

Leonard Cheshire Disability

Alne Hall - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service

Requires improvement



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?

Requires improvement



Overall summary

This inspection took place on 18 November 2015 and was unannounced. The last inspection was carried out in November 2013 when the service was found to be meeting the Regulations assessed.

Alne Hall is a care home that is registered to provide nursing or personal care for up to 30 people with physical disabilities. The service is located in a detached, listed building, set in its own grounds. The building consists of the original hall which has been extended to provide further bedrooms, facilities and services. The ground floor

of the service has been adapted to be wheelchair accessible throughout. At the time of our inspection there were 27 people who used the service, 15 of whom received nursing care.

There was a registered manager in post at the time of our 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

Summary of findings

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.

We identified some areas that required improvement to keep the service safe. One safeguarding concern had not been communicated effectively in line with policy and procedure. There were also areas of medicines management which were not in line with good practice and could place people at risk. We made recommendations about these two areas.

There were enough staff on duty to make sure people's needs were met. Recruitment procedures made sure staff had the required skills and were of suitable character and background. Staff told us they enjoyed working at the service. Staff were supported through training, regular supervisions and team meetings to help them carry out their roles effectively.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted. The registered manager had taken appropriate action for those people for whom restricted movement was a concern. Best interest meetings were held where people had limited capacity to make decisions for themselves.

People were supported to maintain their health and well-being and had access to other professionals, such as

a doctor or dentist as needed. People were given sufficient amounts of food and fluid. Where people had specific dietary requirements, these were catered for, and suitable assistance was provided where required.

People told us that staff were caring and that their privacy and dignity were respected. Care plans were person centred and showed that individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met.

People's needs were reviewed and appropriate changes were made to the support people received. People had opportunities to make comments about the service and how it could be improved.

There was an experienced, registered manager in post. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified. However, this system was not always effective at identifying areas of practice that needed improvement. For example, some of the records relating to the care and treatment of people who used the service were not completed in a consistent manner. Some records were not fit for purpose which was a breach of Regulations 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to make at the end of the full report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not fully safe.

Medicines were not always managed in line with recommended good practice.

The provider had not always taken appropriate action to protect people from abuse and improper treatment.

Risks to people had been identified but were not always reassessed at appropriate intervals to make sure people received safe care and support.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Requires improvement



Is the service effective?

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and relevant legislative requirements were followed.

People were supported to eat well and maintain good health. There was access to relevant services such as a doctor or other professionals as needed.

Good



Is the service caring?

The service was caring.

People told us that they were looked after by caring staff.

People made day to day decisions about the support they received.

People were treated with dignity and respect whilst being supported with personal care.

Good



Is the service responsive?

The service was responsive.

People received personalised care. Care and support plans were up to date and reflected people's current needs and preferences.

People knew how to make a complaint or compliment about the service. There were opportunities to feed back their views about the service.

Good



Is the service well-led?

The service was not always well-led.

An experienced, registered manager was in post

Requires improvement



Summary of findings

Records relating to the care and treatment of people who used the service were not always fit for purpose.

There were systems in place to look at the quality of the service provided. However this was not always effective at identifying areas that needed improvement.

There was a positive, caring culture at the service.

Alne Hall - Care Home with Nursing Physical Disabilities

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 18 November 2015 and was unannounced. The inspection was carried out by one inspector, a specialist advisor in nursing and an expert by experience. 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 expert by experience on this inspection had experience of using services for disabled people.

Before the inspection we reviewed the information we held about the service. This included notifications regarding

safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we looked around the premises, spent time with people in their rooms and in communal areas. We observed a lunchtime meal. We looked at records which related to people's individual care. We looked at four people's care planning documentation and other records associated with running a care home. This included four recruitment records, the staff rota, notifications and records of meetings.

We spoke with nine people who received a service and a visiting relative. We met with the registered manager, two nurses and four care staff. We also talked with the activity coordinator and main chef.

Is the service safe?

