. I would like someone to take me out". We spoke with the registered manager who told us that during warmer weather people were able to go outside in the garden or in the local area but at the time of the inspection cold weather meant that there were limited opportunities for staff to take people out. They also told us the activities organiser had only recently been appointed to the role and was "finding their feet" but they were confident that individual requests such as going out for walks would be accommodated in the near future.

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Care plans contained information about people's risks, emotional and physical support needs. We looked at four care plans and found they covered all areas of each person's care and support needs. We found the information was not always easy to locate, although when we spoke with a member of staff who knew the person and the care plans well they were able to locate the relevant information and describe the person's care needs. However, after the inspection we heard that social care professionals who had recently carried out reviews of people's care needs found some care plans were badly organised and information was not always easy to follow. We also heard that some information such as records of falls had been duplicated, making it difficult to find out from the care plans how staff had responded after the falls, and any changes to the care plans as a result.

Care plans had been regularly reviewed. The review documents had been signed by the person to show they agreed to the support being provided. There was also information about people's end of life wishes. There was clear guidance for staff about how the person should be supported, for example, "leave walking stick or frame next to [person's name]". Risks were reviewed monthly. However one person, relatively new to the service told us, "Nobody has spoken about a care plan". This was discussed with the provider and

registered manager who told us people were involved if they wished to be. They showed us records that demonstrated people had the opportunity to discuss their support with their key worker every week and have their views recorded. The records showed that staff had given people the opportunity to be involved in their care plan reviews, and their responses were recorded. Family members were also invited to be involved and consulted in the care planning and review process.

One person told us how quickly the service had responded to their request for a bath after a stay in hospital. They said "It was heaven!" They had been told they could have a regular bath or a shower if they wanted it. Care plans recorded people's bathing or showering preferences.

At the end of every shift a handover meeting took place to ensure information was passed on to the incoming shift about any changes in people's needs and preferences. For example at the meeting a member of staff reported one person preferred to have a wash than a bath. The senior carer asked them to write this information down in the persons care plan. Staff also reported if people were feeling unwell and needed closer monitoring.

We looked around the home and saw that bedrooms were personalised with photos and ornaments. People were encouraged to bring items of furniture and personal effects to make their rooms feel homely. One person who was new to the service told us their heart had 'sunk', when they first arrived and saw their empty room. They spoke with the manager who immediately acted to provide the items requested.

People told us they would feel able to raise complaints and concerns if necessary. One person said, "We're so pleased with all we've got. We don't have to ask for much". The home had received six formal complaints which had been investigated by the provider and actions taken to address them. Before this inspection we also heard that a relative had raised concerns with the local safeguarding team, and with Alphington Lodge management team, about a number of issues including poor lighting in a person's room, furniture not secured safely to the wall, and staff failing to follow instructions by a medical professional after the person had received hospital treatment. The provider had investigated the concerns promptly when the relative brought the matters to their attention, and took actions to address them. The relative was satisfied with the outcome.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection of the home on 12 and 15 January 2016 we found the service was not fully well-led. We rated the management of the service as 'requires improvement'. We recommended the provider looked at guidance on quality monitoring and audits to ensure these were used effectively to improve the quality of care and support. During this inspection we found the provider's and registered manager's system to assess and monitor the quality of services to people had not improved. Health and social care professionals, and some staff, told us they lacked confidence in the management of the home.

During this inspection we found that the actions taken by the provider following the last inspection had been reactive and only partially effective. For example, in response to the last inspection, the provider had introduced a tracking system to monitor people's falls to ensure any actions necessary to reduce the risk of further falls was in place. However, before this inspection we heard from health and social care professionals who were concerned that the home had failed to adequately investigate falls, seek medical advice and treatment promptly, and put in place any control measures necessary to reduce the risk of further falls or injury. This indicated that the monitoring systems for falls were not fully effective.

In addition, the provider had failed to recognise, in a timely manner, that the current management arrangements were not effective. The provider and registered manager did not have a robust oversight of the service which had led to a number of failings in the home. These failings should have been addressed by having good management systems. For example, failure to organise staff rotas in a timely way meant there was a risk that some shifts may not always be fully covered, or alternatively that some staff may find themselves working longer shifts at very short notice.. There was no management presence in the home at weekends, although there was an on-call system. Staff could call for advice and support from a member of the management team, although we heard that on one occasion staff were unable to contact a manager promptly when needed. The governance arrangements around administration of creams and lotions failed to ensure safe practices were always followed. People's rights were not fully protected because the registered manager and provider had failed to ensure staff used appropriate legislation designed to protect people's rights. There was no system for supervising staff in an organised way and in a way that ensured they could monitor staff performance. Staff training on end of life care did not ensure they could support people in a safe way. The provider had failed to ensure staff treated people with dignity and respect at all times.

