Allendale Rest Home Ltd

Allendale Residential Home Limited

Inspection report

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Ratings

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

Overall summary

This inspection took place on 2 June 2015 and was unannounced. This means the manager and staff did not know we were coming in advance.

The previous inspection had taken place on 20 August 2014. At that inspection we found that the service was not complying with regulations relating to management of medicines, safeguarding people from abuse and assessing and monitoring the quality of service provision. There had been breaches of equivalent regulations relating to management of medicines in five previous inspections since December 2012. Part of the purpose of the inspection in June 2015 was to see whether the service had made improvements in these areas.

Allendale Residential Home ('Allendale') is a privately owned residential care home without nursing. Accommodation is provided for up to 24 people.

Following our last inspection a new manager was appointed in November 2014, who was registered in

Summary of findings

March 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the inspection on 2 June 2015 we found there were still breaches of regulation in relation to the management of medicines. Medicines were not always obtained in a timely manner. A new medicine recommended for one person by a consultant psychiatrist had not been obtained for nearly a month. This resulted in a risk to that person's health.

We found there was a breach of the regulation relating to providing care and treatment safely, in regard to ensuring there were sufficient quantities of medicines and the proper and safe management of medicines Some medicines were not being administered at the correct times. The recording of other medicines was poor and medicines were not always stored safely.

We found four examples where the premises were unsafe or being used unsafely. We found this was a breach of the regulation relating to providing care and treatment safely, in regard to ensuring the premises were used safely.

The service used regular staff who knew the people who used the service well. We observed there were enough staff on duty, but at times staff were not present to supervise meals. We found this was a breach relating to the regulation on meeting nutritional needs.

Staff were trained in safeguarding and knew what to do if they witnessed or suspected abuse.

Proper processes were followed for the recruitment of staff.

We found that staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards, but that correct processes were not always followed. In particular we found that the procedures in the MCA in relation to the covert administration of medicine were not being followed. We found that this was a breach of the regulation relating to consent.

There was a good record of training in some areas, but not all. The registered manager was conducting regular supervisions of staff.

The food was good but the mealtimes were chaotic due to the lack of staff presence.

Feedback from professionals, relatives and the residents themselves was that the care was good, and the staff were compassionate. However, we observed that some interactions showed a lack of respect.

The service was involved in the regional Six Steps programme for end of life care. The lead practitioner spoke highly of Allendale's contribution to improving end of life care.

At this inspection we found there was little improvement in the accuracy and continuity of care records which meant some people were at risk of unsafe care and treatment. Care plans were not person-centred. They lacked individual detail about people's lives. We found examples where people's needs were not being met. We found this to be a breach of the regulation relating to person-centred care.

We found that the service had not responded to a request from a hospital to continue monitoring one person's weight. We found this was a breach of the regulation relating to providing care and treatment safely.

Relatives knew how to complain although most issues were dealt with informally. One complaint in 2015 had been dealt with by the registered manager.

There was a system of audits but it had failed to identify and deal with ongoing failings in regard to the management of medicines. This was a breach of the regulation relating to the requirements to assess monitor and improve the quality of the service, and mitigate risks relating to the health safety and welfare of people using the service.

Not all notifications required under the Health and Social Care Act 2008 had been made. We found this was a breach of the regulation relating to submission of notifications.

Staff told us they felt well supported by the management. The registered manager was still new in post and was told us she was still establishing herself in that role.

We found there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2014. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always obtained when needed. Administration of medicines and records were poor, and medicines were not always stored safely.

Defects in the premises caused risks to people living in the home.

Only regular staff worked at the home, and recruitment processes were safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had been trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but correct processes were not always followed.

One person was receiving their medicine covertly but staff had not followed the correct procedure in relation to consent.

Training was lacking in some areas. The food was good but mealtimes were not adequately supervised.

Is the service caring?

Requires Improvement

The service was not caring in all respects.

There was feedback that the care was good, and the staff were compassionate. However, we observed that some interactions were lacking in respect.

People's basic needs were not always met, and we saw that people could be left unattended for long periods.

The home was involved in the Six Steps programme for end of life care, and was commended for its approach in that area.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

Care plans lacked detail about people's personal or medical history.

People's needs were not always being met. There was no activities co-ordinator although activities were being organised by a different member of staff each day.

Most issues or minor complaints were dealt with informally. There had been one formal complaint in 2015, which had been dealt with by the registered manager.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

We had requested the service to send us a Provider Information Return before the inspection but they had not done so. Not all deaths had been reported to us as required.