Our findings

Most people told us that they felt safe at the service. A service user survey carried out in July 2015 also found that all 16 respondents felt safe. However we received information from one person about an incident which had made them feel unsafe and which had not been acted on properly by management. A staff member told us that they had informed a senior shortly after the incident that this person had disclosed feeling unsafe around some care staff. The registered manager had subsequently met with the person but told us they had not been made aware of any allegations against staff members and it had not been reported to the safeguarding authority. At the inspection we requested that this be done and we have since received confirmation that a safeguarding alert had been sent.

We recommend that safeguarding procedures are reviewed to make sure there are clear reporting procedures within the management team.

Care assistants were aware of their responsibilities to safeguard people and had received training in this area. We were satisfied that where safeguarding concerns about people had been identified they had been reported to a senior or manager as required.

There were risk assessments in people's care plans, however we identified a number of concerns about the frequency with which these were being reviewed. The registered manager told us that skin integrity risk assessments were carried out every six months to assess the risk of people developing pressure sores. We found two examples where people at risk of pressure sores had a risk assessment last completed in May 2015. One of these people received nursing care and spent all their time in bed. We also noted that moving and turning charts were not in use to monitor people's care in this area. The provider was not safely monitoring the risks to the person and could not be certain that people received safe care and support which met their current needs. We did note however that there had been no recent incidence of pressure sores with people who used the service.

Incidents and accidents had been recorded appropriately and health and safety incidents had been reported under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations as necessary. There was a nominated health and safety representative within the

service. There were up to date environmental risk assessments in place which included infection control and the use of hazardous substances. A health and safety audit was carried out in October 2015 to make sure the service was a safe place to work and live. A fire risk assessment was carried out in February 2015 which identified a number of areas which required improvement. We saw that this action had been completed.

There were call bells in each person's room to alert staff if they needed assistance. A relative told us that the person they visited was safe and had the right support in an emergency. They told us that as well as a call bell there was an emergency button in their room and that when this was pressed "Staff come very quickly". One person did tell us that if they pressed the call bell during the night it could take a long time for staff to attend. However we did not find any evidence that people had been placed at risk due to the time taken for staff to attend. Each person had a personal emergency evacuation plan which provided staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

Recruitment records showed that all the necessary background checks were carried out before new staff were able to start work. Records held evidence of a criminal records check, references, proof of identification as well as right to work in the UK if required. We noted that people who used the service were involved in staff interviews, which was an additional way of making sure that suitable staff were employed.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. There was one nurse available at all times and the registered manager told us that, as a registered nurse, they would help out on shift if required. The service made use of ancillary staff such as cleaners, cooks and activity workers. There were also four volunteers who lived above the service who acted as additional support when required. We received comments from one person that staff could sometimes appear "Run off their feet", however the staff we spoke with expressed no concerns about the level of staffing. We observed during the day that there were sufficient staff to attend to people as needed.

Staff were trained in the safe handling of medicines and then assessed for competency before being allowed to be involved in medicine administration. Each person who

Is the service safe?

needed their medicine to be administered by staff had a medication administration record (MAR). We reviewed a sample of MAR charts and found overall, they were correctly completed. We saw sample signatures of nurses administering medicines were in place in order to identify who had completed the MAR. Some MAR charts were handwritten. However, some MAR charts with hand written instructions were not signed by two members of staff and there was no record of who had authorised changes. This meant there was no clear line of accountability for changes and a risk that people may not receive the correct medicines.

We observed medicines being administered and saw that correct procedures were followed. However, the MAR charts which were used to check what medicines were to be administered did not have a current photograph of each person. This is good practice and helps to make sure there are no mistakes of identity. However, we did not identify that any errors had occurred because of this.

Although there was information about medicines in people's care plans, there was no written guidance kept with MAR charts, for the use of "as required" medicines, and when and how these medicines should be administered to people who needed them. One person had 'as required'

medicine for a health condition. There was no information with the MAR chart about when and how this was to be administered together with the effect expected and the maximum dose. This meant there was a risk that staff did not use a consistent approach to the administration of this type of medicine.

