

Alpine Health Care Limited

Alpine Lodge

Inspection report

Alpine Road
Stocksbridge
Sheffield
South Yorkshire
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Tel: 01142888226

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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 

Summary of findings

Overall summary

This inspection took place on 10 August 2017 and was unannounced. This means prior to the inspection people were not aware we were inspecting the service on that day. The inspection was prompted in part as a consequence of information of concern sent to Care Quality Commission (CQC) and emerging risk identified by the CCG (Clinical Commissioning Group) and Sheffield local authority. The information shared with CQC indicated potential concerns about the management of risk in the service.

Alpine Lodge is a care home providing nursing care for up to 61 older people, some of whom were living with dementia. The home is located in Stocksbridge, in the North West of Sheffield. The home is a purpose built two-storey building. All bedrooms are single occupancy and have en-suite facilities. On the day of our inspection there were 59 people living in the home.

The home had a registered manager. A registered manager is a person who has registered with the 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.

Our last inspection at Alpine Lodge took place on 1 December 2015. The home was rated as Good. At that inspection we found the home to be in breach of one regulation for safe care and treatment. This was because some people's risk assessments lacked detail, did not reflect all of the relevant risks, or had not been updated to reflect changes in their needs. A requirement action was given for this breach in regulation and the registered provider was told to make improvements. On this inspection we checked improvements the registered provider had made. We found improvements had been made relating to risk assessments. However sufficient improvements had not been maintained to meet all regulations.

The majority of people who used the service and their relatives spoke positively about their experience of living at Alpine Lodge. They told us they, or their family member, felt safe and were happy. Only one person we spoke with told us they did not want to live at the home and they were not happy there.

We looked at the arrangements for the management of medicines. We found medicines were not always recorded, administered and stored accurately and in accordance with instructions.

Staff recruitment policies and procedures helped to ensure the right people were employed which helped to keep people safe.

Sufficient numbers of staff were provided to meet people's needs, although current staffing levels meant staff did not have much time to spend with people, other than to provide the necessary support and care.

People had access to a range of healthcare professionals to help maintain their well-being. A varied diet was provided, which took into account dietary needs and preferences so people's health was promoted and

choices could be respected.

Training provision was good and staff received regular supervisions and appraisals. Staff were clear about their roles and responsibilities and how to provide the best support for people.

People who used the service and their relatives said they were well looked after. People liked the staff and there was mutual respect between people, their relatives and the staff team.

Assessments of people's care did not include all of their needs, including health, personal care, emotional, social, cultural, religious and spiritual needs.

Activities were provided, however these were not well advertised and displayed for people to see. Further improvements and additions to the activity programme were underway.

People were aware of the complaints procedure but said they had not used this as they were happy with the service they were provided with.

The registered provider and registered manager used a variety of methods to assess and monitor the quality of the service. These included satisfaction surveys, audits and care reviews. We found these had not been effective in ensuring compliance with regulations and identifying areas requiring improvement and acting on them.

The registered manager was working in partnership with other professionals to improve the quality of the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Medicines were not always recorded, administered and stored accurately and in accordance with instructions.

Enough staff were provided to meet the needs of people. However, staff did not have much additional time to spend with people for socialising and enhancing their wellbeing.

Staff were aware of their responsibilities in keeping people safe. People and their relatives told us they felt safe.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff had an understanding of, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However records of decisions made were not always recorded adequately.

People were assisted to maintain their health by being provided with a balanced diet and having access to a range of healthcare professionals.

Staff were provided with a regular programme of training, supervision and appraisal for development and support.

Requires Improvement ●

Is the service caring?

The service was caring.

People living at the home and their relatives gave us positive feedback about the care and support they received. People spoke highly of the staff and said they were caring and kind.

People's privacy, dignity and confidentiality was promoted and maintained.

Good ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Care plans were not person centred. They did not always include all of the relevant information required to ensure people's individual health, personal, social and emotional needs would be met.

A limited programme of activity was available. The activity workers spent time with people on a one to one basis carrying out an activity of their choice.

People felt able to report any concerns or complaints and were confident these would be listened to and acted upon.

Is the service well-led?

The service was not always well led.