There was a system of audits but it had failed to identify and deal with ongoing failings in regard to the management of medicines. There were poor audits of other areas including care plans.

Staff felt well supported. The registered manager was still establishing herself in the role.

Allendale Residential Home Limited

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 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 2 June 2015 and was unannounced. It was carried out by two Adult Social Care Inspectors and a Pharmacist Inspector. Prior to the inspection we reviewed the information we held about Allendale Residential Home, including notifications submitted by the home.

Before the inspection, we asked the provider, on 10 March 2015, to complete a Provider 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 improvements they plan to make. The service did not return the PIR by the time of the inspection and we took this into account when we made the judgements in this report.

We spoke with the contract officer from the quality, performance and compliance team of Manchester City Council and a care manager from the Citywide Care Homes Team who had knowledge of the home.

On the day of the inspection we spoke with three people living in the home, two relatives, five staff, the registered manager, the deputy manager and one of the owners. We spoke with three visiting professionals. We conducted an observation known as a SOFI (Short Observational Framework for Inspection). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at three care files, two staff personnel files and other documents relating to fire safety and the administration of the home. We asked the deputy manager to send us an electronic copy of the home's training matrix, and asked the manager to send copies of supervision and appraisal schedules, which they did.

After the inspection we spoke with a practitioner involved with the Six Steps end of life care programme in the North West, who had knowledge of the end of life care at Allendale.

Inadequate

Is the service safe?

Our findings

We asked people living in Allendale and their relatives whether they felt safe. Not everyone was able to communicate in a way which we understood. Some people were able to tell us they felt safe. One person said, "I feel safe." And another resident told us, "Yes, I'm alright." Another resident told us, "Yeah, I only have to pull the thing (pull cord) and someone will come, don't have to wait long." One resident said, "See on telly, where old folks are hit – not like that here."

We spoke with a visitor who told us they had no issues or concerns about their relative and that they felt confident their relative was being cared for properly.

Another visitor said: "My [relative] is looked after very well. The care workers are very good. I feel they are safe." This person added that they had in the past raised concerns about how well their relative had been looked after, but they were now happy with the home.

On six previous inspections the CQC had found failings with regard to the safe handling of medicines. Following the last inspection on 20 August 2014 we had taken enforcement action.

During this inspection we found medicines were still not managed safely. We looked at records about medicines for 15 people and found concerns about the safe handling of medicines for all 15 people.

As at our last visits we found medicines were still not obtained in a timely manner. On this inspection we found two people had run out of some of their medication. One person had run out of their analgesia for five days and staff had failed to order a new supply. This person may have experienced unnecessary pain during that time.

We saw one person had not received their medicine recommended by a consultant psychiatrist, nearly a month earlier. We saw that this person was in a state of anxiety and distress, which might have been alleviated by the medicine if it had been obtained in a timely manner.

We saw one person had returned to live at Allendale after being a visit to hospital. However, we saw they were not given all the medicines they had been prescribed on their discharge. Staff had failed to obtain the medication or even to make any enquiries if the medicines were still needed. If people do not have access to the medicine they require, their health and wellbeing will deteriorate.

We found that people were still not given their medicines as prescribed. During this inspection we found people were not always given the correct number of doses each day. We saw one person was prescribed an antibiotic to be given three times daily, but it was only being given or offered twice daily. We saw another person was prescribed an inhaler to be used twice daily; but we saw that it was used three times daily for five days. If people are not given or offered their medicine in the way it is prescribed then they may suffer unnecessary symptoms such as the infection reoccurring. If they are given more doses than prescribed they may experience symptoms related to taking too much of their medication.

We compared the stock of medicines in the home with people's records. We saw people were not given all their medicines properly. We saw some people were not given the correct doses of anticoagulants, inhalers or their antibiotics. If people are not given or offered their medicine in the way it is prescribed then they may suffer unnecessarily from the symptoms for which their medication was prescribed.

As at previous inspections we found staff had still failed to identify all medicines that needed to be given in relation to the timing of food and these medicines were not given safely. It is important that medicines are given at the correct time to make sure they work properly and do not have adverse effects on people.

We found there was some information recorded to guide staff as to how to give medicines which were prescribed 'as required'. However, the registered manager could not locate this information for any medicines prescribed in this way. We also found there was still no information recorded to guide staff to select the correct dose when medicines were prescribed with a choice of dose (e.g. one or two tablets). It is important that this information is available to ensure people are given their medicines safely and consistently.

