Homestead Homes Limited

Alphington Lodge Residential Home

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 12 and 15 January 2016. The inspection was carried out by two inspectors. This was the first inspection of the service under the present ownership.

The service provides accommodation and personal care for up to 28 older people. At the time of this inspection there were 23 people living there.

There is a registered manager in post. At the time of this inspection the registered manager spent one day a week at Alphington Lodge and four days a week managing another home owned by the providers. A new manager had been appointed at Alphington Lodge and was working in the home on a full-time basis, although they had not yet submitted an application to register. 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.

Since the provider took over the ownership of the home in April 2015 they had implemented many improvements to make the home safer, more comfortable, and more efficient. On the first day of our inspection we found there were still some areas where further actions were needed. However, on the second day of our inspection we found the staff had taken prompt action to address many of the issues we had noted on the first day.

Many of the staff team had been recruited since the new providers purchased the home. The staff were beginning to establish good team working practices and they spoke positively about their work. People who lived in the home said the staffing levels were adequate to meet their needs and felt staff responded to their requests for assistance promptly. However, most of the staff said they had to rush to complete tasks. The manager told us they were reviewing the staffing levels closely. After the inspection the provider told us they had monitored the tasks staff were expected to complete. They had implemented training for senior staff to enable them to manage their teams effectively, and they had found this had resulted in greater efficiency and improved care.

Staff had received a range of training to meet the needs of people living in the home and further topics relating to people's health needs were being planned for the coming year.

Safe procedures had not always been followed when recruiting new staff. 11 staff had been recruited since the last inspection. Recruitment records for two staff did not include evidence of checks and references completed before they began working with people. However, by the second day of our inspection the manager had obtained the checks and references that were outstanding. After the inspection the provider gave us evidence that safe procedures had been carried out for the other nine staff recruited since the last inspection. We were also given assurances that safe recruitment procedures will be followed in future.

Records were not always stored securely to maintain confidentiality. By the second day of our inspection most records of a confidential nature were stored securely, although we saw staff had forgotten to store one record securely when not in use. The manager assured us they would be carrying out checks in future to ensure good practice will be followed at all times.

On the first day of our inspection we found some aspects of medicine administration were not entirely safe. There were unexplained gaps in the medicine administration records, including the records of prescribed creams and lotions. Staff had failed to identify the missed signatures or take actions to check that medicines, creams and lotions had been correctly administered. We also found medicines were not always stored securely. By the second day of our inspection actions had been taken to address these issues. All medicines were stored securely. They had investigated the reasons for gaps in the administration records and had put in place a plan of actions designed to improve all areas of the administration procedures.

A new care planning and risk assessment system had been implemented a few months earlier. This included a range of tools to help staff identify risks to people's health and to help them draw up a plan to support the person to reduce the risks where possible. The risk assessment tools covered areas such as skin care and pressure sores, mobility and falls, weight loss, dehydration, and choking. Procedures were in place to review the risks regularly, for example people were weighed regularly. However, where the information showed there was a change in the risks staff had not always reviewed and updated the care plan. This meant care plans did not always provide detailed or up to date information on the current risk level or give instructions to staff on actions necessary to help people maintain good health. The managers and provider told us they were aware of care plan gaps and had already taken measures to address them. .

People told us they felt safe. Staff had received training and information on how to protect people from the risk of abuse and neglect. Staff had received information and training to effectively support each person's mental and physical health needs.

The staff were caring. We saw staff speaking with people in a caring and gentle manner. One member of staff arrived early for their shift so that they could spend time sitting and chatting with people. They understood the importance of seeking consent before carrying out care tasks and had an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Where people were at risk of their liberty being deprived applications had been submitted to the local authority DoLS team..

People had been involved and consulted in drawing up and agreeing a plan of their support needs. Their care plans were detailed, well laid out and easy to read. The care plans explained each person's daily routines and how they wanted staff to support them. The plans were regularly reviewed and updated. People were supported to access healthcare professionals when needed.

The home was well maintained, clean, warm and comfortable. The providers were in the process of redecorating and improving all areas of the home both internally and externally.

People participated in a variety of social activities within the home and in the community. There were activities organised in the home every morning and afternoon to suit most interests.

