Leonard Cheshire Disability

Alne Hall - Care Home with Nursing Physical Disabilities

Inspection report

Alne Hall
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place over three days on 4, 5 and 25 July 2017. The first day of inspection was unannounced.

Alne Hall is a care home that is registered to provide nursing or personal care for up to 30 people with physical disabilities. The home is a detached listed building, set in its own grounds. The home has 28 single rooms and one shared room, which is currently used for single occupancy. At the time of our inspection the service was full with 29 people using the service, one of whom was on respite (short term stay).

The provider is required to have a manager in post. The manager who was employed at the home was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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. We have referred to the registered manager as 'the manager' throughout this report.

At our last inspection in July 2016 we identified a breach of Regulation 17 – Good governance. We found that effective management systems were not in place to assess the quality of the service and to evaluate and take the necessary steps to improve. We asked the provider to take action to improve the service. At this inspection we found evidence to indicate there was insufficient progress to meet the breach of regulation.

We found that staff on duty were disorganised with no clear leadership from the nurses or team leaders. The deployment of staff was ineffective and care delivery was not person-centred.

The clinical lead and team leaders had not received appropriate training to enable them to effectively and efficiently carry out their job roles and duties. Competency checks of staff performance were not being completed and meetings with staff to discuss their work performance (supervisions and appraisals) were not taking place. There was a lack of effective communication between the care staff, team leaders, nurses and management team.

The assessment, monitoring, review and mitigation of risk towards people who used the service with regard to accidents/incidents, hydration, bowel care, falls and pressure care was not robust.

People told us they were happy in the service, but had little opportunity to discuss or make decisions about their personal care and support. Care was task based and people who could not verbalise their wishes had little choice or say in what happened to them.

There was an activity programme taking place within the service and those people who could communicate their wishes to join in activities were well catered for. However, for other people with less capacity or poor communication the opportunities were not as abundant.

People who used the service did not receive person centred care. Risk assessments were not updated in the care files and did not reflect the current needs of people who used the service. Care plans within the care files were not being reviewed, evaluated or updated on a regular basis.

At the end of our inspection we asked the manager to send us information to show that risks within the service were being addressed as a priority by the management team. We received this information within the given timeframe. We received an action plan from the head of operations to show what changes were taking place in the service to improve the working practices and leadership. We were also given written evidence to show how the quality of life for people who used the service was to be improved immediately. We continue to receive a weekly update of the progress being made within the service.

We have found breaches of Regulations 9, 12 and 18 during this inspection in relation to person centred care, safe care and treatment and staffing. You can see at the end of the report the action we have asked the provider to make.

We found a continued breach of Regulation 17 in relation to good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The deployment of staff around the service was not effective and the disorganisation within the daily routine was impacting on people's lives.

The assessment, monitoring and mitigation of risk towards people who used the service was not robust.

Medicines were managed safely and staff recruitment was robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The junior management team did not have the skills, knowledge and abilities to carry out their roles and responsibilities.

Competency checks of staff performance were not being completed and meetings with staff to discuss their work performance (supervisions and appraisals) were not taking place.

There was a lack of effective communication between the care staff, senior staff and management team.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the service to be meeting DoLS requirements.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect and dignity by staff.

The care and treatment of people was not person-centred and did not meet their needs and people had little input to making decisions about their care and support.

Care staff did demonstrate patience with people and were able to communicate with individuals in a compassionate manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always detailed or accurate about the specific needs of each person. This meant there was no up to date record of people needs, which could put people at risk of not receiving responsive care and support.

Not everyone was able to make choices and decisions about aspects of their lives. Some were unable to retain control of their lives and their independence was compromised. Activities were taking place in the service, but were not easily accessible by people who were unable to verbalise their wish to join in.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management structure within the service did not effectively support the quality assurance systems and management arrangements within the service.

There was a lack of robust audits, although following our inspection there was evidence of action being taken to improve the service.

Alne Hall - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 4, 5 and 25 July 2017 and the first day of inspection was unannounced. On 4 July 2017 the inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 5 July 2017 the inspection team consisted of one adult social care inspector and on 25 July 2017 the inspection team consisted of two adult social care inspectors.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held about the service, including notifications sent to us by the provider. Notifications are when providers send us information about certain changes, events or incidents that occur within the service, which they are required to do by law. The provider submitted a Provider Information Return (PIR) in June 2017 within the given timescales for return. The PIR 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.

