Lifeways Community Care Limited

Alstone House (Registered Care Home)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 15 February 2017. The last comprehensive inspection of the service was on 16 July 2014 and there were no breaches of regulation at that time. Alstone House is a residential care home and provides accommodation and personal care for up to four people with learning and physical disabilities and acquired brain injuries. At the time of our inspection three people were using the service.

There was a registered manager in post. However, they had not been working in the home since January 2017 when an internal quality audit by the provider had identified some concerns. The registered manager was not available on the day of our inspection. The registered manager was still employed but was currently on 'gardening leave' from the service. 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 responsibilities for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had employed an 'acting manager' from another service who had been working at Alstone House since the day before our inspection.

We received information prior to this inspection from a health and social professional telling us that people were at risk. This was because staff were not adequately trained to administer medicines and that people were being placed at risk due to high numbers of agency staff being employed. The local authority had completed a visit to the service on 31 January 2017 and found concerns relating to people's safety. An action plan had been produced, however many of the concerns found had not been rectified when we visited. Our inspection highlighted shortfalls where some regulations were not met. We also identified further areas where improvement was required.

People did not receive a service that was safe. The provider did not have effective systems to assess, review and manage risks to ensure the safety of people. One person was at risk of falls and there was no assessment to determine risks associated for them. Guidance was not available for staff on how to support people safely. People's medicines were not being managed safely and the medicines were not always secure as the keys were not always looked after by staff. Fire checks and fire drills were not being carried which meant people were at risk in the event of an emergency. Harmful chemicals were not being stored correctly. We found hazardous chemicals in the unlocked communal airing cupboard which could be extremely harmful for people. Staff recruitment was unsafe. Checks were not always carried out on staff to ensure they were safe to work with vulnerable people. The premises were in need of decoration, were not fit for use for one person with a physical disability and were not always clean.

Sufficient numbers of staff were available to keep people safe and meet their needs; however a high number of agency staff were being employed. This reduced staff consistency and this in turn negatively impacted on people's care. Some people were not being supported to reach their full potential.

The service did not provide effective care and support. Staff had not received suitable training enabling

them to effectively support the people living at Alstone House such as people living with an acquired brain injury. Staff were not receiving regular supervisions or appraisals. The service was not adhering to the principles or requirements of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). This meant the people's rights were not being protected.

The service was not responsive to people's needs. Support plans and risk assessments were out of date and lacked detail required to provide consistent, high quality care and support. People did not always have sufficient activities to support them to socialise and lead a fulfilling life. Complaints were not documented or dealt with appropriately.

The service was not well led. The registered manager and provider had governance systems in place to monitor the quality of the service provided. However, these systems had not identified the concerns we found around medicines management, recording of information and assessing risks. There was no leadership from the senior staff team. Quality assurance checks and audits were inconsistent and put people at risk. Confidential records were left for anyone to read in the communal living area. This included information on people's finances.

Staff we spoke with said they felt anxious about the service provided and that the morale was low. We observed staff trying to support people in a caring and patient way during the inspection; however staff appeared rushed and did not appear to know the people they were caring for well.

Following our inspection, the provider for this location submitted an application to cancel the registration to provide a regulated activity at Alstone House. We will be following our processes to de-register the service.

We found a number of breaches 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not familiar with safeguarding procedures and had not received adequate training on keeping people safe. There was an increased use of unfamiliar agency staff being used to cover shifts.

The physical environment was not safe, fit for purpose, adequately maintained or clean and placed people at risk.

Medicines were not being managed safely.

Recruitment practices were not safe. People did not have current pre-employment checks to enable them to safely work with vulnerable people.

Fire safety checks were not being completed and records did not give staff sufficient and up to date information on how to support people in an emergency.

People were not always protected from hazardous substances

Is the service effective?

Inadequate

The service was not effective.

Staff had not received training on caring for people living with an acquired brain injury, positive behavioural support, safeguarding adults or diabetes.

The service did not comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant people's rights were not protected.

Staff were not supported and did not receive regular supervision to develop and review their day to day practice. No appraisals had been completed for staff members in the previous 12 months.

