MPS (Investments) Limited

Alston View Nursing and Residential Home

Inspection report

Fell Brow,
Longridge,
Preston
PR3 3NT
Tel: 01772 782010

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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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Alston View is registered to provide accommodation, nursing and personal care for up to fifty people and is owned by MPS (Investments) Limited. The home is located in the village of Longridge where access to local facilities are within walking distance. Alston View is a modern home with accommodation on three floors and overlooks landscaped grounds. All of the bedrooms are ensuite with the exception of two single rooms. A small car park is available for visitors.

We last inspected this service on 06 November 2014 and the home was non-compliant with the regulations we checked during the inspection. The planning and delivery of care and support was not provided in a way that met service user's individual needs. The systems in place to ensure service users were protected were not robust, and there were not always sufficient numbers of suitably

Summary of findings

qualified, skilled and experienced staff employed at the home. The systems in place to identify, assess and manage the risks relating to the deployment of the staff team were not robust.

This unannounced inspection took place on 20 April 2015. The lead inspector for the service and an additional Adult Social Care Inspector undertook the inspection. Prior to our visit we received information of concern from a whistle blower. The information we received raised concerns about staffing levels, medicines management, health and welfare of people at the home and general management processes within the service.

We found the people who used the service did not have their medicines well managed by the service. Appropriate infection control measures were not in place to protect people from the spread on infection. Staff training and supervision was not always carried out in a timely manner to ensure staff were properly supported to undertake their work. In some instances, care records and assessments were very narrowly based on clinical issues, and not focused on the whole person. People were not always supported to take part in a range of activities whilst staying at the home. Quality assurance and governance systems were in place; however they were not always followed and implemented. The staff communication systems were sometimes ineffectual. Staff were found to be caring, but some were not given support to reflect on their feedback through appropriate supervision. The out of hours and on-call management systems were unclear and needed to be clarified so that all staff knew who to contact in the event of an emergency.

Staff recognised the important role that safeguarding people from abuse had in enabling people to live a positive life.

Staff recruitment practices protected people living at the home. Staff were confident in their knowledge and use of the Mental Capacity Act 2005. People told us they had enough to eat and drink throughout the day, and at night if required. The premises were maintained, and adapted to meet people's mobility requirements. Staff interacted well with those who lived at the home. People's privacy was consistently respected. People were treated in a respectful way. The staff were seen to be kind and caring. The service had an appropriate complaints procedure, and handled complaints appropriately.

We found a number of breaches of the Health and Social Care (Regulated Activities) Regulations 2014 in relation to the safe administration of medicines, supporting staff and overall governance.

You can see what action we have taken at the end of the full report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People who used the service did not have their medicines well managed by the service.

Infection control measures were not consistently adequate to protect people from the spread on infection.

Staff recognised the important role that safeguarding people from abuse had in enabling people to live a positive life.

Staff recruitment practices protected people living at the home.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training and supervision was not always carried out in a timely manner to ensure staff were properly supported to undertake their work.

Staff were confident in their knowledge and use of the Mental Capacity Act 2005.

People told us they had enough to eat and drink throughout the day, and at night if required.

The premises were maintained, and adapted to meet people's mobility requirements.

Is the service caring?

Good

This service was caring.

Staff interacted well with those who lived at the home. People's privacy was consistently respected.

People were treated in a respectful way. The staff were seen to be kind and caring.

Is the service responsive?

Requires improvement

The service was not always responsive.

In some instances, care records and assessment were very narrowly based on clinical issues, and not focused on the whole person.

People were not always supported to take part in a range of activities whilst staying at the home.

People were supported to make decisions relating to their lives.

Summary of findings

The service had an appropriate complaints procedure, and handled complaints appropriately.	
Is the service well-led? The service was not always well-led. Quality assurance and governance systems were in place; however they were not always followed and implemented. The staff communication systems were sometimes ineffectual. Staff were found to be caring, but some were not given support to reflect on practice through appropriate supervision. The out of hours and on-call management systems were unclear and needed to be clarified so that all staff knew who to contact in the event of an emergency.	**Requires improvement** 

Alston View Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 took place on the 20 April 2015 and was unannounced. The inspection was carried out by the lead adult social care inspector for the service and a second adult social care inspector.

Prior to the inspection we looked at the information we held about the home. This information included details of notifications sent to us by the provider and information from other sources such as the Local Authority Safeguarding team.

We spoke with a range of people about the service, such as the Registered Manager, five staff members, eight people who used the service and three visiting family members.

Prior to this inspection we contacted the local authority in order to ascertain if there were any concerns about the home. Social workers had been involved in one safeguarding investigation and at the time of the inspection, the investigation was on going and not concluded. We spent time looking at records, which included the care records of five people, three staff members' training and personnel records and a number of management and audit records related to the running of the home.

