Magnum Care Limited

Alston House

Inspection report

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Date of inspection visit:
19 August 2016

Date of publication:
27 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alston House provides personal care and accommodation for up to 19 people. On the day of the inspection the registered manager informed us that 16 people were living at the home.

This inspection took place on 19 and 23 August 2016. The inspection was unannounced and was carried out by one inspector 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. Our expert for this inspection had experience of the care of older people and older people living with dementia.

A registered manager was in place. 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 and associated Regulations about how the service is run. The registered manager had delegated day-to-day management of the services to the deputy manager at the time of the inspection.

We carried out an unannounced inspection of this service on 10 August 2015. Three breaches of legal requirements were found. The provider had not ensured that people were protected against the risks of unsafe care being provided, people's consent and not always been sought in providing personal care to them and systems had not been effective in providing a quality service to meet people's needs. After this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We checked that the provider had followed their plan, and to confirm whether they had now met legal requirements. We found improvements in these issues and these breaches had been rectified.

People using the service and the relatives we spoke with said they thought the home was safe. Staff had been trained in safeguarding (protecting people from abuse) and generally understood their responsibilities in this area.

People's risk assessments provided staff with information of how to support people safely.

Staffing levels were sufficient to ensure people were protected from risks to their safety.

People using the service and their relatives told us they thought medicines were given safely and on time and we found this to be the case.

The premises appeared safe with no tripping or slipping hazards observed, except for access to a storage area, which was then made safe on the day of the inspection visit, and a lack of side tables to place hot drinks on.

Staff were subject to checks to ensure they were appropriate to work with the people who used the service.

Most staff had been trained to ensure they had the skills and knowledge to meet people's needs, and we saw that more training was to be provided to staff so that they had the skills and knowledge to meet all of people's needs.

Staff generally understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives. The service had obtained legal approval for limiting people's choices when necessary for their best interests.

People had plenty to eat and drink and people told us the food was satisfactory. People were assisted to eat when they needed help.

People's health care needs had been protected by referral to health care professionals when necessary.

People and relatives we spoke with told us they liked the staff and got on well with them, and we saw many examples of staff working with people in a friendly and caring way.

There was some evidence that people and their representatives were involved in making decisions about their care, though this needed to show that people and their representatives were involved in drawing up individual care plans.

Care plans were individual to the people using the service and covered their health and social care needs.

There were not always sufficient numbers of staff to ensure that people's needs were responded to in good time.

A comprehensive range of activities had not always been organised to provide stimulation for people.

People and relatives told us they would tell staff if they had any concerns and were confident they would be followed up to meet people's needs.

Not all people's relatives were satisfied that their views had been acted on.

Management carried out audits and checks aimed to ensure the home was running properly to meet people's needs, though these had not always identified safety concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had risk assessments in place to protect their safety. Staff recruitment checks were in place to protect people from unsuitable staff. Staff knew how to report any suspected abuse to their management, and, if necessary, to relevant safeguarding agencies. Medication had been supplied to people as prescribed. There had been some risks in the home's facilities which had not been comprehensively managed to protect people's safety, though the manager had swiftly rectified these issues.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent to care and treatment was not always, sought in line with legislation and guidance. People had enough to eat and drink and they told us that the food was adequate though food was not always served at a proper temperature. There was collaboration with and referral to health services to maintain people's health, though measures had not always been in place to prevent accidents. Staff were trained and supported to enable them to meet people's needs.

Is the service caring?

Good

The service was caring.

People, their relatives, and outside professionals told us that staff were friendly and caring. We observed this to be the case in interactions we saw. Staff protected people's rights to dignity and privacy. There was evidence that people and their relatives had been involved in agreeing to personal care, though this needed to include all aspects of the planning of people's care plans.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities based on people's preferences and choices were not always available to them. Care had not always been provided to respond to people's needs. Adequate staffing levels needed to be in place to ensure this always happened. Care plans contained information for staff on how to respond to people's needs. People and their relatives told us that management listened to and acted on their comments and concerns. Staff had contacted relevant agencies when people needed support.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of evidence that management acted on the comments of people or their relatives. Systems had been audited but had not identified all health and safety issues. Staff told us the management team usually provided good support to them and had a clear vision of how friendly individual care was to be provided to meet people's needs.