Is the service caring?

Inadequate

The service was not caring.

There were no positive comments from relatives or health professionals.

People were not treated with dignity and respect.

Staff were clearly trying to provide good care and support, however staff morale was low and they told us they were concerned about people living at Alstone House.

The confidentiality of people living at Alstone House had not been maintained. People's finance files were left in communal areas.

Is the service responsive?

Inadequate

The service was not responsive.

Support plans did not contain sufficient information to enable staff to deliver person centred care.

There was no focus on getting to know people. There was no emphasis on preferred routines, people's identities and what was important to them.

People were not supported to take part in meaningful activities.

Complaints were not recorded or dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of clear, supportive leadership from the registered manager and provider.

There were no comprehensive audits carried out by the provider since January 2015.

Accurate records on the care and treatment people received were not maintained.

Alstone House (Registered Care 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.

Prior to the inspection we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us.

The inspection took place on 15 February 2017. This was an unannounced inspection, and was carried out by one adult social care inspector. The last comprehensive inspection of the service was on 16 July 2014 and there were no breaches of regulation at that time.

As part of our inspection we spoke to seven members of staff, one relative and we spoke to, or had feedback via email from four health and social care professionals. This included community nurses who visited the service daily and the Local Authority who had carried out a quality review the week before our inspection. The registered manager was not available on the day of our inspection. An 'acting manager' who had commenced employment the day before our inspection was available on the day. We spoke to a team of three members of staff from another Lifeways service who had been asked to support us with records on the day of our inspection.

During our visit we spoke to two people using the service. Because we were unable to speak to everyone because of their communication or learning disabilities we spent time observing what was happening at the home.

We looked at the care records for three people living at the service, six personnel files, organisational

records, staff rotas and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Although people we spoke with said they felt safe and liked living at Alstone House, we identified concerns where safety was compromised and people were at risk.

Prior to this inspection we received information of concern from a health and social care professional. They told us people were at risk of neglect as staff were not adequately trained to administer medicines and that people were being placed at risk due to high numbers of agency staff.

Sufficient numbers of staff were available to keep people safe and meet their needs; however a high number of agency staff were being employed. This reduced staff consistency and this in turn negatively impacted on people's care. Staff did not know people well enough to ensure safe care and treatment. Many permanent members of staff had recently left the service; this included the registered manager and all of the team leaders. Some people were not being supported to reach their full potential. The rota showed us that approximately 60% of agency staff were being employed at the service. On the day of our inspection there was one full time member of staff and two agency workers on duty for the day.

The acting manager told us they used consistent agency staff where possible to ensure continuity for people living at Alstone House. We were told agency workers were never working alone and that permanent staff members were available at all times. One person said, "It is quite chaotic. There are lots of different staff now". Relatives we spoke with expressed concerns over the lack of permanent staff and felt this was having a negative impact on people's care needs. One health professional said, "One staff member had been sent out shopping to buy gloves. The two remaining carers who were fairly new were trying their best to attend to one resident's needs but it was clear they were new and not experienced and seemed unsure of what they were doing".

There had been no system in place to check staff recruitment. Checks were not always carried out on staff to ensure they were safe to work with vulnerable people. We checked six staff files and three staff members did not have a current Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. Some staff did not have a satisfactory evidence of previous employment. This meant people had been put at risk of receiving care from staff that had not undergone satisfactory checks to ensure they were safe to work with vulnerable people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People were not kept safe by staff who knew about the different types of abuse. Some staff had not been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. There were no policies or procedures available at the time of our inspection. Less than half of staff working at the home had been trained in adult safeguarding.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding services users from abuse and improper treatment.

Medicines management records and practices were not managed safely. Examples of areas that had been identified included missed medicines, four medicine administration records (MAR) for one person which meant it was unclear if the person had received the medicine once or more than this, medicines not stored in the fridge as described, no system for signing medicines in and out, insufficient staff training regarding blood sugar levels and no records for medicine errors or quality assurance. Keys to the medicine cupboard were left on the table and staff did not know which keys opened boxes within the cupboard. Risk assessments around medicines were not all up to date or were not visible. There were no records to indicate how people liked to take their medication. One relative said, "I have witnessed a staff member doing the medication incorrectly". One health and social care professional told us, 'When I asked a member of staff to pass me an insulin pen they did not know what one looked like'. Only one member of staff had a competency check for administering medication appropriately.