We saw that some people kept some of their medicines in their rooms including creams. We saw that arrangements had been put in place to record if it was safe for people to look after their own medication. However, we found one

person kept medication in their room despite the form stating they were "unable" to take responsibility for their medication. This might mean that this person was not taking medication in a safe way.

We saw there was no formal monitoring of how safely people were looking after their own medicines. Staff told us that for one person there was no need to monitor this, because their medicines use was "Spot on." We made some checks and found they had taken fewer doses than were prescribed, placing their health at risk.

As at the last inspection, there was still no information recorded to guide staff as to how often to administer creams or where to apply them, so creams could not be applied safely or as needed.

We also found there was no information recorded as to how to use one person's prescribed thickener (to prevent them from choking when drinking fluids). This person's health was placed at risk as if drinks are not thickened in line with guidance it may be the wrong consistency and lead to choking.

We saw one person needed to be given their medicines covertly, which means without them knowing. This is usually done by disguising medicines in food or drink and a plan of how to do this safely and lawfully must be prepared in conjunction with the pharmacist and other professionals. We looked in the person's records and the plan was not in place. We saw this person missed doses of their medication because suitable arrangements were not in place.

We looked at records about the receipt and administration of medicines together with the stocks of medicines in the home. We found, as at previous inspections, that staff had signed for more medication than had been given. We saw that staff still did not always record clearly the reasons why medication, which had been prescribed to be given, had been omitted.

During this inspection we saw that the senior carer who was administering medicines signed the records to indicate medication had been administered before it was given. The registered manager told us she had told all staff they must follow good practice guidance and sign the records once the person had taken their medication. If a record is signed to show that medicine has been given before it is given, it creates the risk of inaccurate recording of what a person has received.

We also found that the records did not show that all prescribed medication could be accounted for. If medicines such as strong painkillers and insulin cannot be accounted for people's health may be placed at risk of harm.

At this inspection we saw medicines were still not stored safely. We saw that although the keys for the medicine trolleys and cupboards were kept securely the fridge was unlocked and the key for the fridge was in the lock. Insulin that was in current use was not locked away but was kept in plastic containers on top of a cupboard in the office. The office was accessible to all staff by means of a numerical code key pad. When we arrived at the home the office door was wedged open which meant all staff and residents could freely access the office.

We saw that creams and inhalers were stored in people's rooms and we found that one person had a cream in their room that was not prescribed for them. We found that staff failed to store nutritional supplements for two people correctly. The supplements carried the direction that they should be stored in the fridge. We found they were stored in the trolley at room temperature. If medicines are not stored at the correct temperature they may not work properly.

We found that the above failings amounted to a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with reference to subparagraphs 12(2)(f) and 12(2)(g) of those regulations.

There was an accident/incident report book which had 24 records added in 2015 up to 2 June. These were mainly falls in bedrooms. This showed that accidents were being recorded but it was not clear that action was being taken to reduce risks.

We noticed some issues, and were already aware of some issues, relating to the safety of the premises.

A person living in the home had gone out of a fire door at around 7.45am on the morning of our visit. They then went through a metal gate and onto the road. Staff were alerted by the alarm on the fire door, and chased after the resident. The member of night staff who caught up with them stated in an incident report that they had been "in the middle of the road…a danger to themselves and road users."

We saw later in the day that the metal gate was not locked and could blow open in the wind. It had been windy the night before and the gate may have been open when the

Is the service safe?

resident went through it. We discussed this with the registered manager who stated she would organise putting a combination padlock on the gate. This would reduce the risk to people living in the home and in addition improve security.

When we were being shown around the home shortly after our arrival we noticed a large wheelchair standing in front of the same fire door as mentioned above. We were told that the wheelchair was used by someone living on the first floor, but we were subsequently told that that person was not mobile and did not come out of their room often. The wheelchair would have proved an obstruction in the event of a fire and the need to evacuate the building quickly.

We had been notified of a serious injury in October 2014 when a resident got up from a dining table, then attempted to climb a staircase but fell. We asked whether consideration had been given to putting a stairgate at the bottom of these stairs to prevent a recurrence. The registered manager showed us a letter from a private fire safety officer who advised that the staircase should not be obstructed by a gate. During this inspection we observed that staff were not present throughout mealtimes. This meant that people were still at risk if they were able to move to the staircase during a meal without being observed.