Following the first two days of our inspection we received some whistle blowing information regarding people's care and allegations of abuse within the service. These were investigated during the third day of inspection and our findings are documented within this report.

During the inspection we spoke with the head of operations, the manager, the deputy manager/clinical lead and 13 members of staff including nurses, team leaders, care staff and ancillary workers. People who used the service had complex neurological and/or physical impairment which resulted in it not being possible to

hold significant discussions with some individuals on their experience of the service. However, we managed to speak with 10 people and we exchanged pleasantries with other individuals. We spoke with one relative after our inspection. We also carried out observations during the inspection in the communal areas and during mealtimes.

We looked at six people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation used in the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for four members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Requires Improvement

Is the service safe?

Our findings

Prior to the third day of inspection on 25 July 2017 a whistle blower had alleged that staff had not taken appropriate action following an accident in the service. Their concerns were passed onto the local safeguarding team who investigated the allegations. The outcome was the allegations were historical and not substantiated. Family who were included in the investigation said they were happy with the actions taken by staff and with the care their relative received.

The system for reporting and recording accidents and incidents was not robust. We looked at the accident and incident records kept by the service. The manager told us that these were recorded onto an electronic system and reviewed at head office. The copy of the analysis tool given to us indicated that this did not carry out an in-depth look for any trends and patterns to incidents within the service. We also noted that it was dependent on staff reporting incidents appropriately, which we found did not always happen. For example, one person's care file recorded that they had sustained bruising to their knee and top of their foot. The cause was given as knocking their leg against their bed rail when in bed and agitated. Staff action was recorded as putting rail bumpers in place. However, on cross checking with the accident/incident records we found staff had not reported the incident to the manager and had not completed an accident form.

We saw a pattern of care plans and risk assessments not being completed or reviewed. For example, one person's care plan for eating and drinking was dated August 2015 and the next review was done in May 2017. The care plan showed a speech and language assessment had been carried out in 2008. No review of this had been carried out since. The care plan contained numerous instructions on what type of diet the person required. The manager told us one of the activities workers had completed a 'Personal placemat' document, which detailed the person's dietary needs and positioning during eating and drinking. However, they were not qualified to do this. We deemed this person to be at potential risk because of the lack of clarity and review of their eating/choking risks. We requested an immediate referral to the speech and language professionals.

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

Prior to the third day of inspection we had received information from a whistle blower that alleged call bells were not being answered by staff; people were being moved by one member of staff when their care plan said two staff should do the task; and the rosters were not recording the actual shifts, so when the numbers of staff were down the roster did not change. The whistle blower also alleged that staff had shaken people and sworn at them; had unplugged electric chairs or knocked them out of gear so people could not move them. We looked at these issues as part of the inspection.

We asked people who used the service if they felt safe in the service and were listened to by the staff. Two people said, "There are staff about and they listen to you" and "Staff are around and I have a call bell." We observed that people in bedrooms all had call bells to hand and one person said, "It can take the staff some time to answer, but they get here eventually."

During the inspection we found staff were disorganised with no clear leadership from the nurses or team leaders. We observed the routine for personal care took a long time with people still receiving their morning routine just before lunchtime. The manager explained that they had implemented a change to staff deployment by asking that staff carry out moving and handling tasks in pairs. Staff had previously done this alone which was unsafe. We were told 28 people required two staff for moving and handling. Staff told us they were struggling to get everyone up on time.

Checks of the staffing rosters showed there were one nurse and eight care staff in a morning, one nurse and five care staff in the afternoon/evening and one nurse and two care staff at night. Discussion with 12 members of staff indicated that there were occasional days when the staffing levels were depleted, but when we checked the rosters this was recorded on them and when gaps were known in advance the manager tried to get staff cover.

We asked the manager for a copy of their dependency tool used to calculate the levels of staff required to meet people's needs. The head of operations told us the dependency tool was not adequate and did not reflect people's increased care and support needs. We asked for an updated copy to be sent to us following the inspection and this was provided. Following our inspection the local authority and continuing health care team have visited the service and reassessed the care and support needs of people who used the service.