Alston House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 consisted of an inspector 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. Our expert for this inspection had experience of the care of older people with dementia.

Before the inspection we reviewed the 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 also reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We spoke with six people using the service. We observed how people were supported during their lunch and during individual tasks and activities. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the deputy manager, three relatives, a friend of a person living in the service, two health professionals, four care workers, and the cook.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at four people's care records.

Good

Is the service safe?

Our findings

At our inspection on 10 August 2015 we found that the provider did not follow care plans and risk assessments to ensure care staff supplied safe care relevant to people's individual needs. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make improvements. At this inspection we found that improvements had been made.

People living in the home and relatives we spoke with said that people were safe.
One person said, "I feel safer than at home." A relative told us, "She's as safe as she can be."

People told us that staff carried out safe moving and handling when they assisted them to move. One person said, "They help me to stand…when I use the buzzer. They're very good." We observed staff assisting people to transfer from chairs to wheelchairs. Staff provided people with good explanations of what was going to happen and encouraged them in a friendly way to ensure their safety.

We observed that there was support for those who needed it and encouragement to maintain independence. This was carried out unobtrusively. Staff understood what assistance was needed to maintain people's safety and wellbeing and care was delivered in a timely manner.

We saw that people's care and support had been planned and delivered in a way that ensured their safety and welfare. Care records contained individual risk assessments completed and regularly updated for risks, including falls, manual handling, and the risk of developing pressure ulcers. The staff we spoke with were aware of their responsibility to report any changes and act upon them.

For example, a person was assessed as being at risk of developing pressure sores. The risk assessment included relevant information such as the application of barrier cream, which was needed to protect the person's skin. There was also information as to the need to regularly reposition the person in bed and to provide the person with a pressure cushion to sit on. A staff member said that the community nurse had ordered additional specialist equipment for the person and this was reflected in the care plan we saw. We spoke with the person who said these measures had been carried out, and we observed that the person sat on a pressure cushion. This meant that proper measures were in place to safely manage the person's condition.

In another person's care plan, there was information that they were assessed as needing to eat soft foods, and staff needed to cut up food to ensure they were protected against the risk of choking. We saw this had been carried out.

We spoke with the cook who was able to tell us about people's nutritional needs, and the type of food needed to ensure people's safety. We checked the nutritional needs of one person which stated that, dependent on their current health needs, they may needed different forms of diet. This showed that relevant information was available to staff to keep people safe. We observed staff following these safety issues.

During the visit we saw no environmental hazards to put people's safety at risk from tripping and falling. Health and safety audit checks showed that water temperatures had been checked. There was regular servicing of equipment such as hoists and fire records showed that there was a regular testing of equipment and fire alarms. Regular fire drills had taken place.

We also observed a shortage of tables in the main lounge whilst hot drinks were being served. Two people were asked by staff if they could manage to hold their mug of tea. This did not completely protect people from the risk of scalding from hot liquids that could have spilled on them. The acting manager said this would be followed up by obtaining more side tables, so that people did not have to hold their drinks all the time. We also observed that, due to corridor redecoration, a lock had been removed from a storage area which stored substances potentially hazardous to health. The acting manager swiftly arranged for the lock to be reinstalled on the day of the inspection visit. These issues meant that people's safety had not been consistently protected.

Staff were aware of issues of how to keep people safe. For example, to put equipment away, to make sure there were no trip hazards in the way of people's mobility and to make sure that people were not rushed when personal care was supplied. There were systems in place to keep people safe such as window restrictors to ensure people could not fall out of windows that opened too far.