The provider had a range of monitoring systems in place to ensure the home ran smoothly and to identify where improvements were needed,. However, these had not been fully effective as they had failed to pick up some of the issues we found during this inspection. People were encouraged to speak out and raise concerns, complaints or suggestions in a variety of ways including resident's meetings, surveys and care plan reviews.

We found one breech 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. We have also made two recommendations relating to guidance in respect of best practice in maintaining people's weight and guidance and best practice in respect of quality monitoring and audits.

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 entirely safe.

Risks to people's health and safety were not managed effectively.

Some aspects of medicine administration and recording were potentially unsafe.

Safe recruitment procedures had not always been followed, although actions have been taken to ensure staff are recruited safely in future.

There were sufficient staff to meet people's needs safely, although staff were rushed at times.

Staff knew how to protect people from the risk of abuse.

Is the service effective?

Good

The service was effective.

Staff received training and support to ensure each person's needs were met fully.

People were supported to access healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

People could be confident they would receive sensitive and well planned care at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People were involved in the assessment and planning of their care. However, daily reports did not always show that care had

been carried out in accordance with each person's agreed plan of care.

Staff understood each person's needs and preferences.

People were offered a range of activities to suit most interests. .

People knew how to raise concerns and complaints and were confident these would be addressed satisfactorily.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Quality assurance systems were in place to monitor the service and ensure policies and procedures were followed, although some areas were not fully effective.

The service promoted an open and caring culture centred on people's individual needs.

People were supported by a motivated and dedicated team of management and staff.

Alphington Lodge Residential Home

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 12 and 15 January 2016 and was unannounced. It was carried out by two inspectors on the first day and one inspector on the second day.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During our inspection we spoke with the registered manager, the recently appointed manager, ten people living in the home and nine staff. We also spoke with three health and social care professionals who were visiting the home at the time of our inspection. We looked at the care records of four people living in the home.

We also looked at records relevant to the running of the service. This included staff recruitment files, training records, medication records, and quality monitoring procedures.

Requires Improvement

Is the service safe?

Our findings

Although most aspects of medicine administration were safe, there were some areas that needed improvement. On the first day of our inspection we saw some unexplained gaps in the medicine administration records (MAR). This meant we could not be confident the medicines had been administered correctly, in accordance with the instructions by the medical practitioner who prescribed the medicines. The registered manager and the new manager said staff had been instructed to report any unexplained gaps in the MAR records promptly to enable them to check that people had received their medications correctly. By the second day of our inspection a number of actions had been taken to identify the reasons for the gaps in the medication records. The management team had put in place improvements to reduce the risk of signatures being missed, for example by ensuring the person administering medicines was not disturbed or distracted during the administration process. Regular checks had previously been carried out on the MAR charts designed to pick up any issues promptly and make sure remedial actions are taken where necessary, and the auditing processes were tightened following this inspection.

Staff did not always follow safe practice when administering medicines. We saw a member of staff left the medicines trolley in the corridor area where it was stored while they administered medicines to two people. They took two medicine pots to the lounge at the same time, giving one to one person and one to another, providing a drink to each. This meant there was a risk the medicines may be given to the wrong person. The medicine trolley and medication administration records had not been brought to the lounge area, for safer administration. This also increased the risk of the MAR charts not being completed correctly.

The 'breakfast' medicines round was still being carried out at 9.40am when we arrived (we saw the manager give medication at 10.20am to one person). One person had been prescribed an antibiotic, their medication administration record showed this was to be given at 'breakfast', 'lunch' and 'bed'. Staff told us the medicine rounds were carried out at 8am, noon and 7.30pm. We discussed the spacing of such medicines over a 24 hour period, as best practice to ensure their continued effectiveness, with the manager. They informed us the prescriber was aware of the timings and agreed them (with regard to not waking the person earlier for the first dose).

On the first day of our inspection we found records had not always been completed when a prescribed cream had been administered. This meant there was a risk that skin problems may fail to heal or may deteriorate. We also found some tubs of creams had labels that could not be read easily, and the date of opening was not always clearly recorded. This meant some creams may not be discarded within the recommended period and may no longer be effective or safe to use.

