Alness Lodge Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Alness Lodge is a residential care home for up to 10 people living with mental health needs. Single occupancy accommodation is provided over two floors; the service does not have a passenger lift. Bathing, showering and toilet facilities are shared.

At the time of this inspection there were nine people living at service and one person was away staying with relatives.

People's experience of using this service and what we found:
The service did not have effective systems in place which sought to protect people from abuse or improper treatment. This exposed people who used the service, and others, to a risk of harm.

The provider considered the majority of people who used the service to be either independent or semi-independent. This meant there was a distinct lack of person-centred care and support. The service did not always provide support to people that was appropriate, met their needs, and reflected personal preferences.

Some people were able to access the community independently and instigate their own social activities, many people were not. There was no evidence of activities organised by the service and people simply spent the majority of their time watching TV in the communal lounge or remaining in their private room, only coming out at meal times.

Potential new admissions into the service were offered an opportunity to participate in trial visits. However, the provider did not complete a specific pre-admission assessment and there was an overreliance on the information provided by other external professionals, some of which was historical.

There was no regular schedule of audit and quality assurance which meant the provider lacked oversight and was reactive, rather than proactive.

Since our last inspection, 14 incidents had been recorded in the accident book, one of which resulted in a serious injury. However, no overarching analysis had been completed to identify themes or trends and action needed to reduce the likelihood of such incidents occurring again in future.

Staff prioritised completing tasks rather than assisting people to be as independent as they could. Staff we spoke with told us they would like to spend more time with individuals, but the daily routine of the home meant this was not always possible.

During this inspection we observed staff speak openly about people's care needs in front of other people. This did not respect their privacy and confidentiality.

People who used the service were from diverse backgrounds and the workforce was reflective of this. However, the provider had no clear philosophy or approach round equality and diversity, and how the needs of people from different backgrounds would be met.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was requires improvement (published 23 July 2018) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found insufficient improvements had been made.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
At this inspection we have identified new and continued breaches in relation to providing person-centred care, safeguarding people from abuse, good governance, and staffing. Please see the action we have told the provider to take at the end of this report.

Follow up:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Alness Lodge Limited

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector from the Care Quality Commission (CQC) 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.

Service and service type:
Alness Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Alness Lodge is a family run business. The provider (and a company director) was also the registered manager. Throughout this report, we simply make reference to the provider.

Notice of inspection:
The first day was unannounced.

What we did:
We reviewed information we had received about the service since the last inspection. We also liaised the local authority and other external agencies who work with the service.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.

During the inspection:
We spoke with seven people who lived in the service and a visiting relative to understand their experience of the care provided. We spoke with five members of staff including the registered manager, assistant manager and care workers.

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 reviewed a range of records. This included nine care plans and associated documentation. We looked at three staff files in relation to recruitment and three to review staff supervision records. We reviewed multiple records relating to the management of the service and a variety of policies and procedures.

After the inspection:
We continued to seek clarification from the registered manager to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not always safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; assessing risk, safety monitoring and management; learning lessons when things go wrong:

- During this inspection, we identified a number of areas of concern where there were ongoing issues associated with safeguarding and the management of risk.
- We found risks associated with a person who used the service accessing the community had not been effectively addressed, including where there had been a clear deterioration in behaviours and police involvement. Whilst it appeared external professionals had been involved in this case, there was no clear plan or risk management strategies in place. This placed this person, and others, at significant risk. We raised a safeguarding alert with the local authority about this.
- A person had been living at the service for 10 months, but throughout this time they had not had access to their personal finances. We discussed this with the provider and we were told this person lacked mental capacity to manage their own money which meant the local authority were planning to take over responsibility of this. The provider told us they were providing this person with 'pocket money' whilst they were waiting for the local authority to take action. However, because this person was unable to access their finances, this impacted on their freedoms and choices, which was a fundamental infringement on their human rights. We raised a safeguarding alert with the local authority about this.
- A person who used the service disclosed to a member of the inspection team they felt bullied by a member of staff. We made immediate enquiries about this which included a period of observation in communal areas and a review of this person's care records. During our observations, we observed the member of staff implicated in the bullying allegation, speak to them in an improper way which had a negative impact on their emotional state. We spoke with the provider about this and ensured positive action was taken. We also raised a safeguarding alert with the local authority.
- Whilst we acknowledge other external professionals and agencies had ongoing involvement in each of the examples given above, the provider had not worked effectively with these external professionals and agencies to contribute to individual risk assessments and plans for safeguarding. This included regularly reviewing outcomes to ensure people's safety.
- We found the provider did not have effective systems in place which sought to protect people from abuse or improper treatment. This exposed people who used the service, and others, to a risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Staffing and recruitment:
● Staffing levels in the service were historical and not based on an assessment of people's individual needs. During the day, one care worker and the assistant manager would be on duty. The provider was not always present each day, and it was not clear how much time they spent in the service. At night, there was one waking care worker on duty with another member of staff on a 'sleep in' shift to provide additional support if required.
● Throughout the inspection, we observed prolonged periods of time where people were unsupervised in communal areas. This was because the care worker or the assistant manager were engaged in other activities, such as cleaning, kitchen duties or escorting people to appointments.
● We spoke with the provider about this and we were told the majority of people who used the service were considered to be 'semi-independent'. However, whilst we found no evidence of harm, due to the lack of a systematic approach in assessing people's dependency, we were not assured by this explanation.

We recommend the provider explores credible sources of information and guidance for assessing people's individual dependency levels. This is commonly known as a 'dependency tool' and is used by health and social care providers as an aide to ensure sufficient numbers of staff are deployed to meets people's needs.

● Safe recruitment practices had been followed. This included pre-employment checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions.

Preventing and controlling infection:
At the last inspection, systems for the prevention and control of infection were not effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. At this inspection we found enough improvement had been made and the provider was no longer in breach of Regulation 12.

● At this inspection, we found communal areas of the service and the kitchen area to be visibly clean. Cleaning schedules were in place and staff understood their individual and collective responsibilities towards infection prevention and control.
● In March 2018, the local authority visited the premises and awarded a rating of 'Five' which meant food hygiene practices were deemed 'very good.'

Using medicines safely:
At the last inspection, we made a recommendation that protocols needed to be put in place, to guide staff for medicines administered 'as and when required.' At this inspection we found improvements had been made.

● Systems for the ordering, storing, administering and disposal of medicines were operated effectively. People were receiving their medicines when they should.
● Staff were trained to handle medicines safely and had completed competency assessments to ensure their knowledge remained up-to-date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● At the last inspection, the majority of staff had completed or were working towards completing the Care Certificate. However, given the nature of the service provided at Alness Lodge, we found no specific training for mental health and managing behaviours that challenge was provided to staff. This meant staff were not always able to provide a responsive level of care and support that met people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Staffing.

● Staff told us, and records demonstrated that supervision meetings took place on a regular basis. Supervision meetings provided staff with the opportunity to discuss with senior staff any worries or concerns they had and to discuss any other service related matter. Staff also participated in an annual performance appraisal.

Adapting service, design, decoration to meet people's needs:

● At our last inspection we highlighted the outside space at Alness Lodge required improvements to make it a more welcoming and a 'user friendly' space.

● At this inspection we found no improvements had been made. We discussed this with the provider and we were told the long-term plan was to build an extension to the service which would incorporate a newly designed outside space. However, this was still only a proposal and did not detract from the fact nothing had been done in the short-term to improve the outside space.

● However, since our last inspection we acknowledge improvements had been made inside the building. For example, communal areas had been re- carpeted and paint work refreshed. The bedrooms of three people who used the service had also been redecorated.

Supporting people to eat and drink enough to maintain a balanced diet:

● The service provided meals to the majority of people living at Alness Lodge. A small number of people were able to prepare their own meals and had access to the main communal kitchen. Where able to do so, people also accessed the kitchen to prepare their own drinks and snacks.

● Food options were based on a four-week rolling menu. If people preferred something else on the day we saw an alternative option was provided. People had been consulted about their individual food preferences, which the Provider sought to accommodate.