Requires improvement

Is the service safe?

Our findings

People living at the home said they felt safe. One person said, "I'm ok here. The staff look after me and I feel cared for and happy." Another said, "I like it here. I get on with people and although it's not my home, it feels homely and nice. I feel safe".

The processes for the safe and secure handling of medicines were not robust or in line with the relevant guidance and legislation. The Registered Manager explained that the service had recently moved to a different pharmacy supplier, and that the transition from the old to the new supplier was taking place on that day of our visit. We spent some time trying to reconcile the medicines held at the home, with the written records, but found discrepancies. We found some examples of individualised medicines protocols for as and when needed medicines (PRN). We found that the medicines were difficult to audit as stock balances were not in place for all loose medicines. This meant that staff at the home could not audit the medicines effectively. Some medicine administration records (MARs) had been photocopied and were of poor quality. This left some parts of the documents illegible and signatures unreadable. It was not possible to determine if the records had been signed or who had signed. Again, this meant that the records could not effectively be audited.

We spoke with a healthcare professional who visited the home on a regular basis. They explained that there had been a number of occasions in recent months when people at the home had not received their medication on time. The explanation given for this was that the systems in the home for collecting prescriptions from the local GP, and then obtaining medicines from the pharmacy were poor. Staff from the home were said not to pick up prescriptions when they were ready, and this would then have the knock on effect of delays in people receiving their medicines. The registered manager explained that these issues were being addressed with the staff so that medicines were collected in a timely manner, and she hoped that the change in pharmacy supplier would help to address this issue.

The nursing staff and senior social care staff explained that they had received training in the safe administration of medicines. Nursing staff administered medicines to people assessed as requiring nursing care. Non-nursing residents received their medicines from social care staff. We discussed the training and competency arrangements for social care staff, and the Registered Manager explained none of this group of staff had been deemed as being competent to administer medicines, although they had received training in this area.

Although measures were found to be in place to address the way medicines were managed in the home, a breach in regulation was identified. We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The infection control measures throughout the home were not robust. The Registered Manager explained that cleaning schedules were in the process of being updated, and refresher training in the area of infection control was planned. The records confirmed this. Infection control audits were completed and sent to the local clinical commissioning group, and this was confirmed by the Registered Manager. However, as we toured the home we found evidence of unclean areas and evidence to show that infection control procedures were not properly followed, with overflowing clinical waste bins being left open, and incorrectly stored.

It is recommended that the registered person ensure measures are in place to properly control the potential spread of infections.

Despite this, the people we spoke with and some of their relatives told us they did not have any concerns about safety. People said that they felt safe with and trusted the staff who supported them. People also told us they would feel able to tell someone if they were unhappy about something.

We found a completed staffing rota which was legible, accurate and up to date. The Registered Manager explained that she used a service user dependency tool to identify the staffing levels required to meet people's needs. She added that "staffing levels where reviewed from time to time to take account of people's changing needs." We saw information in the rotas that supported this.

The personnel records showed that safeguarding training was provided for all the staff irrespective of their role within the organisation. We saw records to show that

Requires improvement

Is the service safe?

safeguarding training was updated and refreshed regularly. We saw that the safeguarding policy and procedures were displayed within the home, and contained details of the relevant local authority contact telephone numbers.

The processes in place within the home for identifying and responding to signs and allegations of abuse were found to be appropriate. We spoke with three staff members about their understanding of what constituted abuse and how they responded to signs and allegations of abuse, and they gave a very detailed account. The systems relating to safeguarding vulnerable people were found to take into account both local and national guidance. Staff confirmed they had both seen and had access to the local procedures, and the staff personnel records confirmed staff had received training on the subject.

We found written records to show what arrangements were in place to provide safe care in the event of an emergency. Staff were aware of the fire evacuation procedure and when questioned about it, were able to give an accurate account of what they would do to keep people safe in the event of a fire.

We saw records to show that risk assessments were completed and held within people's care files and covered all relevant areas of care and support. Risk assessments were reviewed and updated to take account of people's changing needs. Accidents and incidents were documented, and if action needed to be taken to address issues or change practice, this was completed by the staff. Risk assessments and care plans had been updated following incidents such as falls or illness. We found that if people's needs changed over time due to deteriorations in their health, the risk assessments and care plans reflected these changes. People at risk of losing weight had risk assessments in place for the staff to follow in order to minimise or eliminate the possibility of weight loss.

The systems relating to the safe recruitment of staff were found to be appropriate. Safe and effective procedures were followed for all staff. Personnel l records showed that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either fit to work in care, or suitable for employment. The Registered Manager explained that the application and interview process was in place to check that potential staff had the right skills and qualifications needed to do the job. We found that all disciplinary action taken against staff was well documented.

