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Alinthia House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Alinthia House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People who live in Alinthia House receive nursing care through the local community health team. The home provides both short and long-term care. The home accommodates up to seven people in one adapted building. Accommodation is provided over two floors, with a stair lift giving access to the first floor.

This focused inspection took place on 30 July 2018 and was unannounced. At the time of our inspection, six people were living in the home.

Alinthia House was previously inspected in April 2018 and was rated requires improvement. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified improvements were required in how the providers managed risks to people's health and safety, how they recruited staff, their quality assurance processes and notifying the Care Quality Commission (CQC) without delay of significant events within the home. We asked the providers to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. Before and since that inspection, the providers have been working with the local authority's quality assurance and improvement team (QAIT) to make the improvements needed.

Prior to this inspection in July 2018, we received information from the providers and the local authority's safeguarding team that two people had fallen and had sustained an injury. At the time of this inspection the safeguarding team were undertaking an investigation into the circumstances of one person's injury. We undertook this unannounced focused inspection of Alinthia House to look at how people's risk of falls was being managed and whether people were receiving safe care and treatment. We also checked that improvements to meet the legal requirements, planned by the provider, had been made.

We inspected the home against two of the five questions we ask about services; is the home safe and is the home well led? This was because the home was not meeting some legal requirements. No risks, concerns or significant improvements were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

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

At the time of this inspection, in July 2018, the home was continuing to work with QAIT. They were supporting the providers to review the quality and effectiveness of the home's documentation and systems

to monitor and protect people's safety and well-being. We found some progress had been made with the home's quality assurance processes and some of the information in people's care records. However, further improvements were required with how staff were recruited and the level of detail included in people's care plans and risk assessments. These required more information to fully describe people's care needs and associated risks as well as more detailed guidance for staff about how to minimise these risks.

People told us they felt safe living at Alinthia House. A relative told us they were confident with the care their relation received and felt they were safe. We found that although care records were insufficiently detailed to provide a full description of people's abilities and care needs, people were receiving safe care and support.

Since the previous inspection in April 2018, the home had employed a new member of staff. The newly employed member of staff had not competed an application form and as a result, the providers did not have information about the member of staff's employment history. This meant the providers could not be assured of the staff member's suitability to work at the home.

People and a relative told us they had confidence in the providers to support them safely and to ensure their care needs were met. The providers completed a monthly checklist to monitor areas such as the safety and cleanliness of the environment, care plan reviews and to monitor whether people received their medicines as prescribed. However, these reviews had not identified the improvements still required to people's risk assessment and care plans.

We identified continuing breaches in three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments and care plans were insufficiently detailed to provide staff with the information they needed to ensure risks were managed consistently and safely.

Recruitment practices were not robust in identifying the information required to judge staffs' suitability to work at the home.

Medicines were managed safely and people received their medicines as prescribed.

People benefitted from having enough staff available to meet their needs.

Is the service well-led?

Requires Improvement

The home was not always well-led.

Care records were not accurate, complete or contemporaneous.

Quality assurance systems were not used effectively to identify improvements.

People benefitted from having providers who were present in the home, approachable and who knew people well.

Alinthia House

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

The inspection was prompted in part by CQC receiving information from the providers and the local authority of two people living at the home sustaining an injury. The information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. This inspection examined those risks.

This inspection took place on 30 July 2018 and was unannounced. One adult social care inspector undertook the inspection.

During the inspection we met and spoke with four people who lived at the home. We spoke with the providers, two staff and a relative. We looked at the care records for two people and sampled information in a third person's. We also looked at records relating to staff recruitment, people's medicines and the running of the home. Following the inspection, we spoke with a healthcare professional.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in April 2018, we found risks to people's health and safety had not always been assessed. At this inspection, in July 2018, we found that risks had been assessed but improvements were required with the quality of the information included in the risk assessments and the guidance provided for staff about how to minimise these risks.

We looked at the risk assessments relating to mobility and the risk of falls for two people. The assessments stated both people were able to walk with a frame and assistance. However, the guidance provided for staff in the risk assessments, and in the care plans, did not include a description people's abilities, such as whether they could get in and out bed unaided and whether they could stand from a chair. One person's risk assessment stated they had at times walked without assistance, but there was no indication on the other person's risk assessment whether this was the case. For one person, a sensor mat was in use to alert staff to their movements should they get out of bed without staff support, but this was not referred to in the risk assessment. This meant that staff were not provided with the information they required to provide safe and consistent care to people.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the care of these two people with the staff and providers and it was clear they knew each person well and were able to describe their abilities and how they required support. A healthcare professional who knew one person well, told us they were confident in the quality and safety of the care provided at the home. We reviewed the daily care notes and established staff were supporting these people appropriately, with risks being managed as safely as possible.

