

Alverstoke House Nursing Home

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Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This unannounced inspection took place on 3 December 2015. Alverstoke House Nursing Home provides nursing care and accommodation for up to 30 people. On the day of our inspection 28 people were living at the home.

At the last inspection in October 2014 we found there was a breach with a minor impact regarding records. Whilst we could see the format of care plans had changed at this inspection there was still concerns over records.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a manager, who in this report will be referred to as the manager. They had applied to the Commission to become registered but now have withdrawn their application. The provider was already seeking to appoint a replacement manager.

People had risk assessments but these were not in all relevant sections of care planning and had not always been updated as people's needs changed. Staffing levels were consistent and there were enough staff on duty to meet people's needs. Staff had undergone recruitment checks but attention was needed to ensure all documentation was available and we have made a recommendation about photographic ID being available. Staff had a good understanding of how to keep people safe and what action they should take if they had any concerns. Medicines were administered, stored and recorded safely.

All staff had not received training to ensure they could meet people's needs. Staff had knowledge of the Mental

Capacity Act but people's records did not show people's capacity to make specific decisions had been assessed. People enjoyed their meals but records of people's nutritional intake were not adequate to know a person's food and fluid intake. People were supported to access a range of health professionals.

People were supported by caring and kind staff who knew them well.

People did not always have their individual needs met in a personalised way. People felt confident they could make a complaint and it would be responded to.

The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the manager and provider. Records were not always accurately maintained and the quality assurance process had not identified the shortfalls we identified.

We found breaches in four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Some people's risk assessments were not reflective of their current risks and did not guide staff on how to care for people.

Staffing levels were always planned to ensure the needs of people could be met. Recruitment procedures were in place.

Staff had a good understanding of how to safeguard people and what action to take if they thought people were not safe.

Medicines procedures were safe.

Requires improvement



Is the service effective?

The service was not always effective.

Not all staff had received training to ensure they could meet people's needs safely.

Staff had knowledge of the Mental Capacity Act 2005. However records were not always reflective of these considerations.

People received support to ensure they had a balanced diet but records of people's nutritional intake were not adequate.

People were supported to access a range of healthcare professionals.

Requires improvement



Is the service caring?

The service was caring.

People were supported by caring staff who respected people's privacy and dignity.

Good



Is the service responsive?

The service was not always responsive.

People did not always receive personalised care, which was in line with their needs or preference.

People felt they could complain and records were maintained of these.

Requires improvement



Is the service well-led?

The service was not always well led.

Records were not accurate or well maintained and the quality assurance process had not picked this up.

The home had a positive and open culture.

Requires improvement



Alverstoke House Nursing Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 3 December 2015 and was unannounced, which meant the staff and provider did not know we would be visiting. One inspector and a specialist advisor in nursing and the care of frail older people, especially those living with dementia, carried out the inspection. We visited the service between the hours of 12:00 and 8:00pm.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spent time talking to 10 people, two relatives, five members of care staff, two nurses, the manager and the provider. We looked at the care records of nine people and staffing records of four members of staff. We saw minutes of staff meetings, policies and procedures and the complaints log and records. Certain policies and procedures were sent to us following the inspection. We took copies of the duty rota for a month, which included the week of the inspection.

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 observed interactions between people and staff.

Is the service safe?

Our findings

People felt safe and were confident if they felt unsafe they would report their concerns to staff. Staff had a good knowledge of safeguarding procedures and policies. They were aware of their responsibilities in terms of safeguarding and whistle blowing. Some staff had received training in these areas during the previous six months.

The provider sent us a copy of their emergency contingency plan, which was brief and just advised of an alternative location in an emergency situation. A fire risk assessment had been completed and this advised what action staff should take in the event of a fire. Personal Emergency Evacuation Plans (PEEPS) were available by the entrance doors in the case of a fire. The fire officer visited the service in May 2014 and made some requirements relating to fire safety in the home. The nominated individual of the provider stated he had completed these actions and we have asked the fire officer to confirm these are to their standards to ensure people are safe.

Risk assessments had been completed and were available in people's care records. However these had not always been updated where necessary. For example the behaviour of a person in their care plan, identified a possible risk to them self or staff. However no risk assessment had been completed. We identified instances where a risk assessment had been completed, but not updated to reflect the persons changing risks as their needs had changed. For example a person's risk assessment in relation to their mobility care plan reflected they needed to have their walking stick when they mobilised. However the care plan reflected the person's mobility had declined and they were no longer independent with their mobility and needed support from staff. It was clear the risks had changed but the risk assessment had not been updated to reflect the change in the risks.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager did not use a tool to assess and show how staffing levels were sufficient to meet the needs of people. However they said they would increase staff on duty if this was required to meet people's needs. The duty rotas for three weeks from the 17 November 2015 were viewed. These showed for the majority of shifts the staffing levels were static with the same numbers of staff on duty each day and night. Agency staff were used but we were told at the current time this was only to cover nursing shifts, which usually equated to one shift per week. Some people felt there was a need for extra staff, but they were unable to tell us how this would improve the care they received. They were unable to say how this affected them.