Staff recruitment practices were in place. Staff records showed that before new members of staff were allowed to start, checks had been made with previous employers and with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. This showed that the necessary documentation for staff was in place to demonstrate staff were safe to supply personal care to people.

People and their relatives told us that staffing levels were sufficient to keep them safe. Staff also told us they believed there were sufficient staff on duty to ensure people were safe. We observed at least one staff member based in the lounge during the day, so they were able to check that people were safe at all times. Call bells were responded to in a timely manner by staff. A relative told us, "She uses her bell quite often and sometimes they're really quick coming and at the most 10 minutes." Another relative said, "They (the staff) usually come quickly."

A procedure was in place which indicated that when a safeguarding incident occurred, management staff were directed to take appropriate action. Referrals would be made to the local authority and other relevant agencies. This meant that other professionals outside the home were alerted if there were concerns about people's well-being, and the registered manager did not deal with them on their own. We saw evidence of a recent incident where the acting manager had cooperated with the local safeguarding team with regard to a safeguarding incident.

We spoke with staff about protecting people from abuse. Staff knew how to recognise the signs of possible abuse and their responsibility to report it. One staff member said, "We discuss this all the time so we know we have to always do something about it." Staff were also aware of relevant agencies they could report abuse to. The provider's safeguarding (protecting people from abuse) policy properly set out the roles of the local authority in safeguarding investigations.

No-one we spoke with raised any concerns with the management and administration of medication. A relative told us, "She seems better here now. Her medication is managed for her and they'll take her paracetamol (for pain relief) too if she needs it."

A system was in place to ensure medicines were safely managed in the home. Medicines were kept securely and only administered by staff that had been trained and assessed as being able to do this safely. We looked at the medication administration records for people using the service. These showed that medicines had been supplied to people as prescribed.

We observed some people being given their medicines by senior staff. This was carried out properly and people were given fluids in order to be able to take their medicines more comfortably. There were regular medicine audits undertaken so that any errors could be identified. Temperature checks for the medication fridge holding medication had been carried out. These were in line with required temperatures to make sure the effectiveness of medication was safely protected. This ensured that medicines were kept safely and not exposed to temperatures which can result in them not working safely and effectively as they should.

We found the home to be in a clean condition and no odorous areas. A relative said, "She's kept clean and her room is clean enough." Another relative said, "It's always very clean. She has fresh towels every day too and gets showers three times a week."

Requires Improvement

Is the service effective?

Our findings

At our inspection on 10 August 2015 we found that the provider did not ensure that they ensure that people had the opportunity to consent to the care provided to them. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make improvements. At this inspection we found that improvements had been made.

The people and relatives we spoke with said people received the care and support they needed. People we spoke with told us that they had confidence in the abilities of staff. One person said, "They're very well trained." A relative told us, "They do a good job."

Staff said that the training they had received had been effective in giving them the right skills and knowledge to enable them to support people appropriately. One member of staff said, "We get all the training we need. We are asked if we need any more. If we do, it gets arranged." Staff told us there were always opportunities to discuss any issues with senior staff to help them provide effective support to meet people's needs.

The staff training matrix showed that staff had training in essential issues such as dementia, protecting people from abuse and moving and handling techniques. We saw evidence that staff were being provided with care certificate training, which covers essential personal care issues and is nationally recognised as providing comprehensive training. We saw that training not yet provided to staff had been planned to ensure staff had skills and knowledge to provide effective care to people.

Staff told us that when they began working in the service they were shadowed by experienced care staff. Staff members explained that this had been useful in being shown how to provide care and being able to seek advice on how to effectively meet people's needs. We saw that induction training, such as moving and handling and protecting people from abuse, had also been provided to ensure that staff understood how to effectively meet people's needs.

Staff had received training to be aware of their responsibilities in relation to the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and approval to ensure that any restrictions are in people's best interests, to keep them safe. The staff we spoke with explained their responsibilities in relation to the MCA.