Before this inspection we heard that staff had raised concerns with a member of the management team about a member of staff. We were told "It has been reported to (a member of the management team) that a member of the night staff is extremely heavy handed and verbally abusive to residents, often reducing residents to tears and afraid to use their call bells whilst she is on shift." We were also told "A member of night staff (name) has been verbally abusing residents, and myself and every other member of staff has reported this to our manager and one member of staff actually wrote a letter of concern due to the verbal abuse. But our manager seems to brush it under the carpet." The matter was passed to the local authority for investigation and was thought to be resolved by a staff member being dismissed for a different reason. However, the provider had failed to investigate the actual allegations of abuse. This meant they had not

followed their safeguarding processes.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

When the provider purchased the home in 2015 they initially appointed a registered manager on a part-time basis until a full time manager was appointed. The registered manager also managed another home owned by the provider. At the last inspection a new full time manager had been appointed and was in post but they had not yet registered with the CQC, however, this person left soon after the inspection. A senior care staff member had been promoted to trainee manager, while the registered manager continued to oversee the management of the home on a part-time basis.

Most people we spoke with including staff, relatives and professionals were positive about the registered manager. A member of staff told us, "They are brilliant. If there is a problem they sort it really fast. They are approachable and easy to talk to. If I have a problem I can still contact them even if they are working in the providers other home." Another member of staff said, "I feel well supported by the registered manager. They come around now and again and ask if there are any queries". However, other staff raised concerns about the management of the home when the registered manager was not present. They told us they had raised concerns with the deputy manager but these had not been addressed. For example, a member of staff told us "I have spoken to the (trainee) manager about (staffing concerns) several times as has many other staff and she always says "it's in hand" and never seems to change." At weekends when staff were unexpectedly off sick, or when staff had arrived to find the rotas had not been fully covered resulting in the home being short-staffed, staff had been unable to contact the deputy manager for support. One person living in the home told us they hadn't met the registered manager and didn't know who they were. We spoke with the provider who assured us the registered manager would be present in the home on a full time basis for the following month to enable them to review the management arrangements and take any actions necessary.

There were some monitoring systems to ensure people received safe care. This included monthly checks to review the risk of falls, and the risk of malnutrition. Where people had fallen these were monitored using a tracking system to consider any trends and any further action needed to reduce the risk of further falls. A falls management plan was put in place and reviewed regularly. However, some documents within care plans, including risks such as falls were not always detailed, accurate or easy to follow. There were also daily checklists completed by staff to confirm they can checked people's rooms for risks such as light bulbs not working, any trip hazards, and staff to check that people's glasses are clean, hearing aids in place (where required) and they are wearing safe footwear.

Daily monitoring systems were in place to ensure staff followed safe and hygiene practice. Records showed staff had been observed on a daily basis to ensure they used protective equipment such as gloves and aprons correctly, and to ensure they followed good hand washing practice before and after entering bedrooms. There were also weekly checks carried out and recorded to ensure the environment was clean and hygienic. Where issues were noted, for example cobwebs, staff were instructed to address these. Medicines audits were also carried out regularly. Where issues were noted an audit feedback sheet was placed in the medicines administration records folder for staff to read and action.

At the handover meeting staff reported to senior carer the tasks they had completed. The Ssnior carer then distributed tasks that still needed completing, and checked whether staff had completed care plans, medicine administration charts, food, fluid and bowel charts.

The views of each person were sought on a weekly and monthly basis on the services provided by the staff.

People sat down with their key worker to complete a questionnaire asking for their views about topics such as the food, the environment and the care they received. The records completed during January 20107 showed people were positive about the service. In addition, they rated the care as good / very good and the same for activities and the environment. Comments included, "I enjoy the food, I get enough to eat", "The home is lovely and I like my room" and "The girls are friendly and helpful."

The views of people who used the service, family members, friends and health professionals were also sought through the use of questionnaires. The most recent survey had produced positive feedback. People had been asked to rate the service on a variety of questions. Responses to questions about the care, environment, cleanliness and activities were good/very good. Responses to questions about the food showed people had rated the food as excellent.

A timetable was in place setting out when each care plan must be reviewed. The names of staff allocated to review each care plan were set out. This reduced the likelihood of care plan reviews being missed.

To the best of our knowledge, the registered manager has notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities. The provider and the registered manager promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Regulation 11 (1) HSCA 2014(Regulated Activities) Regulations 2010 Need for consent<br><br>The provider has failed to ensure staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and have the information and guidance necessary to apply the principles appropriately. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Regulation 19 (2) Fit and proper persons employed<br><br>The provider has failed to establish and operate an effective recruitment procedure. The provider has failed to ensure sufficient evidence is gathered about an applicant's previous employment history, their character and trustworthiness before applicants are appointed and begin working with vulnerable people. |

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 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (2) ( a)<br><br>The provider has failed to adequately assess, monitor and improve the quality and safety of the service.<br><br>Regulation 17 (2) (b)<br><br>The provider has failed to implement adequate systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. |

**The enforcement action we took:**

We issued a warning notice