We observed that a pull cord required for a resident was extended over a table in an inappropriate way, using tights, which meant that the resident could not use it in a case of emergency. The resident asked us if the cord “could be made a bit longer for me”. On test, the pull cord did not function to alert staff, because of the way it had been extended. This showed us that the provider was not ensuring the safety of the resident.

We found that these four instances of risks amounted to a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with reference to subparagraphs 12(2)(b) and 12(2)(d) of those regulations.

The registered manager told us there were always four or five staff on duty in the morning, two or three in the afternoon and two at night. We saw staff rotas for four weeks including the two weeks preceding our inspection, and the week after, which confirmed these arrangements. Allendale had 17 regular staff, and they told us they did not use agency staff or bank staff. The registered manager told us that staff made themselves available to cover extra shifts in the event of staff sickness or holidays. This meant that people living in the home always had familiar staff caring for them.

We found concerns relating to the absence of staff in the dining room at lunchtime. Staff were bringing plates in and out of the kitchen but did not remain constantly in the main dining area. We saw a resident dropped a knife on the floor. The resident became frustrated as no staff were present to pick it up for them. We considered that the absence of staff showed no lessons had been learnt from the incident mentioned above, when the resident had left the table during a meal and attempted to climb the stairs. We found that there was room for improvement in relation to the deployment of staff at meal times.

The registered manager, deputy manager and one of the owners took turns on call for a month at a time. This meant that they could be contacted at any time in the event of an emergency. Staff could therefore call for help if they needed it.

All care staff, with the exception of two, had received recent training in safeguarding vulnerable adults, in March 2015. Staff we talked with had a satisfactory understanding of the various types of abuse, and told us they would report any concerns to their manager immediately. We spoke with the registered manager about this and they told us they recognised the importance of increasing staff confidence to make decisions and escalate things themselves rather than rely on senior staff.

We looked at the files of two recently recruited staff to check that the provider had followed correct procedures in relation to the recruitment of new staff. We saw that the necessary paperwork was present, including evidence of a check of any previous criminal convictions or cautions with the DBS (Disclosure and Barring Service). This meant that the required checks were in place to ensure that only suitable staff were employed.

Inadequate

Is the service effective?

Our findings

All care staff had received recent training on the Mental Capacity Act 2005 (MCA). The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which form part of that Act. They are intended to protect the rights of people who lack the capacity to make their own choices about their care. Most of the care staff, but not the four latest recruits, had also received training on DoLS.

The registered manager was aware of a Supreme Court judgment in 2014 which had widened the definition of restrictions that might amount to a deprivation of liberty. She explained that she had been in touch with Manchester City Council regarding submission of applications for authorisation under DoLS. Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

The registered manager told us that she had submitted six applications for DoLS standard authorisations since February 2015. None of these had yet been authorised. We saw the paperwork associated with these applications. However, the registered manager had not at the same time issued an urgent authorisation in each case. This meant that these six people were being deprived of their liberty without lawful authority. Moreover no mental capacity assessments had been completed for the people for whom DoLS applications had been submitted. The registered manager stated it was their understanding that psychologists appointed by the Council would complete these assessments a part of the authorisation process. However, it would be better to complete an assessment in the home before submitting an application, because only people assessed as lacking capacity would be eligible for a DoLS authorisation

The registered manager stated that Manchester City Council had requested that applications for a standard authorisation should not be accompanied by the urgent authorisation. But this did not mean that the urgent authorisation was unnecessary. The manager told us she would complete the urgent authorisations straightaway.

Subsequent to our previous inspection a concern was raised about one person who received covert medication without the proper procedures having been followed. Covert medication is where medication is given without the person's knowledge, for example mixed with food. There was a strategy meeting organised by Manchester City Council on 25 September 2014 which discussed the concerns. The allegation that covert medication was not being administered correctly was partly substantiated. A care manager advised that a mental capacity assessment should be undertaken to determine whether the person could consent to receiving medication in this way. If they could not, a recorded best interests decision should be made by appropriate individuals to determine whether the medication was required to keep the person safe and healthy.

At this inspection we found that the resident in question was still receiving their medication covertly. However, there was no mental capacity assessment on their file. Nor had there been a best interests meeting to decide whether receiving medication covertly was in this person's interest. There was a letter from the person's GP stating: "We took the decision to allow the staff to crush and give covertly tablets if necessary." The registered manager remained responsible, nevertheless, for ensuring that the correct procedures were followed in relation to obtaining consent, or following the MCA if consent could not be given.