We also spoke with a community nurse who told us that supplies of creams had sometimes run out. New supplies had at times taken several days to arrive, which meant people may be at risk of skin conditions becoming worse. On the second day of our inspection the manager told us they had taken a number of steps to ensure creams would be recorded accurately in future. They had placed a copy of the MAR chart along with a body chart and other information on the administration of the creams in each person's bedroom. Senior staff will in future carry out checks on all creams and records of administration before the

end of each shift. Procedures had been agreed to ensure there are adequate stocks of creams and lotions at all times. Medication administration had previously been discussed at each staff handover session. The provider told us medication records will in future be checked at every handover session and any concerns relating to low stocks of particular medications will also be covered.

Medicine administration will in future be reported on at each handover session. This gave us assurance that safe procedures had been put in place for the administration of creams and lotions, but this needs to be sustained, reviewed and monitored regularly.

On the first day of our inspection we found the medicines trolleys and medicines refrigerator were stored in a communal area but were not secured to the wall. By the second day of the inspection the trolleys were securely attached to the wall when not in use, and the medicines refrigerator had been moved to the manager's office which was locked when not in use. Records showed the temperature of the refrigerator and of the storage area for other medicines were monitored and within the limits of manufacturers' recommendations. Controlled drugs were stored securely, administered safely, and records were completed each time they were administered.

Some people held and administered their own medicines after a risk assessment had been completed to ensure they were able to do so safely. Where people had agreed to let the home hold and administer their medicines, their care plans contained goals explaining the procedures that had been agreed to help them work towards holding and administering their own medicines safely. Secure storage was in place in bedrooms for those people who administered their own medicines.

Care plans contained risks assessments on all aspects of each person's physical and mental health, personal care needs, including the risk of pressure sores, malnutrition, dehydration, weight loss, falls and poor mobility. Although the risks had been regularly assessed, the outcome of the assessments had not always been transferred to the main care plan file. This meant staff did not always have up to date information throughout the care plan on the actions to be taken to minimise risks. The managers and provider told us they were aware of shortcomings in the care plans and risk assessments and had already taken measures to address them.

Where people had been assessed as being at risk of falls, staff had been instructed to review the falls risk assessment each time the person fell. Accident reports were usually completed after each fall and these were stored in the person's care plan. However, the risk assessments had not always been updated in line with the instructions. The inconsistency in recording and storing records of falls meant it was not always possible to check how many falls each person had experienced, or if the measures put in place to reduce the risks were effective. After the inspection the provider told us they were introducing a centralised falls tracker to monitor the incidence of falls.

A risk assessment tool developed by the NHS (known as 'GULP') had been used by staff to help them assess the risk of dehydration. However, the tool was incomplete and did not provide staff with instructions on how to use the information gathered to assess the level of risk. The staff we spoke with did not fully understand how the tool worked. This meant we could not be certain the assessed level of risk identified was correct. Where risks of dehydration or malnutrition had been identified monitoring charts had been put in place and staff had recorded the level of intake of food and fluid regularly. However, the outcome of food and fluid intake charts had not been reflected or analysed in daily notes to help them determine if the care that had been given was effective. Since the inspection the provider has given us further information to show staff were being trained in this system.

Where people were at risk of developing pressure sores staff had been instructed to complete 'turn charts' each time they repositioned the person. The entries had been competed at varying intervals, occasionally of more than six hours. We looked at the records for one person who had been assessed as being at risk of pressure sores. The condition of the person's skin was not reflected in daily records despite the care plans instructing staff to monitor the person's skin carefully. However, staff told us the person's skin was good with no signs of pressure ulcers at the time of our inspection.

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We also noted some instances of good practice, for instance a person who had a pressure-relieving mattress on their bed, had a 'Pressure mattress checks table' form in their room. Staff had regularly recorded that the mattress was at the correct setting for the person in accordance with the instructions set out in the person's care plan.