Medicines were stored securely in a locked, organised medicine trolley which was secured to the wall in a medicine treatment room when not in use. There were daily records of medicine storage room temperatures. Although we identified some gaps in recording there were no occasions where the temperature was higher than that recommended on medicines guidance.

There were suitable systems in place for the receipt and disposal of medicines. There were also appropriate arrangements in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse.

We recommend the provider reviews medicines practice in line with the National Institute for Health and Care Excellence (NICE) guidance on managing medicines in care homes.

Is the service effective?

Our findings

Staff received the support they needed to provide effective care. Comments included “I love it here. I love what we do and the people we support. I feel supported. Very much so” and “I enjoy it here. We are supported as a team”.

Staff members told us they received a suitable induction when they started working at the service. This included two weeks shadowing other staff and observing practice. New staff were also provided with a mentor who helped with introducing them to the requirements of the role. One member of staff who recently started working at the service told us “I’m enjoying it very much. I am definitely supported”. Another recent employee commented “I’m new to care work. I have been shadowing other staff. Everybody has been helpful. If I am not confident about something I don’t have to do it”.

Staff told us they got the training they needed to support them in their roles. A staff member told us “I have the training I need. There is specific training about particular disabilities. I’ve also had training in communication”. Training records showed that training was provided in key areas such as moving and handling, health and safety and infection control. A recent monitoring visit by North Yorkshire County Council identified that there were some gaps in the training provided to staff. However, we saw that this had been actioned by the registered manager and suitable training had either taken place or had been arranged.

Staff received regular supervisions where they could discuss any issues in a confidential meeting with the registered manager. Supervision records showed that they took place approximately every three months. There were also regular team meetings where the team could share information and discuss issues together.

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 and hospitals 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.

The registered manager and staff were aware of the principles of the MCA and DoLS procedures. We noted that there was information about MCA/DoLS on the staff noticeboard for ease of reference. DoLS referrals and authorisations had been made as required. We found examples of best interest meetings being held where people were unable to make decisions for themselves.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held ‘Do not attempt cardio-pulmonary resuscitation’ decisions for people. The correct form had been used and was fully completed recording the person’s name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

People were assessed against the risk of poor nutrition through the use of a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. People’s weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals, such as doctors, dieticians and speech and language therapists, for advice and guidance to help identify the cause.

Care plans contained clear guidance about the support required however, we identified inconsistent completion of charts to monitor people’s fluid intake. For example for one person there were four gaps on the fluid chart for November 2015. Although this had not had an impact on the person’s wellbeing, it meant that there was not effective monitoring to make sure the person had sufficient amounts of fluid

The chef showed us how they were kept aware of the dietary requirements of people who used the service. A list of people’s dietary needs was displayed in the kitchen and this included special requirements due to, for example,

Is the service effective?

diabetes or an allergy. The chef explained “I know the residents well, what they like and need. I know who needs to lose weight and who needs to gain weight”. They confirmed that if people’s needs changed the kitchen was made aware straight away.

We observed a lunchtime meal. The tables were appropriate for wheelchair users to eat their food. Non-slip plate mats and special cutlery were used appropriate to need. People were asked what they wanted to eat and drink, and extra drinks were provided if wanted.

Care staff sat at an appropriate height to assist people with eating. It was not rushed and people took their time to enjoy their meal. Wet wipes were available on tables so that people could clean their hands as needed. Overall it was a happy, sociable experience.

People told us that they were shown a menu in the morning so they could choose what to eat. Alternatives were available if people wanted something else. We received good comments about the quality of food. These included “It’s so nice to have tasty vegetarian food and not just eating vegetables and potatoes which is what some people think that vegetarians eat. Here is it lovely and tasty” and “The food is nice. They provide me with the food I choose”.

Each person had a health plan which contained clear information about their health needs and how they were to be met. Health plans covered areas such as eyesight, hearing and skin care as well as emotional health and well-being. End of life care plans were in place where needed. This meant that healthcare information was available to inform staff of the person’s wishes at this important time.