We considered that failure to follow correct procedures, even despite the outcome of the earlier strategy meeting in September 2014, was a breach of Regulations 11(1) and 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about the training they received. They told us there was an ongoing programme of training, and staff members' attendance at the training was monitored. For example, there had been manual handling training for all staff the day before our inspection, and all staff including night staff had attended, except for one member of staff who was on sick leave. On the day of our visit there was fire safety training, which four members of staff did not attend. The deputy manager told us it would be rearranged for them at a later date.

We requested a copy of the 'training matrix' which was a record of all training provided and received since 2009. It showed care staff had received recent or fairly recent training in core subjects such as emergency first aid,

safeguarding, risk assessment, and dysphagia (difficulty with eating or swallowing). The matrix showed that recent recruits had been given training in these areas, as part of their induction training.

In other subject areas the training was not as recent. For example training on advance care planning and person centred planning had been delivered in May and June 2013 respectively. Many staff had received their last training in food safety and hygiene in 2012, although the cooks had received training much more recently, in April 2015. Three staff last received nutrition training in 2009, and three others in 2012. No other staff had received this training. There was therefore a need to bring staff members' skills and knowledge up to date.

Nine of the care staff had last received training in medication handling in 2013. Six others had received training in January 2015, but the registered manager reported that this had not been of a high standard. There had also been training described as 'medication' for 11 staff in February 2014. Given the history of breaches of regulations relating to the safe handling of medicines, and the issues identified elsewhere in this report, the training in medication handling should have been more recent and more effective. The training in medication was essential for staff. We found this to be a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager, who started in November 2014, had conducted annual appraisals with all staff in January and February 2015. She had also held supervisions with most of the care staff approximately two months after their appraisal, with the exception of two staff whose supervisions had not yet taken place. Prior to November 2014 the records showed that supervision had been sporadic. Some staff had received regular supervision every three months, but others had not received supervision for six months or longer. This meant that staff had not had the opportunity to discuss their work or training needs with their manager until recently. But we acknowledged that the new registered manager was now conducting supervisions on a regular basis.

People told us they received healthy meals. We saw that the menu varied on a four week rota and there was choice of two main meals and desserts on a daily basis. A member of the kitchen staff told us "There used to be a lot of waste." But they added "The residents are good eaters, the men eat and eat and eat." One resident told us they had written a list of what food they liked and didn't like which the kitchen staff then cooked for them.

The home had signed up to the Tamsin initiative which is a programme designed to monitor and improve diet and nutrition in care homes. The first meeting with staff from the Tamsin project was due to be held the day after the inspection with the kitchen staff.

In order to experience the quality of the food offered to people at Allendale we spent time eating with the people who used the service and sampled a meal in the main dining room. People were enjoying their meals.

The dining area was noisy and chaotic, and staff were not present to support the number of people who needed assistance to eat. This meant that people were not protected against the risks of inadequate nutrition and hydration. In the small dining room, the tablecloths were plastic, ripped and cut in places.

Some staff did not explain to people what they were eating and there was not much interaction between the staff and the people they were supporting. Although we did observe one resident requested a different meal, which was provided to them.

The lack of staff presence in the dining areas was a breach of Regulation 14(4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they monitored the food and fluid intake of everybody. We checked care records and found there were inconsistencies. For example we looked at one person's nutritional care plan which clearly outlined the risks and directed staff about how to support the person to meet their nutritional needs. A letter from the hospital dated 5 December 2014 directed staff to weigh the person regularly and monitor their weight as they were seriously malnourished. We saw the weight monitoring chart had been completed regularly and the person had begun to gain weight, however this was stopped on 12 February 2015 with no reason recorded. This meant the resident was potentially put at risk of harm due to their condition and inadequate monitoring of their weight. The registered manager told us she had decided that people did not need to be weighed weekly unless there was a medical reason. However in this case the person's health needs meant that they needed to be weighed regularly.

Inadequate

Is the service effective?

We found this was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with reference to subparagraphs 12(2)(a) and 12(2)(b) of the Regulation. This was because staff had not adequately monitored the person's weight despite the hospital describing them as seriously malnourished.

Requires Improvement

Is the service caring?

Our findings

We spoke to one of the professionals from Manchester Council Mental Health Team who were at the home on the day of inspection. They commented that it was like, "home from home, welcoming, comforting." They also said they, "would put my Mum and Dad in here." They added that they had observed, "staff have lots of interaction with patients, and staff listen to them."