Recruitment records showed relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service (DBS) were made before staff started work. For one member of staff their DBS had not been returned. As a result this member of staff was paired with a permanent team member of staff and was working in a shadowing role, to ensure people's safety. Application forms had been completed and included staff's qualifications and employment history including their last employer had been recorded. It was noted for two staff members no photo identification was available.

We recommend that photo identification is available for all staff employed, to ensure the safety of people.

The medicines management systems at the home were safe. Medicine trolleys were attached securely to the wall. Controlled medicines were being stored and recorded appropriately. The contents of the CD (controlled drugs) cupboard concurred with the CD record book. The temperature of the medicines room and the refrigerator temperatures were recorded daily. The provider had an efficient system of ordering new stock and was not over stocked on any product. A medicines disposals book was maintained and products for disposal were stored safely. We observed medicines being administered and records being maintained which ensured practices were safe.

Is the service effective?

Our findings

People told us they enjoyed their meals and they thought the cook was good. People told us they had access and were supported to attend health appointments.

We were given a copy of the training matrix and a copy of the training statistics which was dated December 2015. From the information recorded on the training matrix we could not be assured all staff had the necessary and up to date training required to meet the needs of people. For example the statistics showed us 47.7% of staff had received training in fire safety, 38.64% of staff had received training in infection control, and 42.11% of staff had received training in nutrition. No staff had received training in pressure sore/ulcer care, end of life care or dementia. The manager advised she was aware staff were not up to date with supervision sessions. We were not able to establish how often and when each member of staff had last received supervision. We could not be assured staff had received adequate training or support to be able to meet the needs of people at all times.

The lack of staff training in all areas and support to ensure they could meet people's needs was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications to deprive people of their liberty had been made to the local authority responsible for making these decisions.

Consideration to the Mental Capacity Act (2005) had not always been evidenced in people's records. 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. Whilst we found staff had some knowledge of the Mental Capacity Act records did not always reflect this consideration. We did not see any evidence of people not being offered choices or being restrained in any way, but records did not reflect the provider had considered people's capacity.

The cook was aware of people's preferences and the special diets people were on. They had introduced a colour coding system to identify who had high, medium and low nutritional needs. People were supported in a respectful manner at meal times and people had the choice where they ate their meal. Meal times were relaxed and enjoyed by people as a social time. Some people enjoyed a sherry or glass of wine with their meal. Staff told us people who needed more support had their meal half an hour earlier so staff could support all people in an unhurried and uninterrupted manner. Records relating to people's nutritional needs were not adequate.

People were referred to health care professionals as necessary. Details of the referrals and appointments were maintained in people's records. At times we could see people had been referred appropriately to health professionals but we could not see what advice the health professional had given as it had not been recorded. Staff were able to tell us what the outcome had been and how this had impacted on the person.

Is the service caring?

Our findings

People were complimentary about the staff and there was banter between staff members and people. A relative told us how happy they were with the care their relative received. They were seen discussing aspects of their relatives care with staff and the nominated individual of the provider. They told us they always had time to discuss any concerns.

Staff demonstrated they knew people and their preferences well. Staff knew what people's preferences were when they offered drinks throughout the day. Staff used people's chosen names when they spoke with them and in addition used terms such as "dear", "darling" and "sweetheart" which people seemed to like. Staff were patient when talking to people and would make sure the person understood what they meant when explaining something to them.

Staff interacted with people in a kind and compassionate manner. Staff responded promptly to people who were requesting assistance and they did so in a patient and attentive way. There was a considerable amount of good humoured and friendly exchanges between staff and

people which were, when people were able, reciprocated in the same manner. This indicated there were good relationships between people and staff. When a person left their tea and it became cold, a staff member replaced it and sat with the person until they had finished the new cup of tea. During this time the staff member chatted to the person, encouraging the person to drink in a skilled manner.

From people's records we were not able to establish people were involved in making decisions about their care. However when speaking to people it was clear they were involved. People knew the nominated individual of the provider by their first name. We saw people and the provider in discussions about differing aspects of the home.

Staff spoke with people while they were providing care and support in ways which were respectful. Staff ensured people's privacy was protected by ensuring all aspects of personal care were provided in their own rooms. Doors were always kept closed when providing personal care to ensure people's privacy and dignity was maintained. People's records included information on how to support people's privacy and dignity in all aspects of care.

Is the service responsive?

Our findings

People had an assessment of their needs completed before they moved into the home. From this a care plan was developed. This included information in 19 areas, including moving and handling, mobility, communication, sleeping, medication, continence, sociability and recreation. Care plans were kept in people's records and they were aware of their records. However it was difficult to establish people were involved in the planning and reviews of their care.