Requires improvement

Is the service effective?

Our findings

People indicated to us that they got on well with staff and that staff provided 'excellent support' that they liked. Relatives we spoke with told us they had confidence in the skill and knowledge of the staff that supported their loved ones. Comments from relatives included, "The staff are really good. Some are more experienced than others, but they appear to work well together."

Staff explained that handovers gave them current information to continue to meet people's needs, and provide an opportunity to receive updates regarding incidents, and what action to take to minimise or reduce the possibility of further accidents or incidents.

We found that staff were not in receipt of regular support by way of appropriate supervision. We viewed three staff personnel files, two of the people were recently appointed. Neither contained any evidence of probationary meetings or supervisions that had taken place. In the case of one staff member, there had been numerous complaints about their behaviour, and although this was documented, there was no evidence to show that supervision had taken place. In another file we found that supervision had not taken place since December 2013, despite written evidence to show that concerns had been raised regarding this staff member's attitude and behaviour.

We spoke to two staff who said that supervision was not regularly provided. One said, "If we need to talk to a senior staff member, then we can do this on a day to day basis, but we hardly ever get proper supervision." We noted that handovers were provided to agency nurses and care workers when they arrived on shift, but there were no formal induction processes in place for agency workers.

The records showed that although training needs had been discussed and planned for with some staff, not all had been given this opportunity due to the lack of formal supervision.

We found that the registered person had not ensured those employed had received appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity. The registered manager had a good understanding of MCA and DoLS.

We found that the service had appropriate processes in place to ensure that people were able to give consent to their support and care. Where people lacked capacity, the staff and manager knew how to comply with the MCA. Assessment and review processes were found to be in place to ensure that staff and relatives were kept up to date with a person's ability to make decisions and to ensure that staff followed the correct procedures when supporting people who lacked capacity. We found documentary evidence to show that the systems operated within the home relating to consent to care and treatment took into account both local and national guidance. Where needed, mental capacity assessments took place; best interest meetings were convened and referrals to the Local Authority were made if a DoLS authorisation was required. The staff we spoke with understood the need to ensure people were enabled to give consent to care, and understood the requirement to seek external advice and guidance if there were any doubts about a person's ability to make informed decisions. The training records showed that staff had either received training in this area, or were due to undertake training such as MCA awareness and Best Interests Meetings.

We found documentary evidence to show that ongoing assessment, planning and monitoring of nutritional and hydration needs and intake took place. We observed that food and hydration was provided and made available in sufficient quantities and on a regular basis, and this was supported by comments from people living at the home.

Requires improvement

Is the service effective?

Examples given were, “The food is always very good, and we always get enough to eat.” We found there to be a choice of food and drink that took account of people’s individual preferences. We observed staff offered support to enable people to eat and drink when necessary.We discussed the use of fluid intake charts with the Registered Manager, particularly in relation to people admitted from hospital. The Registered Manager said that there had been occasions when the home had admitted people from hospital who were very poorly, and in one instance, the person had been sent back to hospital due to their poor state of health. She explained that the use of fluid intake charts were used for people who were very poorly, but she was unclear if these charts were routinely used when people experienced general illness or frailty. We spoke to staff at the home, and they were unsure if fluid intake charts would be routinely used if people experienced poor health or general illness due to frailty.

The Registered Manager explained that many of the people who lived at the home had significant healthcare needs. We found information to show that some people had been assessed as being at risk of losing weight and of dehydration. Systems were found to be in place to monitor and manage these risks, and record keeping was both accurate and up to date. We found examples of involvement of external healthcare professionals such as dieticians, tissue viability nurses, GPs and District Nurses. The records showed that the service had a good working relationship with these external professionals. Staff at the home confirmed this.

We found the building to be large and spacious, its design and layout was appropriate to the meet the needs of the people living there. Reasonable steps had been taken to ensure that premises were accessible to all those who needed to use them. The premises and grounds were well maintained and potential risks to people’s safety had been identified and managed through a risk assessment process.

Good

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. Comments included, “The staff are always positive and caring, ready to listen and give you time if you need it.” “Staff work in a dignified way, and I always feel special and well cared for.” Staff showed they cared for people by attending to their feelings. For example, one person was confused about which room they should be in and a care worker came to the person’s assistance and spoke with them. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them.

Interactions we observed between staff members and those who lived at the home were all pleasant, polite, friendly and unhurried. Staff expressed their genuine concern about individual people when talking with us.

We asked the Registered Manager what arrangements were in place for people to access advocacy services if they required them. She explained that information relating to advocacy services was available in the home, and that the staff were aware of how to inform people of these services. We spoke to a staff member regarding this, and they confirmed that information was displayed within the home, and on touring the home we noted this information.