The service had not always followed safe procedures when recruiting new staff. 11 staff had been recruited since the last inspection. On the first day of our inspection we found the records of two recently recruited staff did not contain sufficient satisfactory references, or confirmation from the Disclosure and Barring Service (DBS) before the staff had started working in the home. DBS checks provide evidence that applicants for jobs have not been placed on a national barring list preventing them from working with vulnerable adults. This meant they did not have sufficient evidence that the applicants were suitable for the posts they had applied for. By the second day of this inspection a DBS check that had recently been applied for was received and outstanding references had been chased up and received. After the inspection the provider gave us evidence that safe procedures had been carried out for the other nine staff recruited since the last inspection. We were also given assurances that safe recruitment procedures will be followed in future.

Sufficient numbers of staff were employed to meet the personal care needs of the people living there. People told us there were usually enough staff to meet their needs, although some added that staff were busy. For example, one person who spent much of their day in their bedroom said "They're very busy people". When we asked if staff answered their call bell quickly, the person was initially reluctant to answer then said "They come as quickly as they can." We asked if staff came in to chat and they replied "Sort of, yes, they do." However, staff told us they often struggled to complete tasks within the expected timescales. They experienced difficulties during periods of staff sickness when it was not always possible to provide cover at short notice. Initially there was no tool being used to evidence how staffing levels had been decided based on people's assessed needs. By the second day of our inspection they had implemented a dependency level tool to help them check the staffing levels were adequate. After the inspection the provider told us they had monitored the tasks staff were expected to complete. They had implemented training for senior staff to enable them to manage their teams effectively and they had found this had resulted in greater efficiency and improved care. They said "As carers are being organised better, they are getting more time to do other work (e.g. focusing on records)".

On the first day of our inspection we saw people with mobility needs sitting in the lounge without easy access to a call bells. We asked the manager if people were offered pendant call bells if they were unable to reach the call bells. On the second day of our inspection we saw that people with mobility problems had been given a pendant alarm. We met one person who was in their bed. They showed us their call bell was in reach.

A care plan for one person had been updated to reflect their changing and variable mobility needs, including that they needed two members of staff to support them, and might also need certain equipment. We saw two members of staff assisting the person to move. We saw information from a physiotherapist on

exercises for this person had been recorded in their care plan, but not referred to in their mobility reviews. The manager told us the exercises were no longer part of the person's care plan because the person was no longer well enough to carry out the exercises.

Staff knew how to recognise signs of abuse and knew who to contact if they had concerns people may be at risk. Information on safeguarding procedures including contact numbers for relevant authorities was available in a staff area of the lounge. Staff also knew about the provider's whistle blowing procedures and were confident any concerns they had they would be listened to and acted on.

All areas of the home were clean, hygienic and free from any odours. Protective clothing such as disposable gloves and aprons were available around the home. Staff wore a particular colour apron when handling food and another for personal care. Liquid soap and paper handtowels were also available. Two housekeepers were on duty the day of our visit. Bags had been provided for staff to transport soiled laundry from bedrooms and bathrooms to the laundry, although we did observe one instance where this was not the case.

A recent visit by the Environmental Health department had found the kitchen was clean and safe methods of storage, preparation and cooking of food were being followed.

Some people had asked the service to hold agreed sums of cash to pay for day to day personal requirements such as hairdressing, toiletries or chiropody. Safe procedures were being followed to hold the money securely. All transactions were recorded, and balances checked regularly to make sure the money had been handled correctly in accordance with the person's wishes. We noted one small discrepancy (50p) in the balances held for one person. The manager said they will improve their monitoring of all transactions in future to ensure balances are checked after each transaction.

The building was well maintained and safe. The main front door was kept locked, there was a coded security lock to prevent people from entering or leaving the building without staff being aware. Other exit doors were alarmed, we were assured the staff would be aware immediately if a person had entered or left the home by these doors.

Good

Is the service effective?

Our findings

Where we saw evidence that people had lost weight the records did not always explain clearly the plan to encourage the person to maintain a healthy weight. The records showed that health professionals had been consulted and involved. Some people had been prescribed dietary supplements. The manager told us people could always ask for snacks between meals. The staff knew that certain food items were available in the kitchen if people wanted anything to eat during the night. However, this was not always clearly explained in the care plans. For example, the plans did not always instruct staff to offer snacks between meals or during the night, or to specify high calorie foods the person might like.