At this inspection we found evidence of comprehensive mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. Deprivation of liberty (DoLS) applications had been made with proper authorisations granted to enable staff to take decisions in people's best welfare interests. There was also instruction for staff to seek people's consent in their care plans, such as, "Staff to seek consent prior to care intervention."

When we asked the person about staff providing them with personal care, the person told us, "They always ask me nicely first." We also observed staff asking for people's consent before moving a person or moving away crockery. However, at lunch time, we saw that two people were not asked if they would like a plastic apron put on. Instead the staff member chatted to them about general things whilst putting on the apron. The deputy manager said this would be followed up with staff so that they always sought people's consent before providing personal care to them.

People we spoke with told us that the food was satisfactory, with individual preferences and dietary needs taken into account. We saw that a choice of main meal was offered at each meal. A person said, "I don't eat a lot – the hot meal smell makes me feel sick so I have a sandwich. I can choose it. (the filling)" The person said that were pleased that they had the choice of eating in their own bedroom. Another person told us, "It's edible. We get a choice for each meal and they'd do me a special if I ask. I always have an evening sandwich made for me when I ask." A relative told us, "She says the food's not too bad. She gets a choice but says they get carrots and peas a lot. She says 'I look like a carrot!" The cook said carrots and peas were only served twice a week. We checked food records but found that vegetable provision had not been recorded. The acting manager said this provision would be reviewed to ensure proper a variety of vegetables and food records would be fully recorded so this could be monitored.

We observed the lunchtime meal. Food looked well cooked and there were good portion sizes offered to people. People with communication needs had photos of food to help them choose what they wanted. However, the displayed menu beside the kitchen hatch was written in a pale felt pen on a large whiteboard. This was not easily visible to people, especially those with sight impairment. The deputy manager said this issue would be followed up so that menus were always prominent.

In the morning prior to lunch, we saw that staff asked people what they wanted for their main course, so there was an effective choice, but this was not the case for dessert has only one dessert was offered. The acting manager said that a choice of desert would be offered in the future.

People who needed support were encouraged by staff to eat more and staff assisted people with cutting up food as needed. A relative told us, "The dietician had been called in as she won't eat proper meals – just sandwiches and the pudding – so she put her on build-up shakes three times a day." Both the person and the relative confirmed that specialist drinks had been provided to effectively meet the person's nutritional needs.

We saw that a staff member asked the cook for a sandwich for a person who did not want hot meals. The cook stated that the person would have to wait as she had just cleared the main course away and soon had dessert to serve. The cook set up the hot dessert on the hatch and proceeded to portion the dessert into bowls, whilst a number of people were still eating their main course. This meant the desert became lukewarm. The acting manager said she was aware of this situation and would be looking into it to ensure food quality was maintained.

People said they received drinks at all times. Hot drinks were served mid-morning and mid-afternoon. A person told us, "I've got my jug of water (in the person's bedroom) and like a hot chocolate. They make me three banana shakes a day too." A relative said, "She's offered enough drinks and always has her vitamin juice the doctor prescribed as a supplement." Staff offered people squash or water at lunchtime with the offer of top ups later. This effectively protected people from dehydration.

We saw that people had received care from to healthcare professionals. This included visits from GPs, community nurses, chiropodist and optician, and they had been assisted to attend hospital appointments.

One person told us, "I've got a plaster on …at the moment and on my foot. The district nurse comes to do the dressings. The staff found the sore parts." A relative said, "The optician has been... she gets to see the doctor when she needs it and has her feet done too." A visiting health professional told us, "It's a good place – the staff have been supportive. They seem to manage as well as they can in the circumstances . The other lady …..we had concerns that she'd settle but they've got her into a routine and she's doing better."

We also spoke with a community nurse about the standard of health care at Alston House. The community nurse stated that staff had carried out any identified tasks to maintain people's health care needs.

This enabled people to receive the care necessary for them to effectively maintain their health and wellbeing.