● We asked people about the mealtime experience and their feedback was indifferent. Comments included,

"I come down for my meal and then go back to my room, that's it really.", "The food is OK, not great.", and, "We get a choice but it's the same things really."
● People's care records lacked detail around nutrition, hydration and specific dietary requirements, in particular how this linked to maintaining good health.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● Whilst we acknowledged potential new admissions were offered an opportunity to participate in trial visits to the service, the provider did not complete a specific pre-admission assessment. There was an overreliance on the information provided by other external professionals, some of which was historical.
● The model of care and support provided was not in line with national best practice standards and guidance for people living with enduring mental health needs. This meant outcomes for people could not be measured.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care:
● The service did not have a framework in place which sought to promote and encourage people to participate in health and wellbeing activities. For example, physical health activities or initiatives linked to good nutrition.
● People were supported to access routine and unplanned healthcare appointments.

Ensuring consent to care and treatment in line with law and guidance:

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● At the time of this inspection, one person who used the service was subject to restrictions and the provider had submitted a DOLS application to the local authority. However, this person's DOLS application lacked detail and their care plan was contradictory. It was unclear what aspect of daily living they lacked capacity about or to make decisions to keep themselves safe. The care plan also indicated this person may on occasions leave the care home unsupervised.
● We discussed this with the provider and we were told there were ongoing delays with the local authority DOLS team assessing this person. We were also told this person did not go out alone and to date, had not made any indication they wanted to leave.
● Whilst we acknowledged there were ongoing delays with the local authority, this person's care plan did not sufficiently demonstrate how the service was acting in their best interests and as least restrictive as possible.

We recommend the provider explores credible sources of information and guidance around the MCA and requirements associated with DOLS.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence:
● Throughout our inspection visit, we observed how support was delivered in communal areas of the service. We found staff prioritised completing tasks rather than positively engaging with people.
● Staff we spoke with told us they would like to spend more time with individuals, but the daily routine of the home meant this was not always possible.
● During this inspection we observed staff speak openly about people's care needs in front of other people. This did not respect their privacy and confidentiality.
● People were encouraged to maintain relationships with people who were important to them. Comments from people included, "My partner comes to visit most days and is always made to feel welcome by the staff."

Ensuring people are well treated and supported; respecting equality and diversity:
● We looked at the approach to equality and diversity and how the rights of people who shared a protected characteristic were promoted and respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination on the basis of age, disability, race, religion or belief and sexuality.
● We found people who used the service were from diverse backgrounds and the workforce was reflective of this. However, whilst we found no evidence of discrimination, there was no clear philosophy or approach around equality and diversity and we found no tangible examples of how the service had recognised and responded to the needs of people from different backgrounds.

We recommend the provider consults CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.'

Supporting people to express their views and be involved in making decisions about their care:
● People had planned annual reviews of their mental health. However, these reviews were completed by external professionals, with input from staff at Alness Lodge, and the person who used the service. The provider did not routinely carry out their own regular reviews of people's health and wellbeing.
● When required, people who used the service were supported by independent advocates. Advocates help to ensure the views and opinions of people who use services are considered in any decisions being made about their care, support or treatment.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:

- At this inspection, we reviewed various sources of information to check the actual service being provided was in line with information published by the provider. For example, we reviewed the providers most recent statement of purpose and service user guide. A statement of purpose is a legally required document that providers of health and social care services must complete, which describes what they do, where they do it and who they do it for. We found the provider was not providing services as described in either their statement of purpose or service user guide.
- The provider considered the majority of people who used the service to be either independent or semi-independent. This meant there was a distinct lack of person-centred care and support and we were not assured that staff truly knew people well or understood their needs.
- In addition to this, care plans and associated documentation failed to take account of people's individual likes, dislikes and personal preferences. This included people's, goals and aspirations for now and in the future. Care plans also lacked meaningful information concerning physical health needs.
- Whilst some people were able to access the community independently and instigate their own social activities, many people were not. There was no evidence of person-centred activities organised by the service and people simply spent the majority of their time watching TV in the communal lounge or remaining in their private room, only coming out at meal times. Comments included, "It gets pretty boring and I don't get to go out much at all, and, "I can't remember the last time there were any activities."
- During this inspection, we spoke with a person who used the service who was presenting as highly anxious, emotional and upset. We looked in this person's care records and we spoke with the provider. Despite this situation having been on-going for over a year, it was apparent to us this person's needs were not being met by the service.
- We found the provider had failed to take sufficient action to involve other professionals and had not acted in a timely way in fully exploring appropriate management strategies and/or whether an alternative placement was needed. The situation had been left to deteriorate which resulted in the person who used the service being served a notice to move out and find alternative accommodation. We raised a safeguarding alert with the local authority about this.

