Alpine Health Care Limited

Alpine Lodge

Inspection report

Alpine Road
Stocksbridge
Sheffield
South Yorkshire
S36 1AD

Date of inspection visit:
01 December 2015

Date of publication:
11 April 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 1 December 2015 and was unannounced. Our last inspection of this service took place in November 2013 when no breaches of legal requirements were identified.

Alpine Lodge is a care home providing nursing care for sixty-one older people. Within the home is a twenty-bedded unit for people with dementia. Alpine Health Care Limited owns the home. The home is located in Stocksbridge, in the North West of Sheffield, opposite a school and within walking distance of shops and the bus route. The home is a purpose built two-storey building. All bedrooms are single occupancy and have en-suite facilities. At the time of the inspection there were sixty people using the service.

There was no registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a new manager, who had started work in the home around six months ago. The manager told us they were preparing to apply to become registered.

People said they felt safe and the staff we spoke with had a clear understanding of safeguarding people from abuse, and of what action they would take if they suspected abuse. The way staff were recruited was safe and thorough pre-employment checks were done before they started work.

The individual plans we looked at included risk assessments, which identified most risk associated with people's care. However, 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.

We found there were enough staff with the right skills, knowledge and experience to keep people safe. The manager was undertaking a review of the staffing levels and deployment in order to make improvements in this area, as there was a lot of pressure on staff to meet people's needs at busy times.

People's medicines were managed and administered safely.

Staff were provided with appropriate training to help them meet people's needs. This included appropriate training to help them to respond positively when people displayed behaviour that challenged.

We found the service to be meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and the staff we spoke with were aware of the Act. There was a need to further develop some of the assessments, records, and the practice in some areas, and the manager was taking action to address this.

People were supported to maintain a balanced diet. The people we spoke with told us they liked the food

and were happy with the choice of meals.

People were supported to maintain good health, have access to healthcare services and received on-going healthcare support. We found that people had received support from other professionals and appropriate healthcare services when required.

People's needs were assessed and care and support was planned and delivered in line with their individual support plan. We saw staff were aware of people's needs and the best ways to support them. The manager and all of the staff we spoke with and saw supporting people, had a caring approach and treated people with respect and dignity.

People's individual plans included information about their family and others who were important to them and they were supported to maintain contact. We saw that people took part in activities and events in the home and in the local community, and people told us they were happy with the activities on offer.

People who used the service, their relatives and staff told us the manager, although relatively new, was very approachable and responsive. They were pleased that the manager had introduced regular meetings with them, and had made improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
People had care plans and risk assessments associated with their needs and preferences. Although some people's risk assessments did not reflect all of the relevant risks, or had not been updated to reflect changes in their needs.

Although there were enough staff to keep people safe, the management team were aware that there was a lot of pressure on staff to meet people's needs at night and at other busy times. A staffing review was being conducted in order to make improvements in this area.

The people we spoke with who used the service told us they were well looked after and felt safe. We know from our records that safeguarding incidents were reported and dealt with appropriately.

Medicines were stored and handled safely.

The way staff were recruited was safe and thorough pre-employment checks were done before they started work.

Is the service effective?

Good

The service was effective.
The Mental Capacity Act 2005, and it's Code of Practice were being followed, although there was room to improve practice and records in some instances.

People were supported by staff who were trained to give care and support that met people's needs.

People liked the food and were supported to have a balanced diet.

Staff supported people appropriately with their health needs and people saw their GP and other specialist healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.
People told us they were happy with the care and support they received.

Staff spoke to people with warmth and respect, took into account people's privacy and dignity and had a good knowledge of people's needs and preferences.

People we spoke with said they were listened to and participated in their assessments and care planning.

Is the service responsive?

Good

The service was responsive.
People had detailed care plans, which were regularly reviewed.

There was a complaints system in place.

People told us that they enjoyed the range of activities available.

Is the service well-led?

Good

The service was well led.
The manager asked people, their relatives and other professionals what they thought of the service and also checked the quality of the service themselves, using audit tools.

People who used the service, their relatives and staff told us the manager, although relatively new, was very approachable and responsive. They were pleased that the manager was making improvements to the service.
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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.

The inspection team was made up of a CQC adult social care inspector and a specialist advisor, who was a qualified nurse, with had experience of managing older people's services, both in health and social care settings.

Before our inspection, we reviewed information we held about this service and the provider, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the service. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted representatives of the local council commissioning team, who commissioned services from the provider.

During the inspection we spoke with 12 people who used the service and six people's relatives and one visiting health care professional. We spoke with 10 staff including carers, and ancillary staff, along with the manager. We also checked the personal records of six people who used the service. We checked records relating to the management of the home, team meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the management team.