Risks to people's health and safety had not been assessed appropriately and the provider was not doing all that was reasonably practicable to mitigate any such risks. Support plans and risk assessments were brief and had not been reviewed regularly to assess changing needs. It had been identified that one person was at risk of falling and injuring themselves and they did not have a risk assessment in place to keep them safe. There was no information or guidance to support staff on how they managed these risks. One relative said, "[The person] had a fall a few weeks ago and hit their head. They were vomiting all night and after their breakfast the next morning. No-one had taken them to the hospital". Another person was at risk of choking and we witnessed them coming out of their room with an item of clothing in their mouth.

There were no written accident and incident documentation. There were four body maps in one person's support plan showing cuts, bruises and marks for January 2017 but these were unexplained. We saw no evidence that the registered manager had taken any action to address this, therefore it was unclear whether accidents were avoidable and whether there were any patterns or themes. One relative told us, "[The person] had fallen and hit their head on 3 February 2017. They had been vomiting after the fall, throughout the night and after their cup of tea the next morning. This was at least 12 hours. No-one took them to hospital. This only happened when I arrived the next morning". We viewed the daily records for this person on that day stated that they could not be taken to accident and emergency service due to there being no member of staff on duty that could drive as advised by the out of hours 111. There was no accident book available.

We found shortfalls with equipment and practice within the service which did not protect people from the risk of infection control. People were not always protected by the prevention and control of infection and harmful chemicals were not stored appropriately. The airing cupboard was unlocked and we found bottles of coolant, white spirits, and a large tin of paint and diesel oil. We asked the acting manager to store the items appropriately. Two hours later we found the bottle of coolant and tin of paint holding open the back door in a communal laundry area. A member of staff then removed these items into a skip on the front driveway. These were still accessible to people at the time we left the property at the end of our inspection. Mop buckets and mops were stored outside in the garden. We were told a secure shed was on order for these and would be arriving soon. One person's bathroom had significant damp and mould which had been present for a long period of time due to the ventilation fan being broken. This had been reported to the registered manager in October 2016 but nothing had been done. This could cause harm to people using the bathroom. We were told by one staff member that there were concerns about people's health with regard to one washing machine being used for soiled clothing and the risk of cross contamination. Red and yellow bags were available but were not being used appropriately.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Inadequate

Is the service effective?

Our findings

Training records confirmed that staff did not have the appropriate knowledge and skills to support people effectively. No staff member had training in positive behaviour support, acquired brain injury, autism and were unable to measure blood sugars for one person who had diabetes. Less than half of the staff team had training in mandatory areas such as safeguarding, MCA and DoLS and medication competency. A number of people using the service at the time of our inspection were living with an acquired brain injury. The lack of staff knowledge and skills in these areas had a negative impact on how effective the service was provided. One relative said, "I know staff have not had autism training, I am very worried about [The person]".

Staff were able to complete an induction when they first started working at the home. This was a mixture of face to face training, online training and shadowing more experienced staff. The Care Certificate had been introduced and newer members of staff were completing this as part of their induction. Training records confirmed that three members of staff had not completed this within the three month deadline. Three people had not completed their on-line training before starting employment.

Staff were not receiving regular one to one supervision with a line manager. Individual supervision is an opportunity for the line manager and staff to evaluate performance and plan to improve their effectiveness in providing care and support to people. When we viewed supervision records for staff, only one member of staff had received supervision during 2016. None had been completed for 2017. This meant the registered manager/provider was not formally monitoring staff performance, supporting the staff to work together as a team or monitoring staff morale. One staff member said, "I wasn't consulted or able to input into support plans. A negative culture developed over time".