There were monitoring and audit processes in place. However, these were not always fully completed which meant improvements to the service were not always made in a timely manner.

The service had a full range of policies and procedures available to staff. These were being reviewed and updated.

People who used the service and their relatives were asked their opinions of the service and the majority of people said they felt, "Listened to."

Requires Improvement ●

Alpine Lodge

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.

This inspection took place on 10 August 2017 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor and two experts by experience. The specialist advisor was a registered nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience had experience in caring for older people and people living with dementia.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection we reviewed the information included in the PIR, together with information we held about the home. We also contacted commissioners of the service, the local authority safeguarding team, Healthwatch (Sheffield) and other stakeholders for any relevant information they held about Alpine Lodge. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We received feedback from Sheffield local authority contract officers, commissioners and the safeguarding team and Healthwatch (Sheffield).

In order to understand what people's experience was of living in the home we carried out a SOFI in a lounge/dining room area of the home. SOFI is a way of observing care to help us determine the experience of people who could not talk with us.

During the visit we spoke with ten people who used the service, 11 of their relatives, one healthcare professional, the registered manager and the regional manager. We also spoke with eight staff including qualified nurses, care workers, the activity worker and ancillary staff. We looked at four care plans, four staff files and records associated with the monitoring of the service.

Is the service safe?

Our findings

The people we spoke with told us they felt safe at Alpine Lodge. Everybody reported that Alpine Lodge was a friendly, caring and safe place to live. The majority of people were positive the care they or their relative received was safe. Comments included, "Yes, they [staff] are up on everything, like pressure areas," "Yes, I have got a buzzer but I don't really use it so I can't grumble," "They [staff] are in and out of my room during the day to check up on me," "I feel safe, I have no problems," "Yes, I talk to all of them they all know me" and "Yes, I think staff manage residents very well."

People we spoke with were confident in the way medicines were managed and were particularly positive about the close working relationship the home had with the local GP. All of those who were given medicines were happy this was given in a timely manner. People told us, "Yes, I get the right medicines at the right time," "Mum has been on a course of antibiotics and I checked just yesterday if she'd finished. I was able to get the information easily from the staff here and I have known the GP ring us at home to give us feedback too" and "The doctor from Stocksbridge surgery is here on a Tuesday so any medical matters are sorted out promptly."

There was a mixed response to questions about the staffing levels with negative comments from half of the people interviewed. Comments included, "They need more staff, they need an extra one or two to keep an eye on the challenging ones," "We need more staff, so there's less time waiting for things, but I can't grumble about the staff," "I wish there was less waiting for the buzzer to be answered," "The staffing levels are pretty good," "At weekends it seems to be quiet. But generally speaking you can get hold of somebody," "I don't think I've ever been here and thought there's not enough around. There's always someone to go to if I've needed someone" and "I used to bring up staffing levels. They have no time to talk to the residents properly, but there was no change."

At the last inspection on 1 December 2015 we found people had risk assessments in place if they were at risk of falls, pressure ulcers and poor nutrition. However, some people's risk assessments did not reflect all of the relevant risks, or had not been updated to reflect changes in their needs. At this inspection we found improvements had been made.

The care planning process included the completion of risk assessments which involved an assessment of the level of risk and action taken to mitigate the risks to the health, safety and welfare of people and keep people safe. Risk assessments were completed for moving and handling, mobility, falls, nutrition and hydration, continence and skin integrity. The registered provider used recognised risk assessment tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments, which helped identify the level of risk and appropriate preventative measures.

We looked at the arrangements for the management of medicines. For medicines with a choice of dose, we found the records did not show how much medicine the person had been given at each dose.

We found there was no guidance information kept about medicines to be administered 'when required' (PRN). Staff told us they were in the process of completing this information. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way. For example, several people were prescribed medicines for pain relief and there were no care plans or guidance in place to assist in staff decision-making about when it would be used. We did not see the use of the Abbey pain scale to measure pain in people who were unable to verbalise their pain.

We looked at the records for two people that had creams applied by care staff. There were no records kept for one person to show when and where the topical preparations were applied. For the other person the cream was listed on the Medication Administration Record (MAR), however it was coded as 'G' and there was no description for this code. This meant we could not be sure if people were having their medication administered correctly.