We looked at accident records. We found that where people had potentially serious injuries, such as following falls, staff had alerted the emergency services and people had been taken to hospital for treatment. We also saw one record of an accident that occurred due to a person scalding themselves on a hot drink, when the care plan set out that they needed to use a beaker to protect themselves from this. The acting manager acknowledged that this should have happened and stated that she would look into this and it would be carried out in the future.

Good

Is the service caring?

Our findings

People told us that staff were friendly and caring. We observed staff being friendly and helpful to people, often going down to their level to talk or taking their hand for reassurance. One person said of staff, "I wouldn't be without them." A relative told us, "We see them interact with mum and it's lovely." Visiting professionals told us that they had observed staff being friendly to people.

We observed good interaction by a staff member serving drinks in the lounge. She squatted down beside a seated person living with dementia and asked for her hot drink preference, using a friendly, calm tone.

We observed staff being respectful and caring in their dealings with people living in the home. Care staff interacted with people in a warm way and this created a positive and relaxed atmosphere. They greeted people when they saw them. However, there was one instance where a staff member shouted to another staff member who was some distance away about a care matter. This disrupted the friendly atmosphere of the home. The acting manager said that staff would be reminded to speak, and not to shout, to each other.

People we spoke with told us that staff encouraged their independence. One person said, "They encourage me to help wash myself. They ask me when I want to go to bed and work round me. They show me some clothes in the mornings and I decide what I want to wear."

People told us that their privacy and dignity were respected. One person said, "They'll knock even if my door's open. They draw the curtains when I need the loo." Another person said, "They always knock me before coming in. The curtains get closed when I'm getting undressed." We observed staff knock and wait before entering a bedroom and knocking on a toilet door and enquiring if the person was ready before entering. Staff told us that people were able to choose the gender of staff who assisted them with personal care.

People we spoke with told us they were able to make choices about their bedtimes, clothing, meals, and drinks and where to sit. One person said, "I like to get up early at 5.30am and go to bed around 11pm after the TV." A relative said, "She chooses to be on her own in her room, so staff respect that." Another relative told us, "We were allowed to change her room round and do what we like with her belongings when she moved in."

Some family members we spoke with told us that they felt involved with their relative's care planning and were kept informed. Another relative said, "They tell us everything and update us on her health." However, other families felt less involved. One relative said, "They just give me her care plan to sign – they didn't go through it." Another relative said, "We don't feel so much involved now. We've not had a meeting." The acting manager said that people and, when appropriate, their relatives signed the care plans, agreeing to their contents. We saw evidence of this. However, the acting manager said that she would speak with staff who had drawn up care plans to ensure that people and their relatives were involved in making up the care plan to meet people's individual needs.

Relatives told us that there was no restrictions on visiting times throughout the day and or evening. They said that staff welcomed their visits and were friendly to them.

The philosophy of care at Alston House was set out in the literature of the service. This emphasised respect for people, encouraging independence, respecting privacy and for people's rights and needs to be respected. This gave guidance to staff to provide a caring service.

We saw that people from all communities had been consulted about issues of importance to them. For example, a care plan of a person included the need for the person to follow their religion. During the inspection visit, we saw the person had received a visit from a priest who was able to provide communion. There was also evidence that the person had been assisted to go to church. This showed us there was respect for people's cultural and religious needs.

These issues showed that staff were caring and respectful in their dealings with people and respected their rights to choose their lifestyles.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff looked after and responded to their care and health needs. A person told us, "I have a hearing aid so they know to help me with that." A relative told us, "The caring staff make all the difference. We go away with peace of mind."

People we spoke with felt that the care they received was appropriate to their needs and their feelings were considered. A person told us, "I get the best." A relative said, "She's got the right equipment she needs."

We saw instances of staff responding to people's needs. For example, a person said they could not find a book so a staff member said they would try to find it for them. However, we also saw instances where staff did not respond when people were in need of some assistance. For example, a person playing a board game with a member of staff said that they could not see the white counters on the board. There was no attempt to ask the person if they needed an optical test or to ask the person if the counters could be marked with another colour to help their vision. When another person repeatedly said, "I don't know what to do now," staff just told the person "You don't have to do anything." This led to the person to asking the same question without staff providing them with an opportunity to do something. This caused people frustration and did not respond to their needs.