Care plans were brief and did not give sufficient detail to ensure staff knew how to care for the person. Care plans had not always been updated as people's needs had changed. In one person's care plan titled 'Physical Condition' on 18 November 2015, it recorded "Very frail and does not like to be moved unnecessarily leg is fixed so care needs to be taken when transferring". This was insufficient and did not give information about the reasons why the person did not like to be moved. It was not clear if this related to pain on moving or if they were afraid of being dropped. There was no detail on how staff should support the person, or of the triggers to look for; which created the anxiety. In the person's 'Communication Comprehension' section it stated the person "Usually chants for much of the day and night". However the care plan gave no explanation of why the person may be doing this and how staff could support the person. There was no chart of the person's behaviour to show attempts had been made to identify any triggers or trends relating to this behaviour.

In the care plan of another person we found conflicting information relating to the needs and consequently the support the person needed. In the 'Mobilisation' care plan it referred to the person being able to use the call bell. In the 'Moving and handling' care plan, it stated the person

was unable to use the call bell system. The care plan made reference to the fact the person was an insulin dependent diabetic, but there was no care plan relating to this. In the 'Continence' care plan it made reference to the person being doubly incontinent. However in the 'Elimination' care plan it made reference to the person being continent of urine and faeces. The lack of specific and updated information in care plans made it difficult to know a person's current needs and know if these were being met.

There was a lack of detail in people's records as to what their wishes were regarding activities. We could not see people took part in personalised activities. When we asked the manager about activities they told us they were aware there was a lack of activities for people and was hoping this would change in the future. The nine people we spoke with in the dining room, told us they enjoyed the meal times and felt this was a social time. They and other people relied on family and friends to call in or take them out for personalised activities. In the surveys carried out with people in August/September 2015 one person had requested more daily activities.

The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt able to complain and had confidence their complaint would be listened to and acted upon. The manager had kept a log of the complaints made and we could see they had been responded to within agreed time scales. Complaints were analysed in the monthly audit to look for any similar areas of concern identified.

Is the service well-led?

Our findings

The home had a positive and open culture. Staff and people reported they felt they were able to contribute to discussions on the home and decisions relating to the day to day running. Service user, health and family questionnaires had been carried out in August/ September 2015. The results had been collated and it was clear the majority of the responses were of a positive nature. The home also had many letters thanking them for the care they had given to people. Relatives were welcome at any time and they said they were always made welcome. Staff were aware of the whistle-blowing policy. Staff meetings took place on a regular basis and the minutes demonstrated staff could raise any issues or concerns they had.

The home did not have a registered manager in post and the provider was trying to recruit a manager as the current manager was leaving their position. Staff had confidence in the manager and the provider and believed they shared the views and values of the home. The manager had sent notifications to us appropriately. The manager was visible around the home and provided direct care to a number of people. The manager and provider had a good knowledge and rapport with people and relatives. The provider spent time in the home on most week days.

The manager had started clinical governance meetings with all nurses to discuss and see if any areas could be improved. Minutes were seen of these meetings. A record was made of all incidents and accidents in the home. This had been broken down and analysed to look for patterns, so the manager was able to tell us how many falls there had been in the last month and who these involved. This made it possible to ensure there was learning from these events. Medicines audits were conducted well and thoroughly on a regular basis.

Whilst there were some adequate quality audits in place regarding the environment and medicines, we identified concerns with people's records which had not been picked up by the provider. For example In three people's records we saw they had a Do Not Resuscitate (DNCPR) form which

had been signed by their family. However there was no evidence the people's family had the legal right to sign on the person's behalf. For one person the 'consents' in the care plan had been signed by the family, but we did not know if the family had any legal right to sign the consent forms. A nurse told us "There is no lasting power of attorney for this person". In two people's records we found two mental capacity assessments had been completed but these were not decision specific. On the handover sheets dated 2 December 2015 reference was made to people's capacity. For some people it was recorded they had 'Full capacity' whilst others recorded, 'Gets mixed up capacity variable'. Whilst it was good capacity had not been assumed there was no further details in people's care plans regarding people's capacity. For three people, records showed they or others on their behalf had consented for bed rail bumpers however we found bed bumpers were not in place.

Records in the kitchen relating to people's nutritional needs had not been kept updated and they were not an accurate reflection of people's current needs. This was a concern as at times the cook was not always available at meal times. Records relating to people who had high nutritional needs were not adequate to establish their nutritional intake and identify their changing needs. When a person's fluid recorded intake was low this was not transferred to their care plan. The records for the amount of food people had eaten were not clear. For breakfast a record of a person who had a high weight loss recorded, "Rice crispies- half", it was not possible to know half of what had been eaten or if the person had eaten a sufficient breakfast. This person's weight had been recorded on 06 December 2015 as 58.5kg, BMI (Body mass index) 24 and 18 November 2015 49.5kg, BMI 18. Whilst there may have been a recorded medical reason for the rapid weight loss this information had not been transferred into the person's nutritional care plan.

The lack of well maintained records and the failure of the quality assurance process to pick up on them was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Treatment of disease, disorder or injury	Care plans were not personalised and people were not always receiving personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not have current and relevant risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Treatment of disease, disorder or injury	The quality assurance system was not effective as it had not picked up the lack of effective records. 17 (1) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	All staff must receive training and support to ensure they have the skills to carry out their roles.

This section is primarily information for the provider

Enforcement actions

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