People we spoke with who were able to tell us said they were happy with the care provided. One person said, "I like the members of staff." And they said they felt they were, "well looked after." Another person told us the staff were, "great people, good people." However, they added, "I don't like asking them to come and change me, especially a woman – personal like that." We noted there were no male staff working at Allendale. The resident told us this was made worse as, "I don't know who is on from one night to another."

The relatives we spoke with on the day of our inspection were also positive about the care their family members received and we were given some positive feedback about the caring attitude of the support staff. Comments included: "They tell me what [my relative] needs." Another relative said: "I am happy with Allendale as a place for my [spouse]. I think they are looked after very well. The carers are great."

It was not possible to obtain verbal feedback from some people who were living with dementia about their care. We therefore carried out a series of observations throughout the home to ascertain how staff interacted with the people they supported.

We found the atmosphere within the home was noisy and chaotic at times, and staff appeared busy throughout the day. We found a lot of interactions were task orientated and staff did not always engage with people in a kind and caring manner. We found that the quality of care provided differed throughout the home and people were not always treated with dignity and respect, as the following examples showed.

Soon after we arrived at 9.15 am, we noticed one gentleman in his pyjamas in the quiet lounge, waiting for a bath. We learnt that he had been waiting since he got up at 6.05 am that morning. In another person's care file there was a bathing/showering log which recorded they had last had a bath on 25 April 2015, but nothing since then. We checked this person's daily notes and there was no bath or shower recorded since that date. The registered manager assured us that they must have had a shower or bath in that time, but this could not be proven without a record of it. This suggested a lack of concern to provide for, or at least to record, this person's basic needs.

We noted that although most members of staff were polite when addressing the people they supported some were not, and many interactions took the form of instructions. For example at lunchtime we observed a senior member of staff saying to one resident: "Stop scratching, I am watching you", rather than offering any assurances or engaging in meaningful conversation which would help stop the person from scratching. This might have appeared to be disrespectful, although the registered manager explained this was a form of two-way banter with the resident.

We saw at lunch time people were not supported to wash their hands prior to or after lunch and when people spilled food and stained their clothes they were not supported to change or clean their clothing. This showed us not everybody was treated with respect, and staff did not understand the impact this may have had on the people they were supporting. Similarly a member of staff told us: "The tablecloths were put in the washer by a lunatic." This showed us that this member of staff had no understanding of the use of inappropriate language, which might be offensive to some people.

We found that these examples of lack of dignity and respect shown to people living in Allendale constituted a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed The Six Steps programme. The Six Steps is an end of life programme, in the North West, designed to enable care homes to improve end of life care. We saw that appropriate paperwork was present in some people's files, intended to help avoid unnecessary pain and suffering in the last days or hours before death. We noticed that one of these forms, a 'DNAR' form which instructs the staff and paramedics not to attempt CPR (Cardiopulmonary resuscitation), had not been completed correctly by the relevant GP. This might make it invalid if the paramedics arrived. However, during our inspection the GP visited and the registered manager requested them to complete a new form, which they did, albeit still not quite fully. When we checked care records the 'death and dying'

Requires Improvement

Is the service caring?

care plan for one person had not been updated recently. This meant that potentially any changes in the person's views, needs and wishes regarding their end of life, along with any new support required, had not been recorded.

After the inspection we spoke with the lead practitioner for the Six Steps programme who told us they had been involved in training the deputy manager of Allendale and other staff in the principles of Six Steps. They said that when there had been a resident at the end of life the staff had demonstrated good quality care and had followed all the principles of end of life care, including obtaining the correct medication. They added: "They follow through my recommendations. They are genuinely very caring."

Requires Improvement

Is the service responsive?

Our findings

We looked at three care files in detail to assess how well the staff at Allendale were delivering person-centred care. Person-centred care is tailored to the individual needs of each person, recognises their particular strengths and needs, and offers them compassion, dignity and respect. One aspect of person-centred care is to build up a detailed history of people's past lives, in order to enable staff to develop meaningful relationships with them and understand what and who is important to them and how they want to be supported.

The registered manager told us she was in the process of rewriting care plans, and about half the people had new-style care plans. We looked at a sample of both old and new. We did not notice any significant difference in terms of any more emphasis on person-centred care in the new care plans. One example arose when we talked with one person about their interest in football, which made them alert and enthusiastic. There was no mention of this interest in their care file, which meant that new staff would not become aware of it.

On one person's file we saw there was a section headed 'background information' but there was no detail about the person's life history. Similarly on another file the care plan had a heading 'Previous medical history' underneath which was written 'as above'. There was no medical history anywhere else in the document. This meant that care staff or other professionals consulting the plan would not be informed about that person's medical history.