People told us they enjoyed the meals provided. For example, one person told us "On the whole it's very good." We spoke with a group of people in the lounge who told us "The food is good". The menu for the day was displayed on a notice board in the corridor which gave people information about the main choice of food on offer each day. People were offered a wide choice of breakfast and evening meals options, for example some people liked cooked breakfasts while other people liked toast or cereals. We observed at lunchtime people being served the meal of their choice and in accordance with their wishes.

Staff told us the quality of the food people received was always high. We saw a 'Breakfast and meal preference's form in people's care records which included where they preferred to eat their meals, their likes and dislikes for food and drink, and preferred portion sizes. Staff told us they went around to each person every day to let them know what the meals were going to be at lunchtime, and asked what their preference was. They said if people did not like the choices offered they could always choose an alternative to their liking.

The cook was knowledgeable about the foods people needed to maintain a balanced diet. Fruit puddings, including fresh fruit salad were offered several times a week at lunch or tea. Staff knew the foods each person liked and disliked. Kitchen staff were informed if people required a special diet, such as diabetics. In some cases, people had requested their diet was adapted, for example one person requested pureed meat as they found it difficult to chew meat.

People were offered drinks of their choice regularly throughout the day. People who had chosen to stay in their rooms had a drink within reach. Staff knew the drinks each person preferred, for one person told us staff knew they preferred water rather than squash.

People received effective care and support from staff who had the skills and knowledge to meet their needs. People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. Training records showed there was a programme of training for all staff covering health and safety related topics and also topics relevant to the support needs of the people living in the home. Training was provided by a variety of methods including on-line computer based training, face to face to face training, staff meetings and shadowing. The manager checked staffs competency and knowledge through the completion of workbooks and knowledge checks, records showed these checks were being carried out.

Staff told us they had received manual handling training in the last year which had been sufficient for meeting the needs of current residents. They explained that when new equipment had been required by individuals since the main training sessions, the senior carers or manager had shown staff how to use it. Staff had not been allowed to use the equipment until they had received the training. A staff member who had been recruited in the previous year told us they had received training on health and safety topics such as manual handling and fire safety. They were very positive about the quality of this training, saying it was better than training they had received in other care services they had worked in.

Staff had a basic understanding of people's health needs. For example, staff told us about the measures in place for people at risk of choking including advice provided by the Speech and Language Therapy team (SALT). The manager said they were in the process of sourcing training on choking, diabetes and other topics relevant to people's health for the coming year.

Individual supervision sessions had been given to staff approximately every six months in the previous year. The manager told us they planned to increase the frequency of supervisions in the coming year. Dates for supervisions had been planned and they had begun to carry these out. A staff member recruited in the previous year told us they had just had their first supervision meeting. They said the meeting was positive and helpful. They had made suggestions for improvements and the manager had welcomed their ideas and was considering how to carry them out.

Staff told us there were good systems of communication between all members of staff. For example, a member of the housekeeping staff told us they were informed when new people moved into the home and they were told a little about the person, so that they could communicate with them if they met them.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People were always asked for their consent before staff assisted them with any tasks. Each care plan contained a form which provided evidence that people had been asked to give their consent for certain aspects of their care, for example where they had agreed that staff should administer their medicines.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. All staff were in the process of completing training and workbooks on DoLS. External doors were locked by security coded locks. We were told that some people regularly went out unescorted, or with staff or family members. Applications had been submitted to the local authority DoLS team for those people who had been assessed as being unsafe to leave the building unescorted, and where their liberty may have been deprived.

The manager told us they were in the process of completing mental capacity assessments for people who had difficulty making important decisions about their care needs. Where people had been assessed as lacking capacity to make decisions they will seek best interest decisions where necessary. Staff described how they had sought consent and recorded this in the person's records before providing care. They also told us that relatives and other relevant people were consulted before a best interest decision was put in place.

Daily care records contained information showing care had been provided after individuals had given their

consent to it. Staff greeted people by name as they approached them, gave explanations of their intentions, gave people time to take in this information and respond (verbally or through body language), before they continued with support. For example we saw staff give explanations and seeking consent before encouraging a person to move from a wheelchair to their armchair. One daily report recorded that a person could not find an item in their room. With the person's consent staff looked for it and found it. There were also entries such as 'Preferred to stay in bed.'