We saw some people required thickening agents to be added to foods and liquids to bring them to the right consistency or texture so they can be safely swallowed by people at risk of choking. We found the thickening agents were stored in an unlocked cupboard in the dining room kitchen area. The regional manager assured us they would arrange for a lock to be put on the cupboard the following day. Following the inspection we were given confirmation that this was completed.

Medicines which required cool storage were stored appropriately in a fridge which was within a locked room. Minimum and maximum temperatures were inconsistently recorded. The records seen showed temperatures were not between two and eight degrees centigrade. The maximum temperature recorded was over eight degrees centigrade. This is higher than recommended for cool storage and no specific action had been recorded by staff to rectify this and ensure medicines were safe to use.

This was a breach of Regulation 12 – Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to ensure medicines had been ordered, received and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

Medicine stocks were properly recorded when medicines were received into the home and when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered.

Medicines were given from the container they were supplied in and we observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked all medicines were taken.

On the day of the inspection there were 59 people living in the home. When we arrived at the home the registered manager told us she was working as a nurse. This was because one nurse had called in sick and the registered manager had not been able to get another staff member or agency worker to cover the shift. Staff provided throughout the day comprised of the registered manager, two nurses, ten care workers and ancillary staff. Due to concerns around the behaviours of a person the staff were providing one to one support for one person, throughout the day.

During our SOFI observation we saw staff were all very busy, attending to people's needs and providing people with care, support, food and drinks. This meant staff were attending to people's needs but not able

to spend any quality time with individuals. We observed just one occasion when a member of staff was able to sit with a person and read the local newspaper for a period of less than 10 minutes before they were interrupted to carry out further tasks. Staff told us, "We have to get all the tasks completed, so there's little time to spend with people" and "Yes it would be great to be able to take more time with people, but we can't always do this."

The regional manager told us they used a recognised dependency assessment tool to assess and identify the number of staffing hours required to meet the needs of people living in the home. We saw evidence the staffing hours provided were kept over the assessed level. However, the recent need to provide one to one support for one person was having an impact on this. The regional manager told us they were continually assessing and monitoring staffing hours provided to ensure the needs of people who used the service were met.

We found staff had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm. Staff were clear of the actions they would take if they suspected abuse, or if an allegation was made so correct procedures were followed to uphold people's safety.

The registered provider had a safeguarding and whistle blowing policy which staff were aware of. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. Staff said they would always report any concerns to the registered manager and they felt confident the registered manager would listen to them, take them seriously and take appropriate action to help keep people safe.

We looked at the procedures for recruiting staff. We checked four staff recruitment records. Each contained references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. The staff spoken with confirmed they had provided references, attended an interview and had a DBS check completed prior to employment. This showed recruitment procedures in the home helped to keep people safe.

On 27 July 2017 we were made aware of a concern that the fire system in one of the units at the home was not in working order. We contacted the South Yorkshire Fire and Safety Authority and asked them to visit the home to assess the risk to people. The registered provider was instructed by the fire service to put additional staff on duty until the fire system was repaired. This was actioned immediately by the registered provider. Following the visit from the fire service the registered provider was served with a fire enforcement notice. This was because the fire safety risk assessment was not suitable and sufficient and because inadequate safety training was provided to enable employees to safeguard themselves and other persons on the premises. The registered provider was given until 8 September 2017 to comply or they will be regarded as not being in compliance with the notice and the Fire and Rescue Authority may consider a prosecution. We have asked the registered provider to confirm to us when this work is completed and the fire enforcement notice is fully complied with.

Is the service effective?

Our findings

People living at the home and their relatives spoken with made positive comments about the cooking and the quantity of the meals provided. Their comments included, "They [meals] are very good, there's plenty of good choice," "I would eat it, it's great, it's excellent," "I have no complaints, in fact [relatives name] has put on weight," "I feed [relative] when I come in here. They have their meals liquidised. They also give me a meal. I think it's reasonably good, the last thing I want to do when I go home is start cooking" and "The meals are very good, breakfast is my favourite."