Another person's care plan recorded under 'gut function' that there were 'no concerns'. However, we learnt separately from a member of staff that this person suffered from incontinence and lack of control of their bowel movements. The lack of information about this on the care plan indicated a failure to record or update meaningful details about their condition in the care record, or devise any plan about how to address this issue. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care plan reviews had been undertaken. Each person had a keyworker who was responsible for completing the reviews every month. These were recorded on a pre-printed form which asked whether there had been any changes to each section of the care plan. On one form we looked at the answer to each question was 'No'. We mentioned to the registered manager that a review is only valuable if it represents a thoughtful engagement with a person's care needs. The deputy manager told us they or the registered manager checked that care reviews had been completed properly. We found that this was not always the case.

In some respects the notes on the care plan were more for the benefit of the staff than the person being cared for. For example under one person's medication risk assessment it simply said about that person: 'Very confused. Staff to administer." On another person's assessment was written: 'Dementia. Staff to administer.' More thought could have been given to that person's unique situation because 'dementia' covers a wide range of cognitive ability.

On another care plan under the section 'My morning routine, How can we help you?' was recorded 'Staff to intervene if his clothing is dirty. He may be non-compliant. He can become verbally abusive. Staff to remove themselves should this occur'. This did not represent a respectful or person-centred approach to care planning.

Another person's care plan, written on 17 March 2015, recorded that they needed both glasses and a hearing aid, but on 2 June they had neither glasses nor a hearing aid. They had been visited by an optician on 24 March but no glasses had been obtained. This demonstrated a lack of attention to his individual needs, which would have an effect on this person's quality of life.

We saw that one resident experienced panic attacks which had been recorded on the daily care notes; however no further action had been taken by the registered manager or other staff to address these concerns with a risk assessment or care plan.

These deficiencies in the care plans amounted to a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the information contained within the care plans in relation to behaviour management was complex and not for the purpose it was intended. We discussed this with the registered manager who told us this would be looked at as they were streamlining information and trying to devise simpler ways of capturing information in care plans which was more relevant to the needs of the person being supported.

Requires Improvement

Is the service responsive?

A new "daily evaluation sheet" had been introduced in April 2015 which stated that staff 'need to write in detail about what you have helped the residents with.' We saw examples of these completed sheets, which recorded specific details of each person's day rather than a short standard sentence. This was a positive example of person-centred care.

We spoke with the spouse of a resident who told us that the staff are, "Excellent with [my relative]." The relative told us they knew how to complain; "Yes go to one of the staff." Although they did not know about ways they could complain or the role of the Care Quality Commission in monitoring how a service responds to complaints. This showed us the provider needed to do more work ensuring people knew they had the right to complain, how to complain and where to complain. Another relative said they had no difficulty making a complaint, and indeed had done so on several occasions, although they were not always satisfied with the outcome of their complaint.

One relative told us if they had any concerns about the care of their spouse, the staff would come and talk to them. Although the relative commented it would, "Be nice if there was a little room where visitors can go, it's always busy [in the hallway], people coming and going."

There was no activities co-ordinator in post on the date of this inspection; the previous member of staff allocated to this role had left. We saw on the staff rota that a different member of staff was assigned to organise activities on each day. A file was kept to record each day's activity and how it went. We saw the file recorded a variety of activities and who had taken part.

The registered manager and other staff told us there was always an open door to the office and people could raise issues before they became formal complaints. There was only one complaint recorded in 2015, which the registered manager had investigated. She stated she was satisfied the complaint was unfounded, although the complainant contacted us after the inspection and told us they remained dissatisfied. In the particular circumstances it might have been appropriate to ask for an independent investigation led by the Council.

Inadequate

Is the service well-led?

Our findings

On 10 March 2015, prior to the inspection, we requested the provider to complete and send us a Provider Information Return (PIR). This is a set of details about the service which helps us prepare for the inspection. Providers should have this information readily available to them through the internal systems they are required to have to monitor and improve the quality of their service.

The provider did not return the PIR or supply the requested information in another reasonable format. At this inspection the registered manager told us she had not been aware of the request for a PIR. It had been sent by email to the nominated individual of the provider, who was in fact the former registered manager who still worked at Allendale. The new registered manager became registered on 16 March 2015, and so the request was not sent to her on 10 March. We did not consider there was a valid reason for failure to submit the PIR, as the nominated individual ought to have actioned the request. It is the CQC's policy that failure to submit a PIR, without a valid reason, means the rating under this section cannot be better than "requires improvement", as it indicates management of the service is not performing well.