We received mixed views on whether there were sufficient staff to provide care responding to people's needs. Some people thought there were enough staff; others felt that they were short of staff at busy period and weekends. One person said, "It seems about right." However, another person told us, "I have to wait a long time for them to get me up in the morning." A relative said, "We notice there's less (staff) on at weekends. But most of the time it seems ok in the lounge. The girls (staff) said they need more for when someone calls in ill."

When we asked if staff had time to spend with them, one person told us, "No, they don't have time." A relative confirmed this. The acting manager said that staffing levels would be reviewed to see if there were enough staff to respond people's needs.

We looked at care plans for four people using the service. People's needs had been assessed prior to them moving to the service. The information gained from these assessments was used to develop care plans to aim to ensure that people received the care and support they needed. There was also information about people's interests and lifestyle preferences. When we spoke with staff about people's needs and interests, they were familiar with them as and were able to provide information about people's likes and dislikes. Care plans were seen to be in place and were reviewed regularly.

Staff told us that management staff had asked them to read care plans. We saw there was a sheet at the front of care plans for staff to sign to indicate they had read them. Staff also told us that people's care was discussed in team meetings and we saw evidence of this. They said if people's needs changed then they were informed of this through staff handovers. This meant they were in a position to respond to people's needs.

We observed staff spend time with four people in the lounge in the afternoon doing an activity with a person or talking. The remaining people were not involved in any activity. People we spoke with told us that opportunities for activities and stimulation were limited. One person told us, "There's not much – not as much as I want. I like music. We don't paint or anything. " Another person said, "No, there's nothing. I'd like to be more active, like painting or singing. I get bored stiff!" A relative said, "We listed mum's interests on the form when she came. But we're very disappointed. We see no sign of any entertainment for them. We feel that when staff are busy or short, mum gets left."

We observed some people having one-to-one activity sessions with staff but other people in the main lounge only had the TV, there was minimal opportunity for simulation. For lengthy periods, no one watched the TV. At these times, staff did not give people the option of alternative stimulation such as listening to music instead. We spoke with one person whose face lit up when they talked about singers from the past. When music was eventually put on, staff did not ask people what type of music they wanted. This did not respond people's needs.

Five of the nine people in the main lounge were unable to see the TV from where they sat. The deputy manager later told us that people would be given the opportunity to see the TV in a different lounge.

In the afternoon we observed several staff in the main lounge carrying out one-to-one activities including a game of draughts, colouring book, dementia fiddle blanket, or chatting. We noticed that time was spent mainly with people who were able to communicate or participate, whereas six residents living with dementia did not receive any meaningful interaction and remained in their chairs.

We saw records of activities for people in care plans. However, for periods of up to two weeks, where there were no records of activities offered or undertaken by people. Staff told us that activity provision needed to improve. One staff member suggested exercise sessions for people. Another staff member said that more outings would be enjoyed by some people.

The deputy manager told us that a dedicated activity co-ordinator was not employed and that staff provided activities for people. A noticeboard showed a weekly plan of proposed activities but staff told us that this may not be followed, depending on staffing or people's wishes or co-operation. The deputy manager said that she would look into employing a dedicated activities organiser so that people had more opportunities for simulation. This will then help to provide a service that can provide stimulation and respond to people's needs and help to prevent boredom.

People we spoke with had not had to raise concerns or complain formally. One incident was explained to us and the relative was happy with the outcome. "It was investigated... and was sorted."

We looked at the complaints book which contained a small number of complaints. Proper investigations had been carried out on the issues concerned and action was identified when needed and fed back to the complainant, although this had not always been carried out in writing. The acting manager stated that this would be followed up. This would provide further evidence that the service fully responded to complaints and concerns.