We observed people who used the service and relatives being offered a variety of drinks throughout the day. One person told us, "I like a cup of tea, if I'm having a drink then I like a shandy, I like fruit juice and also a small sherry."

People told us they were weighed regularly and said the care workers kept a, "Watching brief over weight changes." One person said, "They [staff] weigh us. I have lost weight so I have a milkshake." Everybody said there were snacks and drinks available between mealtimes. One person said, "Yes, they [staff] bring things around for you."

Assessments had been carried out using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day and included portion sizes.

We sat with people who used the service when they were having lunch in three of the four dining rooms. The tables were set attractively with tablecloths, placemats, napkins and condiments. We did not see the choices of food displayed; a member of staff told us menu boards were on order.

The lunch service was varied in terms of its management. One dining room at times appeared chaotic, with people who required support with their meals having to wait and therefore meals getting cold or being luke warm before staff were available to offer support. We also observed a minor dispute arose between four people at a table. A member of staff was in the dining room but was alone and attending to other tasks and the dispute became quite heated, resulting in a member of the inspection team having to call the member of staff to diffuse the situation, which they did, skilfully and calmly. In another dining room the atmosphere was convivial and there was some nice conversation between people at the tables. Staff interacted well with people and were available to support people with tasks such as cutting their food up.

The food was well presented and hot and cold drinks were available. Several people were given a glass of beer, which was thoroughly enjoyed. The care workers showed a good level of knowledge about people, knowing where they normally sat and providing some with an apron to protect their clothes. We saw some

people required pureed meals. We noticed each part of the meal was pureed separately and placed on the plate in distinct portions to make the meal look more appetising and help people to distinguish what they were eating.

Where people required encouragement to eat their food staff provided this in a quiet and unhurried way. For example staff sat next to the person and interacted with them in a positive manner. This meant the risk of weight loss was minimised.

Everybody felt there was good access to other healthcare professionals. One person said, "You just tell the nurse and they sort it out for you." Relatives said they were kept informed about referrals to health professionals and other daily changes. One relative said, "They phone me up if anything changes. They get people in if they need to."

Everybody said the staff asked for consent and explained what they were doing. One person said "Yes, they [staff] explain and ask for consent." People who used the service all said they could make decisions about the shape of their day. One person said, "They [staff] like you up at certain times but you can have a lie in if you want."

The Mental Capacity Act 2005 (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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw the registered manager had applied for DoL'S to be authorised for some people who used the service. This was because they did not have capacity and could not consent to the care being provided to them due to their dementia. The local authority had contacted the registered manager to explain there was a delay on authorisations but they would assess these as soon as possible. Staff had received training in MCA and DoL's and those spoken with had a good understanding of this.

We saw limited mental capacity assessments had been completed for some people and limited best interest decisions made for their care and treatment. This meant people's rights to make particular decisions may not have been upheld and their freedom to make decisions may not have been maximised, as unnecessary restrictions may have been placed on them.

We also found consent to care and treatment records were not always signed by people where they were able; if they were unable to sign we did not see a relative or representative had signed for them. For example, we were told one person received their medicines covertly. The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example, mixed with food or drink. There was a 'tick box record' which indicated the person's GP, care home staff, pharmacist and their family had discussed the administration method. However this was not signed by anyone and we were unable to verify who had completed the 'tick box'. The regional manager told us they were aware of the shortfalls in their recording of best interest decisions and were currently working with the local authority to improve this and ensure they met the requirements of the MCA

For some people we saw clear and concise information recorded about decisions made in people's best interests. For example, "[Name of person] is able to make small informed choices in their life in regards to most physiological needs. However due to conditions their capacity and consent in regards to physical and psychological needs are limited and require a MDT (multi-disciplinary team) approach."

The majority of people spoken with responded positively about the level of training for staff and the life quality they provided. One relative said, "Yes, I have no complaints about the staff training."

We checked the staff training matrix which showed staff were provided with relevant training so they had appropriate skills. The matrix showed training in specific subjects relevant to their roles. For example, moving and handling, health and safety and food hygiene. Additional skill training courses were also undertaken, for example, training on dementia awareness and tissue viability. Staff spoken with said the training was "Very good."