We discussed with the registered manager the continuing failure to comply with the regulation relating to the safe management of medicines. She stated that she had rewritten the medicines policy in February 2015. We also saw recorded in the minutes of a management meeting on 13 January 2015 that she had been "working through the CQC report. In-depth work carried out on medication." However, in November 2014 the CQC had delivered a notice of enforcement action which set out the findings of the previous inspection relating to medicines management in much greater detail than in the published report. This document had been handed to the new registered manager but she stated at this inspection she had not read it. This meant that she had not made herself fully aware of the failings identified at the last inspection. She told us she would read it now.

Medication audits were being undertaken by the former registered manager. The findings in this report tended to show that the audits had not been effective. The registered manager was already planning to change the pharmacist that supplied Allendale with medicines. However, the failings with regard to medicine management showed a failure to grapple with the issues identified on previous inspections, including the last inspection in August 2014.

The failure to run suitable medication audits or systems to prevent the catalogue of medication issues identified in this report was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with reference to subparagraphs 17(2)(a) and 17(2)(b) of those regulations.

It is a requirement of registration (Regulation 16 of the Care Quality Commission (Registration) Regulations 2009) that a provider notifies the CQC following the death of a service user. Since the previous inspection in August 2014 we had received notification of three deaths. During this inspection we became aware of four other deaths which had not been reported to us, in November and December 2014 and in April and early May 2015. Reporting such events is an important requirement as it enables the CQC to monitor care homes and take action when needed. We regarded the failure to notify us as a further example of poor management. We found it was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

We asked about other audits to check the quality of the service, and found there was a limited system. Some improvements had been made since the last inspection. There was now a 'job book' kept by one of the owners who had responsibility for the maintenance of the building. An infection control audit had been carried out by Manchester City Council in November 2014, and we saw the results of this had been included in the premises action plan. We noticed some tasks remained undone, for example an unsightly patch of plaster on the ceiling of the quiet lounge remained undecorated since August 2014. On the other hand, work had started to enlarge and renovate a bathroom on the ground floor.

We asked for evidence of other audits, such as analysis of falls or other accidents, pressure care or safeguarding events, but none was supplied. There was an accident report book which recorded 24 accidents so far in 2015, but there was no evidence of lessons learned from these. There had been no recent surveys of residents or relatives, or of the staff, with a view to establishing their views and improving the service. We found this was a breach of

Inadequate

Is the service well-led?

Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with reference to subparagraph 17(2)(e) and 17(2)(f) of those regulations.

We asked staff whether they felt well supported by the management and they told us they did. Many of the staff had worked at Allendale for a long time, but there were some recent new staff.

During our observations we found there was a sense of lethargy and lack of motivation in some members of the staff team which was exposing some residents to poor care. For example, the registered manager herself was the only member of staff in a 25 minute period who spoke with any of the people sitting in the lounge. We spoke with the manager about our concerns and they assured us they knew what the problems were and were going to address them through supervision and performance management.

The registered manager told us that she felt "fully supported" by the owners/provider of Allendale.

She had taken over from the previous registered manager at a difficult time for the service, and was still establishing the new management arrangements. She told us she intended to take a very 'hands-on' approach to managing the home and was not defensive but talked to us openly about areas where improvement was needed. We saw that she had dealt effectively with an internal staff grievance.

We received some positive feedback from a social worker, who said she was satisfied with the registered manager's investigation into a complaint, and from other professionals who commented: "Allendale would be one home I would always tell families to go and have a look at."

However, our conclusion was that the registered manager had not yet managed to address the problems identified in this and previous inspections.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment were not provided in a safe way for people using the service, because the provider was not ensuring that there were sufficient quantities of medicines at all times, and was not managing medicines properly and safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider had failed to notify the Commission of the deaths of service users

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment were not provided in a safe way for people using the service, because the provider was not doing all that was reasonably practical to mitigate risks to the health and safety of service users, and was not ensuring that the premises were safe to use for their intended purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 in regard to giving medication covertly.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not being treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating effective systems to ensure they were assessing and monitoring the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring that people received person-centred care which met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing everything reasonably practicable to mitigate risks, in terms of monitoring weight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that staff received sufficient training in all areas.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The provider was not ensuring that service users received enough support to eat and drink.