We found the provider had failed to provide support that was appropriate, met people's needs, and reflected personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Person-centred care.

Meeting people's communication needs:
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● At the time of this inspection, we were told no one who used the service lived with a sensory impairment or needed information provided in an alternative format.

Improving care quality in response to complaints or concerns:
● In the event of a complaint, the majority of people told us they would simply speak to a member of staff. The service user guide, and information displayed around the home also directed people to log a complaint in the 'complaints book' which was located in the main office.
● We reviewed the complaints book and found this system used by the provider did not detail sufficient information outlining the providers initial response to the complaint, the action to be taken, by when, and lessons learned.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated as requires improvement. This was because we found the provider had failed to ensure systems and processes were in place and operated effectively to improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding good governance.

At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. This was a continued breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care:

- Following our last inspection, we served a requirement notice. This meant the provider must send us an action plan for improvement, with timescales. The provider told us they would be complaint by 29 June 2018. However, at this inspection, we found the provider had failed to implement the action plan for good governance.
- Care plans and associated documentation were not fit for purpose. We found systemic issues in respect of poor-quality recording and illegible handwritten entries. It was almost impossible to identify where handwritten entries started and ended, and which action or outcome of support it related it. This meant eliciting the most up-to-date picture of people's needs was extremely difficult. This exposed people to a risk of inappropriate care and supported being provided that was not in line with their needs.
- Since our last inspection, the local authority quality improvement team had drawn up an improvement action plan which clearly outlined nine areas for improvement and associated actions. However, we found the provider had failed to implement the action plan and continued to fail in ensuring systems and processes were in place and operated effectively to improve the quality and safety of the service.
- There was no regular schedule of audit and quality assurance which meant the provider lacked oversight and was reactive, rather than proactive.
- Since our last inspection, 14 incidents had been recorded in the accident book, one of which resulted in a serious injury. However, no overarching analysis had been completed to identify themes or trends and action needed to reduce the likelihood of such incidents occurring again in future.
- In the service user guide, CQC was incorrectly detailed as the lead agency for complaints. At our last inspection, we told the provider about this but this error had not been corrected.
- The provider had no overall vision for the improvement and development of the service.

This was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

● When a certain incident or untoward event occurs in a service regulated by CQC, the provider is required by law to submit a form called a statutory notification. At this inspection, we identified four incidents that CQC had not been notified about. We are investigating this matter outside the inspection framework.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:
● Staff were not provided with proper training or guidance to enable them to effectively carry out their role, in particular, training around mental health and managing behaviours that challenge.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:
● Policies and procedures to ensure compliance with requirements for duty of candour were not in operation within the service. The provider did not have a service-specific policy about this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others:
● The provider was inward looking and had not sought opportunities to positively engage with other organisations to share best practice, expertise or resources, to improve the service and deliver a good experience of care for people.
● We looked at minutes of residents' meetings and staff meetings which demonstrated people were able to contribute ideas and suggestions about the running of the home. However, further meeting minutes failed to demonstrate whether issues previously raised had been resolved. Meeting minutes also failed to detail who had responsibility for a particular action.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and support provided to service users was not always appropriate, meet their needs, or reflective of their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate support, training and professional development as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems in place which sought to protect people from abuse or improper treatment. This exposed service users and others, to a risk of harm.

The enforcement action we took:

Served Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems or processes established and operated effectively to ensure compliance with the legal requirements.

The enforcement action we took:

Served Warning Notice.