We checked records of staff supervisions and appraisals. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their role. The records showed care staff had been provided with regular supervision and an annual appraisal for development and support. All of the staff asked said they received formal supervisions and could approach management at any time for informal discussions if needed.

Following the inspection we were contacted by one relative who was concerned about the plans to register four additional rooms. The person said, "I have no concerns about general standards of care but feel that profit comes before the comfort of existing residents. The reduced capacity of communal lounges cannot accommodate current residents let alone when extra rooms are filled." We passed this information to our registration team for consideration during the registration process.

Is the service caring?

Our findings

The people we spoke with at Alpine Lodge told us staff at the home were caring. Their comments included, "I love it here very much, I love living here," "Yes I am happy," "I'm reasonably happy, some days are better than others," "Yes I'm very settled," "We are looked after, the carers are very good. They listen to you and try to help," "They [staff] are very nice, you couldn't wish for any better. They are very kind". People spoken with all felt the staff took the time to listen and would try to act on concerns. One person said, "They listen to me and try to help if you need something."

Relatives told us, "It's a nice environment, the staff look after people well. The carers have good hearts and are friendly and caring," "They [staff] tell me if anything has changed, they ask me if I want to feed [relative]" and "Yes, we are happy. It took a long time to find the right place."

Everybody felt people were treated with respect and dignity and that great care was taken over maintaining people's privacy. One person said, "Yes, they [staff] do respect my privacy and my dignity. They close the doors and curtains." Everyone we asked said having their door closed or open was their choice, not the carers. One person said, "It's usually open. I don't like feeling closed in."

There was a mixed response from people receiving support when asked if they could have baths and showers when they wanted. Some people thought there was a rota which meant they could not always have a bath or shower when they felt like it. Others were more positive. One person said, "If I want I can have one, whenever."

Everybody felt as far as possible people were supported in being as independent as possible. One person said, "Yes, absolutely they [staff] try to make you do as much as you can."

From our observations we saw people were dressed appropriately in clothes that looked clean and well cared for and laundered. We saw no evidence of any disrespect to people, with staff members always talking in a calm, supportive and experienced manner. The interactions we saw between members of staff, people who used the service and visitors were all professional and at the same time warm, friendly and caring. It was apparent that people were allowed and supported to move freely around the home. We saw people could choose to be in their own rooms or in the communal areas. People receiving support and their relatives appeared to be comfortable in the company of staff.

Our conversations with people who used the service and their relatives confirmed there were no unnecessary restrictions to people visiting the home or going out of the home. One relative told us "It's very free. For instance today, with the weather being nice, I just came and took mum out, but as they have a cooked lunch and sandwiches for tea, they've saved them a lunch because they knew we were having sandwiches when we were out."

One set of relatives told us end of life care had not been discussed with the staff and another relative said, "They have all the details. It's all sorted out."

We saw in the care records that limited end of life care plans were in place for people, which meant information may not have been available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Is the service responsive?

Our findings

Most relatives said they had made preliminary visits to the home and received written information about the services provided, prior to making a decision about their family member living there. One relative said, "We looked around a lot to find a good one [home for people with dementia]."

Other comments included, "They've [staff] brought my parent on leaps and bounds. When my parent came out of hospital, they couldn't walk. They then went to [another care home]. They didn't encourage them at all, and then we fought to get them in here. Now they can walk, they can get up and out of their chair on their own" and "The staff know my parent and what their needs are. My parent can get a bit irritated being around people all the time; they [the staff] will make provision for them if that happens."

The majority of people receiving support and their relatives were positive about the care workers level of knowledge about people. One person said, "They [staff] are getting to know me."

One relative told us, "The GP from Stocksbridge surgery is here on a Tuesday so any medical matters are sorted out promptly."

We looked at four people's care plans. We found there was no record system in place for people when they had to transfer between services. For example if they had to go into hospital or be moved to another service. These documents are important to detail information about the person, their needs and preferences and should accompany the person, which means they would receive consistent, planned care and support if they had to move to a different service.

Care records contained a limited social profile and very brief details about the person's preferences and interests. It is important information and necessary for when a person can no longer tell staff themselves about their preferences and enables staff to better respond to the person's needs and enhance their enjoyment of life.