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 people lack the mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People's capacity to make choices and decisions had not always been assessed. Where assessments had been completed they were not well developed or decision specific. They were not updated or reviewed regularly. One person had total control over their own finances and had spent a large amount of money within the previous nine months. We found no records for this person relating to finances. One staff member said, "This person who had a lot of money is definitely at risk of financial abuse and is vulnerable. They have

spent £20,000". There was conflicting information on whether this person had the capacity to make financial decisions and there was a lack of safeguards for this person. There were no records to show that people understood what consent was or how they were being assessed in relation to their capacity to make decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

It was unclear if people had contact with health and social care professionals. There were no records of visits or appointments to doctors, dentists or opticians in people's support plans. One relative said, "I don't know when [The person] last visited the dentist, chiropodist or speech therapist. They are not encouraged to brush their teeth or wash their hands". There were no records of people receiving a yearly health check. There were no documents to show how people should be supported when attending appointments or an admission to hospital. One person was being weighed every month and at times had their fluid intake monitored. This was completed sporadically. It was unclear if any of this information was monitored and/ or used to identify any areas for concern. There were no reviews of people's health needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Safe care and treatment.

The physical environment was not accessible for one person with a physical disability and using their wheel chair. The front door was not wide enough for the person and every time they had attempted to leave or enter their home they would cut and bruise their knuckles. We were told this had been happening for a number of years. The front door also had a doormat which was restrictive to them.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

There were mixed reviews about the food and drinks on offer at Alstone House. One staff member said, "There is no food in the cupboards, no fresh vegetables or dairy free yoghurts for one person who requires them. Staff are eating all of the provisions. There is no menu planned and the fridge is full of fizzy drinks". We checked the contents of the fridge and found some meat, fizzy drinks and sweets. There was a bowl of fruit in the kitchen area for people to help themselves. One person said, "The staff help me with cooking and cleaning and to open things like tins etc. I go out and buy my food shopping every week with staff". One relative said, "There is sometimes food on offer that [The person] likes but there are things he likes to eat but doesn't get. There is no encouragement from staff to involve [The person] in food preparation".

Inadequate

Is the service caring?

Our findings

One person gave us mixed views about the staff being caring and said, "They are really caring and they look after me well. The full time staff are ok but it's quite hectic with all of the agency staff we have. I would like more full time staff recruited and all of the team leaders and manager have left" and "They never say hello or goodbye to us". One relative said, "There is not consistent staff. There are one or two that have been there a while and do care but there are so many new ones now". One health and social care professional wrote to us and said, 'As a healthcare professional, I feel that what I witnessed today would compromise the care given to the residents. There was no clear leadership or support to the care staff. Inadequate training given to staff that had been left in charge of a home with vulnerable adults who have significant behavioural, learning and health needs. The two care staff that were there were very distressed and appeared to want to provide good care'. There were no positive comments from staff, relatives and professionals in relation to the caring attitude of the team. We observed a team of staff from another Lifeways home who were clearly trying to provide positive support and care to people. They told us that they had spent time trying, and would continue to sort out things for people but there was 'a lot to do'.

People were at risk of neglect, including with their personal care needs. One staff member said, "There are no cleaning products, people put soiled incontinence pads in normal bins, there are no yellow bags and red bags are not being used properly. When I was here the other day one person who has incontinence issues was just left and not attended to and had food around their mouth. Staff just watched them. There is a culture of bullying and neglect". One relative said, "Personal care is not managed well. I don't feel like [The person] is well looked after. I have seen [The person] with soiled underwear and bedding. I have seen them wearing other people's clothes as they get people's clothes muddled up. There is no care or dignity. I have seen [The person] call out for staff to help when an incontinence accident has occurred. They have to keep asking for support". One health care professional said, "One person had been incontinent on my visit to the home but the staff had not been able to change them as they had no gloves".

People's bedrooms were not always clean and tidy and appeared neglected. Some people showed us their rooms. One person did not have a duvet cover on their bed and the wardrobe had no doors attached so their belongings were falling out. We noted that there was a strong smell of stale urine in one person's room. Staff we spoke with were aware of the offensive smell but were unable to identify why it was so apparent.