In the minutes of residents meetings we saw that people had been encouraged to speak out if they had any worries or complaints. This indicated that the provider wanted to take action if people or their relatives had any concerns about the care provided.

The provider's complaints procedure set out the role of the local authority in undertaking complaints

investigations if the person was not satisfied with the action taken by the provider. There was information about the local government ombudsman should the complainant feel that the local authority had not followed proper processes in investigating their complaint.

We looked at care records which showed that agencies had been appropriately referred to when needed. For example, we saw evidence of a referral to an occupational therapist to obtain a stool. Health professionals told us that staff appropriately alerted them to any issues when the need arose.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 10 August 2015 we found that the provider did not have a system in place to provide care that met people's needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. The provider sent us an action plan outlining how they would make improvements. At this inspection we found that improvements had been made.

People told us they were happy with the atmosphere of the home. One person said, "I think it's a happy place." Another person told us, "It's very friendly." A relative said, "It feels like a family. It has a good vibe."

However, relatives told us when they had spoken with management staff about any issues, these had not always been followed up effectively and quickly. For example, the provision of activities to meet people's needs.

The registered manager had delegated the running of the service to the acting manager. We saw that the acting manager was, at times, visible, available and proactive in managing the service. There were times when they walked the floor and we saw they were supportive to staff as well as knowing people well. Staff interactions were, in the main, relaxed and cheerful. There was a sense of a team with staff in all roles being involved in ensuring the wellbeing of people.

Staff told us they could approach the acting manager about any concerns they had. One staff said, "(Acting manager) is kind and will always help me." Another staff member said, "Yes, I can just go to the office if I have any queries and I am always helped."

We saw systems in place to improve staff performance. For example, there was a work performance monitoring form which included relevant issues such as the attitude of the person towards people, encouraging teamwork and discussing the quality of personal care provided. Where there had been issues of staff performance, we saw the acting manager had taken appropriate measures to improve staff performance.

Staff members we spoke with told us that the acting manager led by example and always expected people to be treated with dignity and respect. Staff said they would recommend the home to relatives and friends because they thought the home was well run and the interests of people living at Alston House were always put first.

We saw that residents meetings had taken place. There were relevant issues discussed in the meetings such as gaining people's views of the service about important issues such as activities and food. We saw that relatives had also been invited to attend meetings to put forward their views. This meant people and their relatives were consulted about how the services offered and they had an opportunity to be included in the running of the home.

Staff said that essential information about people's needs had always been communicated to them by way

of daily handovers so that they could provide appropriate care that met people's needs.

We saw that staff were supported through individual supervision, appraisals and staff meetings. This included relevant issues such as staff concerns, staff training, working as a team and staff attitude towards people. This meant that staff had received support to ensure a quality service to people and to discuss their competence and identify their learning needs.

People and their relatives had been asked in quality surveys their opinion about the quality of care they were provided with. The surveys carried out in 2015 showed that people and relatives, in the main, were satisfied with the service they received. There were some issues raised in terms of the opportunity to go out to community activities, ensuring privacy and how to more effectively communicate with people. However, there was no evidence that these issues had been actioned. The acting manager said that this year's survey was currently being sent out to people and relatives and any issues would be acted on. This will help to indicate a well led service.

The acting manager told us that staff and relevant outside professionals had been asked their opinions of the service in the past year by way of completing satisfaction surveys.

The acting manager had implemented a system to ensure quality was monitored and assessed within the service. We looked at a number of quality assurance audits. These included audits and unannounced checks of the home such as checking infection control, observation of care practice by staff, care planning, fire checks, the premises, maintenance checks and monitoring the health and safety of the most vulnerable people using the service. However, health and safety auditing had not identified the issues we observed with regard to the lock being removed from a storage area storing substances hazardous to health, and a lack of side tables for people to put their drinks on. Having fully effective quality assurance systems in place would ensure comprehensive protection for the safety and welfare of people living in the service.