We found that people's calls for assistance were not always answered appropriately. For example, we saw one person used their call bell to ask for assistance. The bell rang for 10 minutes before we intervened and asked a member of staff to respond to the call (they were talking to a person in the dining room at the time). The member of staff had to call for help from a colleague as they found the person in the room was at risk of falling. We could hear the person was distressed by listening to the tone of their voice. We fed this back to the manager who went immediately to speak to the staff.

On 25 July 2017 we observed at 10:30am that one person was supported into their wheelchair and then placed by their patio door with the television turned on. We observed this person was in the same position at 4:30pm when we walked down the corridor. We then checked their care file which indicated they required regular positional changes, but when we looked at their daily records these indicated that staff had only been in once to them during the day. Our concerns about their care were fed back to the manager and head of operations during the inspection.

We also looked at other documentation that indicated people who needed assistance with maintaining their continence were not having regular checks or attention from morning until night time. Discussion with people who used the service indicated that the majority of people were happy with their care, but one person who used the service told us, "At night I can wait up to an hour for staff to answer my call bell. I sometimes end up wet and that is embarrassing." This was discussed with the manager and head of operations at the end of our inspection.

Staff had received basic training in how to make a safeguarding alert so that they would know how to follow local safeguarding protocols. There was written information around the home about safeguarding and how people could report any safeguarding concerns. Staff said they would go to team leaders, nurses or the manager if they had any issues. We spoke with 10 people who used the service. They all told us they felt safe and that staff looked after them well. People said staff were kind, caring and respectful. We observed people moving freely around the service including those in electric wheelchairs. They told us that they had no issues with using their wheelchairs around the service.

People who used the service had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. However we noted that two people's PEEPs had last been updated in May and July 2016 and did not reflect their current needs. For example one PEEP said the person evacuated the building by walking; currently the person did not weight bear. Following our inspection the head of operations sent in confirmation that these had been updated.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the staff, maintenance team and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. There was a fire risk assessment for the service and evidence in the staff training files showed that fire evacuation training had taken place in March 2017. Staff who spoke with us were confident of their knowledge and skills around this.

Recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

The whistle blower alleged that the nurses working in the service expected care staff to give out medicines. During our inspection we found no evidence to substantiate this allegation. The staff who spoke with us said this did not happen.

Medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The nurse informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training files. Controlled drugs (CDs) were regularly monitored by the nurses. We found that the CD register was recorded in accurately and CD stocks matched those recorded in the register. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

Observation of the nurse on duty showed that they were patient with people when administering medicines and asked if they required pain relief. People were asked if they received their medicines on time and we received a mixed response from two people. They told us, "Yes, the night time is a bit dodgy as I should get my medicine around 10pm to 10:30pm, but sometimes it is midnight or later" and "Tablets are okay in a morning and midday, but the night ones are due at 8pm and some nights it is 9pm before I get them. However, they have never missed any and I have never been given the wrong ones."

We gave the manager and head of operations feedback on this during our inspection. They told us they would investigate and speak to the staff concerned.

All areas we observed were very clean and had a pleasant odour. We saw that personal protective equipment (PPE) was available around the service and staff could explain to us when they needed to use

protective equipment. Ample stocks of cleaning materials were available. We saw that the domestic staff had access to all the necessary control of substances hazardous to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

Requires Improvement

Is the service effective?

Our findings

The deputy manager/clinical lead and team leaders did not receive appropriate induction, training or supervision to be able to carry out their job specifications, in relation to their management and oversight duties. The head of operations told us, "The provider does not have a 'junior management' training course and staff have been promoted into these positions without any additional training." Following our inspection we received information from the head of operations that the 'junior management staff' were receiving additional training and support from more experienced employees within the company.

Checks of three staff files showed that these new staff, in post since February, May and July 2017, had not received an induction since starting at the service. This meant there were no checks that new staff had the appropriate skills and knowledge to care for people effectively.

The whistle blower alleged that management and administrators asked care staff to sign training records for training that had not been completed. Also that night staff had not had training for some time, nothing in the last year. We spoke to 12 staff during our inspection who said they were not aware of anyone being asked to sign for training not completed and they had all completed some training in the last year. The head of operations told us, "The trainer, employed by the provider, comes into the service. Once training is completed they send a delegate sheet to the learning and development administrator who uploads the attendees onto the database. There is no way staff sign any sheets to do with training attendance."