We observed care taking place in the home, and saw staff undertaking various activities, including handling medication and using specific pieces of equipment to support people to move around the home. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and well supported at the service. One person said, "The staff are very nice. I am safe and well looked after." Another person said, "I'm quite at home here. Staff are sometimes busy, but I don't have to wait long if I need anything." A relative said, "I come to visit most days. I'm happy that (my family member) is safe."

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. For instance, we saw that people had been identified as being at risk of pressure damage, without a clear plan being put in place about how this should be managed. One person in particular was assessed as high risk and was seen to be sitting for the duration of the inspection. They had no repositioning regime in place, either in their care plan or on the paperwork kept in the bedroom. There was no record that the staff were repositioning the person during the daytime, although the night staff had recorded that their position was changed every four hours.

We saw two care plans for people who had bed rails. Both people had care plans in relationng to falls, which indicated that bed rails were in use. However, no risk assessments were in place to support their use, and there was no written evidence that mental capacity assessments or best interest decision had been undertaken in relation to this.

In another instance, one person's care plan identified risks of self- harm and indicated that staff should use certain interventions to reduce these risks. We saw that staff were not following the guidance. We were told that the person was now more settled and the risks were not current. However, the person's risk assessments had not been updated to reflect their progress.

Therefore, people who used the service were not protected against risks associated with their care. This was a breach of Regulation 12 (1), (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff we spoke with felt the people who used the service were safe in the home. A safeguarding adult's policy was available and staff were required to read it as part of their induction. We spoke with staff about their understanding of protecting adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They were aware of the local authority safeguarding policy and procedure and would refer to them for guidance if needed. They said they would report any concerns to a nurse or the manager. Our records show that any safeguarding issues were reported and dealt with appropriately. Staff also had a good understanding of the whistle blowing procedure. Whistleblowing is another way in which a worker can report concerns.

Staff were able to explain the strategies they used to manage any behaviour people exhibited that challenged. One staff member told us they had recently attended Non Abusive Psychological and Physical

Intervention (NAPPI) training. They said this training helped them in supporting people with behaviour that challenged. There were care plans in place, in regard to people's behaviour which had been updated regularly, but were not very detailed.

Although people's written plans and risk assessments needed to be improved the risks to people were minimised to some extent, because staff knew people well. They told us this was because there were good verbal exchanges of information. This was due to a very thorough staff induction, and they were kept up to date as people's needs changed because of 'morning meetings' and staff handovers between shifts. The manager was aware that people's care plans and risk assessments needed to be improved and we saw that they had started work on these improvements.

We looked at the number of staff that were on duty and checked the staff rotas to confirm the number were correct. The manager told us they did not use a dependency tool to assist with the calculation of staff needed to deliver care to people. The manager told us that the organisation had calculated staffing numbers, but there was some flexibility to increase staffing hours, if required. We asked several staff if they thought there were usually enough staff. Most said there were busy times, but there were enough staff to keep people safe. Two staff said they felt there were sometimes not enough staff at some key times of the day, and it could be difficult to monitor and respond to people's behaviour, as well as to meet people's physical care needs.

The manager told us they were gathering evidence to help with reviewing the staffing in the home, and that evidence so far supported a need to deploy staff more effectively at key times. Care staff confirmed this. They told us they were keeping particular written records in relation to people displaying behaviour that challenged, and that this was to help with the staffing review.

We found the recruitment checks undertaken for staff were thorough. Applicants had completed application forms, written references had been obtained and formal interviews conducted. All new staff completed a full induction programme, which when completed, was signed off by their line manager.

The manager told us that staff did not commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to make sure only suitable people were employed by the service.

People told us that their medication was brought by staff and they felt it was handled properly. Our observations showed that people's medicines were safely managed. Medicines were securely stored and room and refrigerator temperatures were checked and recorded to make sure that medicines were being stored at the required temperatures. We checked records of medicines administration and saw that these were appropriately completed. There were systems in place for stock checking medicines, and for keeping records of medicines which had been destroyed or returned to the pharmacy. We found the records were clear and up to date.

Some people were prescribed medicines to be taken only 'when required', for example painkillers. We saw protocols to assist staff when administering this type of medication. The medicines administration record (MAR) used by the home included information about any allergies the person may have had. This helped to make sure that staff trained to administer medicines, were able to do so safely.

We observed a nurse administering people's medicines. They did this safely and made sure the medicine in the medicine trolley was kept secure during the process. They recorded medicines correctly after they had

been given. Staff had the necessary training to administer medication safely and competency checks were also undertaken.

The manager conducted medication audits, including the MAR, to check that medicines were being administered appropriately. Staff checked the MAR at each shift change to identify any errors or omissions, so that these could be dealt with immediately.

We checked around the home to see if it was clean and tidy. There were no obvious trip hazards and everywhere was clean. We did not notice any unpleasant odours or stained furniture and bedding. People were clean and well presented.