People’s bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home. We looked at the ways in which people were supported to understand the choices they had in relation to their care and treatment and how staff supported them to make positive decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or manager to discuss issues such as the food, clothing and medication.We spoke to a number of relatives and visitors who told us that they felt they could influence the care and support their relative received, and explained that they had been involved in significant decisions about their relative’s healthcare. They explained that they had been given the opportunity to have input into their relative’s care plan, and had been consulted about changes to the care that had been provided. We found documentary evidence to support this in people’s care plans and risk assessments.

We observed care workers knocked on people’s doors before entering rooms and staff took time to talk with people or assist them to undertake activities. People were treated with dignity and respect by staff and they were supported in a caring way. Care workers used people’s preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them.

The staff we spoke with said that they had received training in the need to respect people’s confidentiality. One staff member explained that this aspect of their work had been covered during their induction, and another added that confidentiality was a topic they had covered during some recent training on the subject of safeguarding.

Requires improvement

Is the service responsive?

Our findings

Information held within the care plans showed that people had been involved in their assessment of need, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers or healthcare staff. If the person was unable to contribute, information had been actively sought from others, such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person in receipt of care where possible. Care plans were found to be held on a central computer system and although they were found to contain good levels of information and detail regarding people's needs, some were very basic and were not personalised. Daily records were found to be very functionally based i.e. recording of what people ate, when they used the toilet and when they had a wash. We found details about people's everyday life was somewhat lacking.

The staff we spoke with understood the importance of involving people in appropriate activities which helped people feel involved and valued. Despite this, they added that very few activities took place within the home. One person said that outside entertainers sometimes visited, but that most activities were undertaken by the staff. For example there were one to one activities such as talking about the news and reminiscence. We saw one staff member reading the newspaper to one person, and they both seemed to be very engaged in this process. A number of people told us that there was very little to do apart from watch TV.

We viewed a number of bedrooms during our inspection. Some we found to be very personalised with objects and pictures displayed that were clearly personal and important to those who lived in these rooms. This promoted individuality and maintained people's interests.

A complaints policy was in place at the home and a system was in place for recording and monitoring complaints. Each step of the process was clear, which enabled a distinct audit trail to be followed. A relative we spoke with told us she would not hesitate to contact the registered manager if she had any concerns and she felt issues would be dealt with appropriately. All the people we spoke with said they knew the registered manager. Everyone said they had no complaints, but if they had they would be happy to tell the staff.

Requires improvement

Is the service well-led?

Our findings

People living at the home said that they thought the home was well-managed. One person said, "The manager is always around and you can talk to her if you need to." Another said, "We get fed on time, and we have the things we need, so I think it is ok here and well run."

The staff we spoke with clearly understood the lines of reporting and accountability within the home. When we questioned staff they were able to give a good account of their roles and responsibilities with reference to keeping people safe, meeting people's needs and raising concerns regarding the quality of care provided at the home.

We found documentary evidence to show that risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control, medication, fire, healthcare, environmental safety and staff training. However, as previously mentioned, infection control measures were not always followed, and the personalisation of care plans was lacking in some areas.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because the quality assurance and governance systems in place within the home were not robust. This was in breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were systems in place to monitor if tasks or care work did not take place, staff supervision did not always take place in a timely manner. Partnership working with other agencies was evidenced within people's care records, and was seen to be an important aspect of service provision.

Our observations were that the Registered Manager engaged with the staff on duty, and with people living at the home. When we questioned some of the staff about communication in the home, they confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that the quality of these handovers was very much dependant on the staff on duty. One person said, "If we have agency staff working at the home, and we have a lot from time to time, the handovers are brief, and lacking in detail. The permanent staff give better handovers and I think this is because they know the people living here very well."

We checked the records held at the home relating to events and incidents that required a notification to the Commission, and other agencies. We found the records to be up to date and accurate. The Registered Manager was able to give a good account of when notifications needed to made, and the systems relating to reporting notifications was found to be appropriate.

The inspection had been triggered by an anonymous complaint to CQC, and one aspect of the concerns raised was in relation to the home not having robust on call arrangements in place. One issued raised by the anonymous complaint was that staff were unable to locate a key to a room they required access to and the on call manger was unable to visit the home to bring a key for this room. The key was eventually found, but this was after the suggestion had been by that the staff break down the door of the office. Although we found that on call arrangements were in place, we felt that the service needed to clarify those arrangements so that everyone working at the home were familiar with them.

We found a number of daily records to show that various people at the home had been involved in incidents that required notification to the Care Quality Commission and/or the local Safeguarding team; we saw records to confirm that these notifications had been processed and sent in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1)(2)(g) The registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) The registered person had not ensured those employed had received appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) The registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because the quality assurance and governance systems in place within the home were not robust.**