Records showed that when accidents occurred, the providers reviewed how these came about and what actions might be necessary to reduce the likelihood of a reoccurrence. We reviewed the accident records since January 2018. These showed there was no one who had experienced a high number of falls and the providers had taken action to minimise people's risks.

At the time of the previous inspection in April 2018, recruitment and selection processes for new staff had not always been fully completed. Since that inspection, the home had employed a new member of staff. We reviewed the records relating to the recruitment process and found improvements were still required. The newly employed member of staff had not completed an application form and as a result, the providers did not have information about the member of staff's employment history. This information is important and the providers are legally obliged to obtain this to enable them to assess the staff member's suitability to work at the home.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers gave assurances the new member of staff was currently working under supervision with an experienced member of staff. Records showed a reference from the staff's most recent employer had been obtained and a disclosure and barring (police) check applied for. The providers said they would ensure a full employment history gained.

In April 2018 we identified the providers had not demonstrated a good understanding of general risk management. Environmental risks were not assessed, and the providers had not yet implemented all of the recommendations made by Devon and Somerset Fire and Rescue Service when they visited the home in February 2018. We also found they had not requested a swallowing assessment with a speech and language therapist as recommended by the hospital for a person returning to the home.

At this inspection, in July 2018, we saw improvements had been made. Records showed the providers had discussed this person's care with a speech and language therapist and recorded their guidance in the person's care plan. Environmental risks had been assessed, although not recorded, and windows had either been locked or fitted with opening restrictors and the razor and cleaning items had been locked away. The recommendations made by the fire service had been partially adopted, with door hold open devices remaining on the kitchen and laundry room doors but only used when the cooker, washing machine and tumble drier were not in use.

People told us they felt safe living at Alinthia House. They said they were well supported and staff assisted them in an unhurried manner and in the way they liked. One person said, "Yes, they do look after me well" and another person said they were "very happy" at the home. A relative told us their relation received very good care and praised the providers and the staff for the care and attention provided. They said they were confident their relation was safe.

The home continued to provide sufficient staff to meet people's care needs. The providers lived on site and were present in the home both day and night. In addition, three care staff were on duty in the mornings, one or two in the evenings and one overnight.

People continued to receive their medicines as prescribed. Medicines were stored safely and medicine administration records were fully completed with no gaps in the recordings.

The premises were clean and tidy. Gloves and aprons were available throughout the home and we saw staff using these appropriately during our visit to prevent and control the spread of infection.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in April 2018, we found the systems in place to manage risks and to monitor the quality of the service were not robust. At this inspection, in July 2018, we found some improvements had been made. The providers had commenced using a quality audit tool to monitor the safety and quality of the service. However, further improvements were required with the quality of the information and guidance provided in people's risk assessments and in how the home recruits staff. The quality audit tool had not been used effectively to identify these improvements were required. We found care records were not accurate, complete or contemporaneous as they did not provide a full description of people's abilities and care needs.

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

The home continued to be supported by the local authority's quality assurance and improvement team (QAIT) who last visited the home in June 2018. Improvements were identified and further support offered to review the home's service improvement plan. This plan detailed the action taken to address the improvements identified at the previous inspection and through QAIT's quality assurance reviews. The providers also completed a monthly checklist to monitor areas such as the safety and cleanliness of the environment, care plan reviews and to monitor whether people received their medicines as prescribed.

People and staff told us the providers were approachable and that they had a good relationship with them. Visitors were seen to come and go from the home and we saw friendly interactions between them and the providers. A relative told us they found the providers friendly, caring and supported their relation well.

Since the previous inspection, the providers have kept CQC up to date with important events in the home and have submitted notifications about incidents they were required by law to tell us about. At the time of this inspection, the providers were working co-operatively with the local authority's safeguarding team while their investigation was underway.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks assessments did not contain sufficient information and guidance for staff to minimise risks to people's health, safety and welfare in a consistent and safe way. Regulation 12 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records for each person were not accurate, complete or contemporaneous. Quality assurance tools were not used effectively to identify where improvements were required. Regulation 17 (1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively and not all of the information necessary to support safe staff recruitment was obtained before staff were employed. Regulation 19(1)(2)