Staff confirmed any changes to people's care were discussed during a shift handover process to ensure they were responding to people's care and support needs. The handover was done verbally in the communal area of the dining room. One staff member said, "One person is present during the handover whilst other people are being discussed. [The person] knows far too much and it's not confidential. There is lots of miscommunication". This meant people's right to confidentiality was being compromised.

There were no established communication methods for people who could not communicate verbally. One person had very limited vocabulary. There were no records available for this person in an easy read format or with pictures. This included their own support plan, risk assessments and a complaints form.

This was a breach of Regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

We could not be satisfied the confidentiality of the people living at Alstone House was always maintained. During the inspection we walked around the home and in the communal living area we found folder's with people's names on. Inside the folders were records relating to people's finances. This had been raised by the local authority during their quality assurance visit two weeks before our inspection but no action had been taken to remove the files. We explained our concerns regarding confidentiality to the 'acting manager'. The files had not been removed by the time we left the property at the end of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Good governance.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs. We were unable to find any compliments with regard to the home.

Each person had a support plan to record and review information. Support plans were not sufficiently detailed or written in a person centred manner. Some people did not have any guidance in their support plans for areas important to them. For example, people assessed as being at risk of falling or choking did not always have a plan in place to reduce this risk. People's support plans did not detail their likes, dislikes or preferences. There was little information for staff to 'get to know' the person and talk with them about things they enjoyed or what was important to them. One person recently had a new diagnosis of a de-generative condition. Their support plan had not been updated with this information.

Support plan's had different sections such as; choice and control, health and well-being, every-day tasks, managing money and family and relationships. There were areas to record what people can do for themselves and what support was needed by staff. Every section of 'what can I do for myself' was blank in one person's support plan. This meant independence and targets and goals were not being monitored or encouraged. A detailed routine page was also blank.

Daily notes were thorough and contained a good level of detail of how people had spent their day. The daily notes contained information around what support had been provided to people, what they had to eat and drink and any activities they had taken part in. This gave staff a good overview of how people were feeling and if any emotional support was needed. If people were feeling anxious or upset this was clearly documented. We were, however unsure if staff read these notes when arriving on shift.

The daily notes had a section for targets and goals to promote independence. These were all blank and we were unable to see any records relating to targets and goals. This meant that the staff were not supporting people to meet their aspirations and goals.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People, staff and relatives we spoke with said that they had made complaints to the registered manager before they left but that there had been no investigations or outcomes. We found one complaint regarding a staff member in the complaints file. One person said, "I told the manager about the damp in my bathroom last September but nothing got done". One staff member said, "Any concerns raised were listened to but not dealt with". Another staff member said, "I am not confident any complaint would be dealt with".

This was a breach of Regulation 16 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

People were encouraged to go out into the community and take part in activities. On the day of our

inspection one person was out spending the day with their relative. We were told that relatives could visit when they wanted to and were welcome. Another person was participating in voluntary work at a local centre. This was a weekly activity. [The person] went out for a while and then returned and they told us they didn't want to be there. There were no other activities on offer for the rest of the day and [The person] stayed around the house. Daily notes for two people confirmed that they often spent many hours during their day in their bedroom, in bed or asleep. Staff confirmed that this was often the case within the home.

We recommend the provider reviews its activities programme to ensure people are supported by the staff to engage in meaningful activities when they do not have planned days out or activities in the community.

Inadequate

Is the service well-led?

Our findings

The registered manager had commenced employment at Alstone House in October 2015. There was a delay in them submitting an application to register as the registered manager. They were eventually registered with us in October 2016. They had not worked in the home since January 2017. A new registered manager for the home had been recruited and was due to commence employment on 1 March 2017.

Following our inspection, the provider for this location submitted an application to cancel the registration to provide a regulated activity at Alstone House. We will be following our processes to de-register the service.

People, staff and relatives knew who the registered manager was and we received negative comments about the management of the home. One person said, "It's been quite hectic here recently but I've coped with it well. I wasn't keen on the manager who has gone. It's better now. Things just got left and not dealt with". One staff member said, "I have real criticisms about the manager. People were neglected. We used to have 22 staff, a deputy manager and two senior staff members. They have all left".