People's care plans in relation to their behaviour management were not personalised and specific. They did not detail the exact support staff were to provide, how they should monitor after any incident and who they should contact for additional support if needed. Triggers for the behaviour were not documented so staff could recognise them and offer intervention before the person became increasingly anxious and distressed. There was no information on why people may be presenting with the behaviour such as pain, being unwell, being over stimulated or having a low mood. This meant staff may not have managed situations in a consistent and positive way, which protected people's dignity and rights.

One person was living with epilepsy. There was no evidence that an assessment of bathing risk in relation to epilepsy had been completed. The care plan stated if the person was to show signs of having a seizure staff were to seek emergency help. However, there were no specific details to ensure safety by removing objects and placing the person in the recovery position. There was also no information on the type of seizure the person experienced, the triggers and what the seizure might look like. This meant staff may not have the

information they needed to support them to recognise if the person was experiencing a seizure.

We saw limited information for staff to follow in relation to how they engaged with people. This approach meant staff may not have provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

We did not see evidence of people receiving support and their relatives being involved in care planning and the care plan documentation was not signed by the person where they were able or family member or representative. This meant people may not have been consulted about their care, and thus the quality and continuity of care may not have been maintained.

When staff changed duty at the beginning and end of each shift we saw handover records showed limited information regarding people's needs; daily care, treatment and professional interventions. We also saw no record of dates on a number of the handover sheets.

This was a breach of Regulation 9 – Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager told us as part of their action plan, agreed with the local authority, they had prioritised the updating and reviewing of all care plans starting with those people who had high risk factors and high dependency levels. This work commenced on 27 July 2017 and was on-going. The regional team were checking and auditing a selection of care files when they visited the home as a secondary check to ensure care plans were completed to the required standard. The deputy manager's supernumerary hours were being used to support the nurses to complete the care plan reviews.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GPs, speech and language therapists, best interest assessors, physiotherapists and dentists. This demonstrated staff worked with various healthcare and social care agencies and sought professional advice, to ensure the individual needs of the people were being met.

There had been a variety of experiences of the admission process but all the relatives were able to tell us that they or members of their family had visited Alpine Lodge and that for them, this setting was an active choice

People we spoke with were confident in and knew how to use processes to raise issues of concern. They told us, "If it was a little niggly issue, I'd probably just speak to one of the carers but if it was something bigger, I'd go to the manager," "If I had an issue of concern I'd probably start by talking to the nurse on duty. If I wasn't satisfied then I'd go to [name of registered manager]. If I still wasn't satisfied, I'd involve the social worker and if I still wasn't satisfied I'd involve safeguarding" and "No, I don't want to [complain], to be honest they are very nice people here. I have never wanted to complain."

The majority of people spoken with were positive about the level and quality of the activities both one to one and in groups. They told us, "The activity lady is always doing something. It is difficult for her but she is brilliant," "I can't sit in my chair long so I have only been to one bingo session" and "The staff assist us in going outside if we ask. You have to let them know so they don't go looking for you."

Alpine Lodge employed two activities coordinators, one 36 hour contract and one 27 hour contract. We saw

evidence of different singers coming into the home and chair exercises. Relatives told us staff took people out into the local community and we saw evidence of a regular church service being held in the home. One relative told us there were also occasions when people were taken to the local church in Deepcar. On the day of the inspection we observed one of the activity coordinators taking a group of people out onto the patio to enjoy the sunshine and a group activity of potting plants. The activity coordinator told us, "Most activities are on a one to one basis as we find people respond to this better than group activity."

We saw the activity programme was not displayed for people to see. A relative told us at the 'Relatives Forum', they had been advised that a new activity program was being drawn up and would be published and advertised shortly.

Is the service well-led?

Our findings

The majority of people spoken with said there was a good atmosphere in the home, one person described it as, "Nice, friendly and comfortable" and said they would recommend the home to others. A relative said, "Yes, I have told quite a few people, I would recommend it very highly." One person told us, "It is noisy, the building works annoy me. No, I would not recommend it."