The provider did have a training programme in place, but the head of operations told us that only 64% of training was completed when 85% was the standard level within the company. We were told staff had been told to complete the training deemed by the provider as mandatory and/or refresher training as soon as possible.

We looked at the training plan and saw that only three of the 51 staff had received moving and handling theory training in the last year and only 12 staff had completed moving and handling practical training in the last year; although the numbers rose to 29 staff with practical training if we looked at the last three years. Staff, the manager and head of operations told us staff had been moving people alone when two staff were required. Checks of the accident records showed that no injuries to people had occurred in the last year relating to moving and handling issues. We were informed by the head of operations that all staff were booked onto moving and handling training in August 2017.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. On 5 July 2017 we spoke with the manager about supervisions of the staff and asked to see any records of these. We were supplied with a sheet which indicated none of the staff had received supervision since February 2017. The team leaders told us that they were supposed to supervise the care staff but had not received any training on how to do this. The nurses were to do supervisions of the team leaders and we were told these were starting the week after our inspection. One member of staff told us, "There is a lack of guidance from the nurses and senior staff. I am confident about giving care, but I have to rely on my own initiative."

We saw no evidence in the staff files to indicate that staff had received an annual appraisal of their work and performance. Discussion with the staff and the manager indicated these had not taken place. Staff told us, "I have not had any feedback on the quality of the work I do" and "No, I have not had an appraisal. I had an ad hoc supervision last week which was the first one in the last year."

The head of operations and the manager told us that clinical observations of nursing practice had not taken place, but additional clinical support for the deputy manager was to be arranged to enable these to be carried out.

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

The whistle blower alleged that people were not getting meals or drinks as some staff did not assist them with eating and drinking. Our observations on the day and discussion with people indicated this was not the case.

People who spoke with us said they were satisfied with the quality and quantity of food provided for them in the service. Our observations of the meals on day one and two of our inspection showed that some people were able to make a choice of food to eat and the empty plates going back to the kitchen indicated the meal had been enjoyed. Staff offered people appropriate support with eating and drinking and their actions were patient and focused on the individual they were assisting. However, we noted that for people who were unable to verbalise their choices there was often only one food option available whether they wanted it or not. Meal times were fixed and there was no flexibility to accommodate people's individual needs.

Following our inspection the head of operations confirmed that changes had been made to the meal time experience.

Food and fluid charts were not being completed appropriately and did not reflect the needs of people who used the service. For example, we looked at the nutritional care plan for one person who had been losing weight. The dietician had created a specific plan which instructed staff to offer the person nourishing drinks, high calorie snacks and a fortified diet. However, the food and fluid charts we looked at did not record any of these being offered. Observation in this person's bedroom showed they had a supplement drink to hand indicating the issue was one of recording and not lack of care. This was fed back to the manager during the inspection.

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. The application procedures for this in care homes 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. We saw evidence from the spread sheet we were given that prior to the manager being in post some DOLs had lapsed as a renewal form had not been submitted. At the time of our inspection the manager had completed new applications and these

had been submitted to the supervisory body of the local authority.

We found that some people who used the service had little say or choice over their care and support when using the service. Where people could express their wishes these were listened to by staff and acted on. For people with more complex needs and limited communication abilities their rights to choice and decision making were not always recognised by the staff. One relative told us, "[Name] cannot say what they want so are dependent on staff going in to see to them and interacting with them. However, the staff seem to think that because [Name] puts their thumb up when they ask if they are okay then that is all the attention they need."

One person's communication care plan said the person had no communication ability but had capacity. They used their eyes to communicate yes and no. It went on to say that this person could vocalise to attract attention or another person in an adjoining room would ring their buzzer for them to attract staff attention. This left the person at risk of isolation or dependent on another person using the service to be available for them to call for assistance. Staff told us they carried out hourly checks on the person. We saw no investigations into assistive technology available to resolve this had been made.

We fed back to the manager and head of operations our concerns about the lack of good communication between staff and people who used the service in regard to their care and support. The head of operations told us that they had arranged for their regional customer support advisor to carry out a series of visits to the service to talk with people who used the service and obtain individual feedback on aspects of the service such as feeling safe, their support, catering provision and activities. This will be followed up at our next visit.