Staff worked with various health professionals and made sure people accessed health services such as doctors and dieticians as needed. People told us that they were supported to attend health appointments. One person told us “If I want to go the doctor I talk to one of the nurses and they make an appointment”. The registered manager told us that a doctor visited the service twice a week and they had good links with a dentist who had a hoist to support people who had reduced mobility. This demonstrated that staff made sure the individual health needs of the people they supported were being met in order to maintain their health and wellbeing.

Is the service caring?

Our findings

People made positive comments about the care they received. Comments included “They [staff] explain thing. All the staff are really friendly and try the best they can. I can't think of anything I don't like”, “It's nicer here than my previous home. I like it here. It's my home” and “I love living here...carers look after me all the time”. A relative told us “They are very well looked after. Staff know her and are good to her”. We noted that in the last survey of people who used the service 100% of respondents felt happy or very happy with the care and would recommend the service to others.

The staff we spoke with also felt that there was a caring culture in the service. One staff member explained “It's a nice environment. Happy. It feels like their home. It's relaxed and informal here. I have never heard anyone say anything negative. I think about how I would want to be treated when I support people”. Another member of staff commented “It is people's home. I feel that people are well looked after”.

We observed relationships between people and staff to be easy and informal which went to create a homely and relaxed feel to the home. Staff did not wear a uniform which helped in creating an informal atmosphere. This was important to some of the people we spoke with, one of whom told us “We want staff to be part of our family. We don't want them in uniforms, that's institutional”.

Throughout the inspection we observed people being treated with respect by staff. For example we noted that when conversations took place with people, staff took time to listen, and often got down to eye level with wheelchair users. When personal care was provided this took place behind closed doors to make sure people had privacy and retained their dignity. We noted that the last ‘family and friends’ survey in December 2014 recorded positive responses in relation to the privacy and dignity of people who used the service. The registered manager explained that the service worked in line with the ‘dignity in care charter’ which underlines what people can reasonably

expect when they use care services and their right to dignity and respect. We saw that information about this was displayed on the staff noticeboard and the staff we spoke with were aware of it.

People told us that they were involved in choosing what they did each day. This included choices about what time to get up and go to bed, what to eat and how they spent their time. This was confirmed by one member of staff who said “I am led by people about what they want to do. My impression is that people are given choice and this is respected”. One person told us “I like to go to bed early to watch the biggest TV in the building in my room. I chose it. I have two showers a week that is my choice”.

A number of people required support with communication. A member of staff at the service had been leading on a project called ‘You Communicate’ which was looking at how to improve communication with individuals. However, we were unable to speak with this staff member as they were away from work for an extended period. The registered manager told us that one way they were supporting communication was through the use of ‘eye gazer’ technology which was soon to be installed on computers to assist people with limited mobility. The provider also used a personalisation and involvement officer who worked within the organisation. They attended some resident meetings and who could act as an advocate on behalf of people who had difficulty speaking up for themselves.

We observed that staff knew people well and understood their communication needs. Communication care plans were in place and we saw specific detail for staff to follow in relation to how they engaged with people. The included how people could use body language or eye movement to communicate their needs. We did find, however, that communication aids, such as picture boards or communication books, were not always located with the people that needed them.

We recommend that the provider reviews the use of communication aids to make sure that people have the support required as specified in their care plans.

Is the service responsive?

Our findings

People had their needs assessed which took account of their preferences, likes and dislikes. A 'How best to support' plan covered areas such as communicating with others, mobility, personal support, friendships and relationships and planning for the future.

Each person's care plan contained 'emotional health and wellbeing' and 'leisure' plans. The information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and lifestyle. This supported staff to better respond to the person's needs and enhance their enjoyment of life.

There was also a one page profile which included details of preferred name, what people like and admire (about the person), and how best to provide support. Care plans were person-centred. Person centred planning provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. We found that care records reflected personal preferences and wishes. This was helpful to ensure that care and support was delivered in the way the person wanted it to be. The staff we spoke with understood the individual care and support needs of people as detailed in care plans.