We observed good practice in regard to infection control. We saw staff followed good hand hygiene procedures and protective equipment such as aprons and gloves were available throughout the building. We saw one member of care staff encouraging people who used the service to wash their hands after using the toilet. We saw there were cleaning checklists to make sure that tasks were completed and staff we spoke with were aware of the importance of cleaning to a high standard.

Good

Is the service effective?

Our findings

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 to 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own. At the time of the inspection the manager told us applications had been made to the supervisory body. There were three people who were subject to DoLS and we found appropriate measures had been taken to make sure people's care was given in the least restrictive way. The remaining applications which had been submitted were still awaiting decisions.

The staff we spoke with were clear about the training they had received. Training also included their role in promoting people's rights and choices. We saw that when people did not have the capacity to consent, procedures were followed to make sure decisions that were made on their behalf were in their best interests. We looked at the care records for four people who used the service and there was evidence that people were consulted and consent was gained about how they wanted to receive their care.

However, we did see areas where good practice had not been fully adhered to. For instance, a number of people had received flu vaccinations and there was no written record to indicate that people had capacity assessments undertaken in relation to this decision, or that the best interests process had been followed for each person. One person had their medicine administered covertly. There was a plan in place, and best interest decision was undertaken, but there was no evidence that a mental capacity assessment had been undertaken. Two of the care plans had DNARs in place which stated they had not been discussed with the person concerned, as they did not have capacity. However, there was no mental capacity assessment for the decision or best interest, although members of their families had been consulted.

The service had suitable arrangements in place that made sure people received good nutrition and hydration. We looked at five people's care plans and found that they included detailed information on their dietary needs and the level of support they needed to make sure that they received a balanced diet. Where people were identified as at risk of malnutrition, referrals had been made to a dietician for specialist advice. There was a MUST (Malnutrition Universal Screening Tool) tool used to determine if a person was at risk from losing weight. We spoke with staff about people that had been identified as at risk in this area. They

told us that they monitored people's intake of food and fluids to make sure they received sufficient to meet their needs.

We observed a group of people eating their lunch. When the meal arrived we saw good interactions between staff and people seated for their lunch. People were given a choice of the main course which looked very nice. Although there were no condiments offered though with the meal. People told us they usually enjoyed their meals. One person said, "I like the food and they know what I like, so I'm well looked after." One person's visiting relative said their family member ate well and there was, "A good choice and fresh vegetables every day."

People were supported to have their assessed needs, preferences and choices met by staff that had the right skills and competencies. People who used the service and relatives we spoke with told us they thought the care staff were competent and well trained to meet their or their family member's individual needs. One relative said, "The staff do a good job. I have no concerns about the care." One person we spoke with said, "The staff are very nice. They ask if people are OK and they help me when I need it."

Records we looked at confirmed staff were trained to a good standard and most staff had obtained nationally recognised care certificates. The manager told us all staff completed a comprehensive induction which included, care principles, service specific training such as, working with people living with dementia, expectations of the service and how to deal with accidents and emergencies. Staff were expected to work alongside more experienced staff until they were deemed to be competent.

We spoke with the nurse on duty. They told us they had worked at the home for five months. They understood people's needs well. They told us they had completed an extensive induction programme and felt supported by the manager. One member of care staff we spoke with had been working at the home for three years and another member of care staff told us they had been working at the home for seven months. They both said they had received lots of training and knew people, their needs and their preferences well.

The care staff we spoke with were confident in the nursing staff and their response to any concerns that may arise with regard to people's care. They both also felt confident that they could approach the manager should they wish to raise any concerns. We saw that staff supervision had fallen behind due to the changes in management, but that the manager was aware of this and prioritised catching up, as new members of the management team started work.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received. They said they felt at home and were listened to. We saw staff had a warm rapport with the people they cared for. People were treated with respect and their dignity was maintained throughout our visit. A visiting heath care professional commented that the care people received in the home was of a good standard.

All of the interactions we saw between people who used the service and staff members were of a caring nature. We observed numerous kind and caring interactions. Staff and people who used the service clearly had a good rapport. It was very clear that staff knew people well and were able to tell us about individual people and their life histories.

The care staff were very patient and understanding. For instance, at lunchtime they did their best to encourage people to eat, offering other options if people did not enjoy what was on offer. Some people were reluctant to eat and staff took time to encourage them and were very courteous.

The relatives we spoke with were very complimentary about the staff and manager. More than one said the service was "Great." For instance, we spoke with one person's relative who told us they visited most days. They told us it was a very good home adding, "I cannot fault it."

People's plans indicated they were involved in the planning of their care and that people's spiritual and religious beliefs were respected. One person's records showed that they were Roman Catholic, and they had a care plan in place which stated their 'End of life' wishes, in the context of their beliefs.