People's health needs were met by staff who were observant and responsive to people's health needs. There was good communication with local health professionals to ensure people received the right care and treatment. The home arranged for people to see health care professionals according to their individual needs. Community nurses' records were stored in the home for people they visited on a regular basis. We spoke with a community nurse who visited the home during the inspection. They told us people were "getting very good care."

Care plans contained detailed information on all aspects of people's health and medical needs. For example, one person had a pacemaker fitted. There was guidance in their care plan about signs the person might show if the pacemaker wasn't working properly and what staff should do if these were observed.

We spoke with a person who was at risk of developing pressure sores. We saw they had a pressure relieving mattress at the right setting, with a pressure-relieving cushion in their chair, as indicated in their care plan. They told us staff applied skin creams after personal care had been given, as indicated in their care plan for promoting the health of their skin and pressure areas.

We recommend the service seek guidance in respect of best practice in maintaining people's weight and what alterative and additional options should be offered to them.

Good

Is the service caring?

Our findings

People praised the staff and told us they were always kind. Comments included "We are very lucky here," and "The staff are very good – second to none." One person told us how happy they were and said "I would scream if they took me away from here." Another person emphasized "The staff are kind" and gave special praise for some of the staff, saying they were "kind, they handle one gently."

We saw staff taking time to chat with people as they passed, listening to their responses and engaging in the topics they spoke of, with smiles and shared laughter. Staff spent time with one person to style their hair attractively. Another member of staff was seen sitting and chatting with people, they demonstrated a genuine concern for people's health and well-being. People were seen to welcome the time staff members spent with them. A member of staff said they arrived early for their shift in order that they could spend time sitting and talking with people.

Staff understood the importance of maintaining privacy and dignity when providing personal care. People told us how staff promoted their privacy for example by closing the curtains during personal care, and knocking on their doors before entering. A health professional told us they were always able to provide treatment to people in the privacy of their own rooms. If the person wanted a member of staff to stay with them while they were receiving treatment staff were always willing to do so. The health professional also told us "Staff are always kind and caring."

We saw that one person approached staff often with various queries. Staff took time to respond and give a meaningful answer, which the person accepted and walked away. The manager told us it had been difficult to engage the person in activities and therefore they had put in place several activities bespoke to the person such as taking them for walks to the shop on a daily basis.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. One person told us his daughters lived a few miles away and visited regularly and were always welcomed when they visited. We also heard other people regularly received visits from their relatives.

There were plans in place to ensure people received good care at the end of their lives. An 'Advance care planning' form in people's records included whether people wished to stay at the home or go to hospital should they develop certain health conditions. This gave information about the care people wished to receive at the end of their lives. A health professional we spoke with told us people received very good care at the end of their lives.

Documents known as 'treatment escalation plans' had been completed by medical practitioners for most people. These were stored in the person's care plan where staff could locate them quickly if the person required emergency medical treatment. The forms contained evidence to show the person and their next of kin had been consulted about their wishes regarding resuscitation.

Requires Improvement

Is the service responsive?

Our findings

Records completed by staff each day did not always demonstrate that care had been given as set out in the care plans. For example, there was a schedule in place which showed the day each person wanted to have a bath or shower. However records completed by staff after people had received assistance with a bath, shower or strip wash did not reflect the frequency shown on the schedule or if the person had been offered a bath or shower but declined. On some records we saw the frequency of showers or baths was lower than the frequency set out in the schedule. This meant we could not be certain people always received assistance with daily personal care tasks in line with the agreed plan of their care needs. After the inspection the provider told us the main reason for the gaps in the records was due to people declining a bath or shower. They were improving the records to show where this had happened.

On the first day of our inspection we saw body maps in people's care records, showing where injuries or wounds were located. This was a useful tool that helped staff understand the areas where treatment or monitoring was needed. However, the records were not always dated. This meant it was not always possible to check how quickly wounds were healing. Some records of wounds were dated but did not explain what treatment was needed. We spoke with the manager about this and on the second day of our inspection they told us they had taken actions to ensure staff completed the records accurately.