The Lifeways quality team had completed an internal audit in January 2017 and a number of concerns had been identified. An action plan had been completed. There were no dates for completion and no specific person accountable to ensure concerns had been dealt with. A team of staff from other Lifeways homes had been drafted in to support the staff team since the quality audit. There had been many new staff and managers since January 2017. An acting manager from a Birmingham service was in the office at the home throughout the day of our inspection. They had arrived the previous day.

Prior to the internal audit completed in January 2017 there was no evidence the provider had completed any quality checks in Alstone House since January 2015. This meant the provider could not be assured people received safe, effective and responsive care that was well led. We were told that the registered manager was responsible for submitting monthly information to the provider on the quality of the service. It was evident from our findings that this form of self-assessment was not robust in informing the provider about the quality of the service.

There was a lack of monitoring how well the home was working. There were no infection control, medication and environmental audits which meant the serious concerns we had found during this inspection had not been identified by the provider or the registered manager. This meant people were at risk of care that was not planned and unsafe. There were no fire risk assessments and the evacuation plans for people had not been kept under review although from talking with staff it was evident one person's needs had changed significantly. Repairs had not been completed promptly for example the mould in a person's bathroom which could have significant consequences to their health and well-being.

Staff morale was low due to poor retention of staff, 22 staff had left in the last 12 months. There were a lack of systems to ensure staff were trained, supervised and supported in their role. There was a lack of staff meetings to aid and build on team communication. From talking with staff it was evident there had been a lack of leadership and direction. Guidance was not available on how people wanted to be supported. This

meant people were not supported consistently and in the way they wanted to be supported. This lack of direction meant people were at risk of unsafe care. The provider and the registered manager had failed to monitor these shortfalls in the service.

People were not encouraged to be as independent as possible. There were no goals, targets or outcomes recorded. Roles and responsibilities within the service were not clear and there appeared to be no accountability for ensuring the safety of people living at the home. There was a lack of communication and staff turnover was high. Complaints were not dealt with appropriately and people were not at the heart of the service.

Feedback from people using the service was not sought. Comments and views were not recorded in care records, minutes of meetings held with people, comments or complaints received or as a result of satisfaction surveys. The failure to assess the quality and safety of the service provided meant regular monitoring and plans to improve the service provided were not in place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good governance.

From looking at the accident and incident reports, we found the provider was reporting to us appropriately. The provider has a legal duty to report certain events that affect the well-being of the person or affects the whole service.

The senior managers were responsive to our concerns during our feedback and assured us they would take action. However, we were concerned about the ability of the management team to take these forward without access to considerable further resources and support from the provider.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure people were treated with dignity and respect. 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured care and treatment of service users was only provided with the consent of the relevant person. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to assess risks to the health and safety of people living at Alstone House and they not always been assessed or reviewed. 12(2)(a) The provider had not done all that was reasonably practicable to mitigate risks. 12 (2)(b) Infection control measures were not in place. (12)(2)(h) Medicines were not being managed safely. 12(2)(g)

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 registered person had failed to ensure that all staff had safeguarding adults training. 13(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure the premises were adequately maintained or clean. 15 (1)(a) The premises were not fit for purpose for one person who used a wheelchair 15(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not investigated. There were no systems in place to identify, record and respond to complaints. 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no regular audits in place to improve the quality of the service. 17(2)(a) No systems were in place to identify risks to the health and safety of people who lived there. 17 (2)(b) The registered person failed to ensure records relating to people were up to date and reviewed regularly. 17 (2)(c) The registered person had failed to store people's records securely. 17 (2)(c) Feedback from people, staff, relatives and professionals was not actively encouraged.

	17(2)(e) Audit and governance systems were not effective. 17(2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure staff had received sufficient training to provide effective care and support. Staff had not received appropriate management support through regular supervision and performance management reviews.18 (2)(a) The provider had failed to complete a robust and thorough recruitment check. 18(1).