Staff were also emotionally supportive and respectful of people's dignity. For example, we observed a person looking distressed and confused. A member of staff comforted them. During this exchange, the person's mood changed and they became more happy and relaxed.

The service had a stable staff team, some of whom had worked at the service for a long time and knew the needs of people well. The continuity of staff had led to people developing meaningful relationships with staff.

People's diverse needs were catered for. People's plans indicated their spiritual or religious beliefs. One person's records showed that they were Roman Catholic, and they had a care plan in place which stated their 'End of life' wishes, in the context of their beliefs. People were asked if they had a preference for the gender of the staff who delivered their personal care and people who wished to attend Church were supported to do so. People told us that staff were caring and respected their privacy and dignity. Our observation during the inspection confirmed this; staff were respectful when talking with people. They called people by their preferred names and we observed staff knocking on people's doors and waiting before entering. Staff were also observed speaking very discretely with people about their personal care needs.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The people we spoke with told us the standard of care they received was good. We looked at copies of five people's assessments and care plans. They gave a clear picture of people's needs. They were person-centred in the way that they were written. For example, they included information about people's likes and dislikes in relation to food, their care arrangements and leisure activities. People we spoke with told us they were offered choices about such things as when to go to bed and get up, where to spend their time and what to eat.

We found that people's care and treatment was regularly reviewed to make sure it was up to date. We saw on care plans how staff evaluated the progress on the plans. There were daily staff handovers, and this helped to make sure that up to date information was passed to staff at the start of each shift. This meant staff knew how people were each day.

There was board which showed the planned activities that were on offer each day, and these were nicely varied. We saw activities taking place in some areas of the home during the inspection this was in small groups and on an individual basis. People told us they were happy with the activities on offer.

However, we spent some time in one particular lounge and dining area, where a small number of people were sitting in specialist chairs. No staff visited the area for the 45 minute period that we were there. The people were at times shouting out or banging their hands on their chairs. The manager reassured us that this was very unusual. They explained that people usually sat in a different sitting room, with staff nearby and attending to their needs, but that particular sitting room was being redecorated. The manager addressed the issue when we raised it, by allocating a staff member to spend time with people. We looked in on people a little later, and staff were engaging with them and encouraging them to join in with activities.

People's plans included information about their family and others who were important to them and they were supported to maintain contact. All the relatives we spoke with told us that the staff in the home made them feel welcome and that there were no restrictions on visiting. One relative said they visited five times every week. They felt that the key members of the family were kept informed and were involved in decisions about their family member's care.

The manager told us there was a complaints' policy and procedure, this was explained to everyone who received a service. It was written in plain English and displayed on the notice board in the home. The manager told us that they met regularly with staff and people who used the service to learn from any concerns raised to make sure they delivered a good quality service. People told us that they would know what to do if they had any complaints or problems and no-one had any complaints or concerns to share with us. The relatives we spoke with told us they had no concerns but would discuss things with the staff or the manager if they needed to raise any issues. One relative told us they found the manager approachable, and they would not hesitate to go to the manager with any worries. We saw the record of previous complaints and this showed that any issues people had raised were taken seriously, investigated

appropriately and responded to in a timely fashion.

Good

Is the service well-led?

Our findings

There was no registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a new manager, who had started work in the home around six months before the inspection. The manager told us they were preparing to apply to become registered.

The people we spoke with knew who the new manager was and said they were very approachable. From our observations and discussion with staff we found that they were supportive of the manager's vision for the service. Staff told us that the atmosphere and culture in the service had improved since the manager had been appointed. They felt that the manager was supportive and that they could approach them if they had concerns. They also felt that they were well supported by the nursing staff.

A number of audits or checks were completed on aspects of the service provided. These included administration of medicines, health and safety, infection control, care plans and the environmental standards of the building. These audits and checks highlighted any improvements that needed to be made to improve the standard of care provided throughout the home.

The manager sought feedback about the service through meetings, including individual service reviews and resident and relative meetings. This was supported by informal feedback via day to day conversations and communication from the staff team. We saw evidence to show the areas identified for improvement were being addressed. There was a programme of redecoration in progress and the environment was being made more suitable for people living with dementia. The manager told us there was to be a competition to encourage staff and relatives to help people to revamp their 'memory boxes' outside their bedrooms. However, the manager did not have a written action plan, to help them to prioritise, and their line manager to monitor progress with the improvements.

We looked at a number of documents which confirmed the provider managed risks to people who used the service. For example, we looked at accidents and incidents which were analysed by the manager, who had responsibility for ensuring action was taken to reduce the risk of accidents/incidents re-occurring.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against risks associated with their care. This was a breach of Regulation 12 (1), (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.