People were weighed regularly, but where a change in the weight was recorded this had not always prompted a plan to be put in place to show how support would be given to help the person maintain a healthy weight. Where some people had lost weight there were instructions for the person to be weighed weekly, but the records showed this instruction had not always been carried out. The care plans contained risk assessments designed to monitor the risk of malnutrition, but where records showed evidenced of weight gain or weight loss the level of risk had not been adjusted accordingly. After the inspection the provider told us "We have encouraged health professionals to provide additional nutritional support or review due to concern about our residents' weight loss."

Bowel monitoring charts were in place, with staff recording when a person had a bowel action. It was not always clear how these were used for the person's benefit. For example, a staff member had highlighted in daily care records that the charts for one person indicated they had not had a bowel action for at least eight days. During this time staff had been administering a laxative prescribed with a variable dose. While staff had administered laxatives (due to the presence of signatures) they had not provided the dose quantity. Thus while laxatives had been given, the amount was unclear. The records did not show if staff had used the monitoring chart information to ensure the person was given appropriate treatment to address possible constipation. The records did not always show how they assessed the effectiveness of planned support. After the inspection the provider told us "We will ensure medicating staff follow their (documented) training in this regard and we will ensure it does not happen again."

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We observed a handover session between staff at the end of their shift and staff who had just arrived for the

start of their shift. The handover was detailed and provided a good update on each person's health, emotional and personal care needs that day. Staff told us handovers were useful and provided them with updates about changes in people's needs such as mobility, and also information about any accidents or incidents.

Each person had a plan of their care needs which set out in detail how they wanted staff to assist them with all aspects of their health and personal care needs. The records contained evidence to show people and their next of kin or chosen representatives had been asked if they wanted to be involved in reviewing their care plans. The care plans were reviewed on a monthly basis.

People told us they were happy with the care they received and praised the staff for the standard of care. Comments included "The staff are very good – second to none" and "They are good staff – I have no complaints."

The care plans explained clearly how each person wanted staff to assist them with daily tasks such as bathing or showering. The records explained what the person could do for themselves and their preferences such as:

- How a person should be greeted, and actions to be taken on or before leaving the room
- The person's preference for soap and toiletries and the areas of their body they liked to use these products.
- Detailed explanation on how to assist a person to clean their teeth, and how to support them to maintain as much independence as possible with this task
- How the person liked to be dressed, for example if they liked their shirt tucked in.
- Continence care plans included the type of pad a person needed, and what signs they might show if they wanted the toilet.

Where there were differing views between people and their family about their care needs this was clearly explained in the care plan. This meant staff were fully informed of the situation.

People told us they were offered a range of group activities every morning and afternoon to suit most interests. One person told us "There are lots of activities going on. There is always something you can join in with." There was a monthly programme of activities with at least two different activities planned for each day. A second person told us they wanted to go into town and the manager was helping them to arrange this. A third person told us they liked to attend church regularly and the manager explained how they had helped the person to organise transport to church services. There were regular visits to the home by local groups and organisations including the local primary school and church.

People's daily care records showed people were supported to enjoy their preferred activities, interests or topics. Their records contained a detailed 'pen picture' which included information on personal histories. For example, staff had discussed the daily paper with one person, or chatted about the person's past and their family. A staff member organised a bingo game in the afternoon of our visit, approaching people in the lounge individually, speaking at their eye level, to explain what was proposed. People seemed to enjoy the game, with banter and laughter going on.

If people did not want to join in with group activities or entertainments their wishes were respected. For example, a musician visited on the day of our inspection. Most people enjoyed the entertainment but one person said "I'm going out when he starts!" and we saw the person returned to their room. Staff understood each person's preferences and respected their wishes. Checklists were completed by staff to show if people had joined in with a group activity or if they had chosen to remain in their room. For example, a checklist

included 'chat/drink' at certain times of day for a person who stayed in their room, helping to reduce their isolation and promoting their fluid intake.

Most people we spoke with told us they were confident they could raise any complaints with the manager and these would be listened to and address. One person was hesitant, saying they felt it was "difficult" to complain. However, they said they could speak to the staff about concerns and added "On the whole they're very nice." Another person told us "I have no complaints." The manager told us they had not received any formal complaints since they began working in the home a few months earlier, although they had receive a number of cards and letters of thanks for the care provided by staff.