The service was working with the local authority, which had put them in red risk status because they had received a number of safeguarding alerts over the last 12 months. Also risk meetings and further investigations had been triggered following a complaint raised by a family. Further meetings were planned to look at the safeguarding concerns. The registered provider had agreed to stop any new admissions into the home until the concerns had been addressed. The local authority told us they had started to see improvements but these had taken time and they were therefore providing support in order to speed up the progress. The regional manager provided us with a copy of their action plan which showed what the areas of concern the local authority had identified and what action they were taking to make improvements.

The registered manager told us she audited all areas of the service, which included accidents and incidents, complaints, safeguarding, staffing, health and safety and medicines. Auditing and monitoring of the service was also undertaken by representatives of the registered provider, for example the regional manager. We looked at audits and found some were not fully completed. For example, the analysis of accidents for month ending July 2017 did not show the times of injuries, the type of injuries or the location of injuries. This analysis should be completed to assist managers to identify any trends or themes in accidents occurring in each month, so that reoccurrences could be reduced or eliminated.

We also found the regional managers report of the overview of accidents and incidents in June 2017 was contradictory to the registered managers' report of the same period. When we looked at this more closely, we found the registered manager's report had been changed following the regional managers review being completed. This meant the analysis was not a true record of what accidents and incidents had occurred in that period and also meant the regional manager's report of this was not accurate.

Audits completed by the registered manager were not always signed and dated and did not always show any actions taken in response to the findings. When we spoke with the regional manager about these gaps and omissions she acknowledged these needed to be addressed as a matter of urgency. The registered manager told us she was aware some of the audits were not up to date or fully completed and said this was because she had been prioritising her work to focus on other areas of concern that were more urgent.

This is a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed throughout the day the registered manager engaged well with staff, visitors and people who used the service. The people we spoke with told us they were confident in the registered manager and if they had a concern, they would go to her. Relatives spoken with all knew the registered manager well and were

confident in her abilities. Their comments included, "I know who the supervisor is [named registered manager]. She's always got her door open but I've never had to go in to say anything to her" and "She is easy to talk to, she understands."

The majority of people said they felt the home was well managed one relative said, "I would say yes, now the manager is back." There was a generally positive feeling about how the staff and management would respond to issues being raised outside of formal meetings, one person said, "I think they would listen to me and do things if I asked."

Relatives felt they were kept updated about major changes in the home. One relative said, "They would inform you about some changes, decorations but not about staff."

Staff said communication in the home was good and they always felt able to make suggestions. There were meetings held for all staff and additional meetings for groups of staff, for example, nurses. Staff spoken with told us, "I like it here, there is good team work" and "We're a good team and work hard to make people happy."

One relative spoken with knew about and attended the 'relative's forum' and another relative said they knew of its existence but did not feel the need to attend. The other relatives spoken with did not appear to know that Alpine Lodge hosted a 'relative's forum'.

There was a mixed response about how much people were involved in the running of the home with the majority of people who used the service saying they did not attend meetings. One person said, "No, not proper meetings, they might ask if you're comfortable, things like that." Relatives were generally more positive about their involvement. One relative said, "Yes [we have a meeting], once every three months." Another relative told us, "We attended a 'relative's forum' on 25th July. There's going to be one every month, and there's a list in the foyer."

The registered manager told us quality assurance surveys were sent to people who used the service, their relatives and healthcare professionals twice each year. When these were returned if there were issues or concerns reported, the registered manager would go and see the person to try and resolve their concerns. We saw evidence of this. We also saw a report on display in the home which gave an overview of the responses received from people. The registered manager told us staff were not given surveys to complete. We spoke with the regional manager about this who said they would include staff in their quality assurance process so they would have the same opportunity to give feedback about the service.

The registered provider had policies and procedures in place which covered all aspects of the service. The regional manager told us a review and update of many of the policies and procedures was due to start and the registered provider had employed a person with expertise in this area to complete this. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.

The registered manager and senior staff were aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008 and evidence we gathered prior to the inspection confirmed this.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments of people's care did not include all their needs, including health, personal care, emotional, social, cultural, religious and spiritual needs.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always recorded, administered and stored accurately and in accordance with instructions.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health, safety and welfare of people.