The registered manager told us that care plans were currently being re-written. For the care files we looked at we found that these had been re-written from May 2015. The registered manager told us that care plans would be reviewed 6 monthly and on a more regular basis, in line with any changing needs.

There was a lack of evidence in care plans to show the involvement of people and their families in how they were developed. Care plan documentation had not always been signed by the people they were about. However, some people did tell us that they were aware of what was in their care plan. One relative also said "I was involved in the recent review. I'm aware of the care plan. I took it home to read and was asked to make changes if needed". The registered manager also told us they involved people's friends and families in initial assessments and ongoing reviews of the support provided.

Daily notes were kept for each person in individual diaries. These recorded information regarding basic care, hygiene, continence, mobility and nutrition. The notes we reviewed showed that support was given in line with care plans. However, the time had not always been recorded so that it was unclear when particular care and treatment had been provided. We also found that one person's daily notes contained inappropriate language which focussed on their behaviour rather than them as an individual. For example, "Rude, grumpy with carers on interventions" and "Behaviour reasonable today".

We recommend that the provider reviews the use of daily notes to make sure that records are factual and do not reflect the views of staff.

People were able to spend their days as they wished and had access to a range of activities within the service or in the community. The service had three wheelchair accessible vehicles to support people with trips out. The activity coordinator told us, "We always ask if there is something that residents want to do", and explained that where people had particular interests these were supported. For example one person was a good artist and enjoyed art therapy each week. We were told that some of this person's work may be displayed at an exhibition in the local community. Activities on site included baking, yoga and a sensory room. On the day we visited some people had chosen to make Christmas cards.

People were provided with information on how to complain about the service if they were unhappy about anything. A recent survey of people who used the service showed that a number of people were unsure about how to make a complaint. Action had been taken by the registered manager in response to this and complaints had been discussed at a resident meeting and information was displayed on noticeboards around the service. People were also able to discuss issues with the organisation's personalisation and involvement officer if they preferred. There had been no formal complaints recorded so far in 2015.

Is the service well-led?

Our findings

The registered manager had been in post for over 10 years and was experienced in the role. People told us that they were aware who the manager was and that they were able to approach them to discuss any issues. Staff told us that they felt supported by the management of the service. One member of staff commented, “Management is fine. Always there when needed”. The registered manager told us that they tried to have a high profile and worked on shifts on occasions. They told us that they regularly spoke with staff and people and this was confirmed by those we spoke with.

We identified issues with the quality of some records relating to people’s care and support. Some of the charts used to monitor people’s health were not completed in a consistent way. For example, the record of one person’s mouth care which was meant to be completed every two to three hours. On some occasions in October the chart had only been completed twice in a day. On one day there were no entries at all. Another person required monitoring for an incontinence problem. We found that recent charts for this person had not been completed consistently and did not always clarify any action taken. This meant that records relating to the care and treatment of people who used the service were not always fit for purpose. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to monitor the quality of care provided. However we found that these systems were not always effective at identifying areas for improvement. For example the issues we found with the management of medicines had not been identified in the medicine audits.

The registered manager described some of the ways in which they monitored the quality of care practice at the service. This included ‘out of hours’ visits every three months to observe staff in the evenings or at night. North Yorkshire County Council also carried out monitoring visits as a funding authority. The last visit in September 2015 identified that improvements were required with the recording of accidents and incidents. We saw that the necessary improvements had been made.

The provider carried out yearly surveys of staff and people who used the service. Any actions needed as a result of these were identified and we saw that appropriate action had been taken in response. There were also opportunities for people to give their views about the service in resident meetings which took place every month.

The registered manager talked about the values and culture of the service. The staff team had decided their own values, which were specific to the service. These included statements such as “Be honest”, “Communicate”, “Treat people like you want to be treated” and “Smile and enjoy work”. This meant that there was ownership of values within the team which promoted a positive and caring culture.

This section is primarily information for the provider

Action we have told the provider to take

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

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance Records relating to the care and treatment of people who used the service were not always fit for purpose. Regulation 17(2)(c) |