Requires Improvement

Is the service well-led?

Our findings

Since the providers took over the ownership of the home in April 2015 they had put in place many changes that had resulted in positive improvements to the quality of the care and the standard of the accommodation and services. They had a range of monitoring systems in place to check all aspects of the service and to ensure people received good care. The systems had picked up some, but not all of the issues we found during this inspection, such as recruitment checks, medication storage and administration, care planning and risk assessments.

On the first day of our inspection we found records containing personal information were not always stored securely. An area of the lounge was used to store care plans and a desk was used by staff to write up daily reports. These records were not locked away when not in use. We also found medicine administration records were left on top of the medicines trolley in a communal area.

After the first day of our inspection actions were taken promptly to address many of the issues we had found. By the second day of our inspection action had been taken to lock up all confidential records when not in use. However, we saw staff had forgotten to store the medicines administration records securely for part of the day. The manager said they will be checking on this regularly in future. This meant it was too soon to be certain all actions put in place were fully effective, or to be certain these would be maintained.

We found many examples of good monitoring checks in place, but in some instances where improvements were identified these were not always followed up to make sure they were carried out promptly. For example, the manager had carried out detailed audits on random samples of care plans each month. A report highlighted where problems had been found. However, actions had not always been taken promptly to address the problems. This meant the care plan audits were not fully effective.

All accidents and incidents which occurred in the home were recorded and filed in individual care plans. These were reviewed on an individual basis but there was no overall review of all accidents and incidents in the home. This meant the provider did not have a system in place to identify any trends or actions that could be taken to reduce the risk of falls.

Complaints, concerns and compliments had not been reviewed as part of the regular monitoring checks. Complaints and compliments had been stored in individual records. By the second day of our inspection the manager showed us new recording systems that had been put in place to address this. The manager was considering further ways they could encourage people to raise complaints and concerns, such as a suggestion box or complaints and compliments book in a prominent place in the home.
Staff told us they often felt rushed and unable to provide care to people within the expected timescales. The manager told us they were monitoring staffing levels closely to check staff were carrying out tasks efficiently. They were also monitoring dependency levels of the people living there and they assured us staffing levels will be increased if they find people's needs are not being met.

People we spoke with told us the home was well managed. They were regularly consulted and involved in

the home through resident's meetings. The provider was planning to send out questionnaires in the near future to people who lived in the home, their relatives and professionals who supported them.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. There was a new manager who had been working in the home for approximately four months before this inspection. They had not yet applied to the Care Quality Commission for registration. There was also a registered manager appointed. This person also managed another home owned by the provider. They visited Alphington Lodge approximately once a week to monitor the management of the home. This was an interim arrangement until the new manage applies for, and is granted registration.

Staff told us there were good communication systems in place, including handovers between each shift. The new manager recognised the importance of providing training and support for the staff team. Regular staff supervision sessions had been arranged , these were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

Staff told us the home was well managed. They praised the new manager and said they were always approachable and willing to give assistance or advice. One member of staff said the manager was trying to "Knuckle everyone into shape". Another member of staff said "She deals with things straight away."

A social care professional who was visiting the home said "I think they are doing a really good job" and told us they were particularly impressed with the new manager. They told us the manager was responsive, and "gives very candid feedback." They felt the new manager was committed to providing a good quality of service.

Staff also said things were much better since the providers took over the home, although they said more improvements were still needed. Comments included "Things are better now, but not perfect." They told us there was good teamwork, for example "We're lucky with our teams." Several members of staff told us their job was much better than previous care services they had worked in. They told us the provider carried out regular checks and was approachable and was willing to help them at any time of the day or night, for example when a person had fallen during the night the provider had assisted the staff.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

We recommend the provider looks at guidance and best practice in respect of quality monitoring and audits to ensure these are used effectively to improve the quality of care and support.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments relating to the health, safety and welfare of people had not always been completed or updated accuratelyto ensure staff have clear and up to date information explaining how risks will be managed. Daily records completed by staff each day did not always demonstrate that care had been given as set out in the care plans. Medicines were not always administered accurately in accordance with the prescriber's instructions.