Information in the care files indicated people who used the service received input from health care professionals such as their GP, dentist, optician and podiatrist. We saw in care files that care plans were in place for oral mouth care and dental care. People received regular check-ups and staff provided people with support to attend their appointments. We asked people who used the service what happened if they did not feel well and they told us, "The staff are lovely, they would arrange for us to see our GP or the district nurse straight away."

The whistle blower alleged that the building was dangerous, with holes in the roof and floor and inadequate electrics. They said the previous week the fire service and ambulance service attended the service as the electrics went out affecting oxygen equipment and fire alarms. They said the cause was water had entered the electrics. We spoke with the manager about the allegations and they acknowledged an incident had occurred.

We looked at the reports from the fire brigade and ambulance team. These indicated that a power surge had knocked out the electrics during the night which affected the alarm system. The ambulance team attended as one person was on oxygen, but their checks showed there were sufficient oxygen cylinders available at the service to meet the person's needs. The person had refused to go to hospital as they said they were fine. Four people were assisted into chairs as a precaution in case their pressure relieving mattresses went flat, but came to no harm. An electrician was called out to check the systems and reset the alarms. Staff had followed the emergency plan appropriately and the manager and other key staff had attended to offer assistance and support.

Our checks of the service showed there were no holes in the flooring and that work was on-going to replace the roof, with adequate steps having been taken to ensure the roof remained sealed against the elements.

Requires Improvement

Is the service caring?

Our findings

The whistle blower alleged that people were not getting washed or showered and the level of personal hygiene was poor. We looked at this during our inspection and found that adequate hygiene care was being provided, but it was not always recorded.

We asked people for their opinions on their care and support and they told us, "Some staff know my likes and dislikes – they do things for me" and "I don't get enough physiotherapy, but okay otherwise." However, one relative told us, "My relative cannot speak up for themselves. They often do not have a shower and their preference of staff gender for personal care is often ignored. The staff make no effort to put them on a DVD or attempt to talk with them." We referred the relative to the local authority safeguarding team so their concerns could be followed up outside this inspection.

We asked staff about records of bathing and showers and were told these were not routinely recorded and if they were they would be in the person's daily notes. Checks of six files showed little evidence of this being recorded. One person who used the service told us, "I declined a shower last week as the staff were so busy I did not want to add to their work load." However, another person said, "I enjoy a bath here, tonight is bath night for me - Jacuzzi, lights, music and candles. I get a bath twice a week." We observed people had showers during our inspection indicating that people did receive adequate hygiene care. The manager told us they would ensure people received personal care and support in accordance with their wishes and needs and that this was recorded.

People who spoke with us said they felt that staff treated them with respect and dignity and we observed staff knocking on doors before entering rooms. On 25 July 2017 we observed that the majority of bedroom doors were left wide open. Staff told us that it was so they could check on people as they went by. There was no indication in people's care files that they had agreed to this and for people who could not verbalise their wishes there was no evidence of a Best Interests decision being made. We saw one person sat in their room who was without any clothing on their upper body. We established they were dependent on staff to deliver their care and were subsequently exposed to anyone walking by. This was not dignified for them, but staff did not recognise this as poor practice when we spoke with them about it.

We asked people about their input to their care and support plans and if their support and care was okay. Responses included, "No idea. I have never been asked if my care is okay before" and "I think I have signed the care plans, but I am not sure." One person told us, "The staff just get on with it, I have no input." We looked at six care files during our inspection and found that these contained little information about individual's wishes, decisions and choices. Some people had signed the consent forms in their files and others had the signature of their relatives acting on their behalf. The manager confirmed that people were not routinely involved in reviews of their care plans.

We asked people what they would change about their care and support if they were able to do this. People told us, "I would like more staff on duty so they could spend more time with me", "I would make my room bigger and have an en-suite" and "I am not really happy here, things have changed and there is no more

laughter." One person commented, "Always seem short staffed and we have to wait for the toilet – the other morning I cried as I had wet myself." However, one person told us, "I like it here, the staff are very caring and treat me well. I get on with them all and they are very nice people."

The above evidence indicated this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The whistle blower alleged that staff were leaving people in bed, when they wished to be up. We checked with the manager and staff and only one person remained in bed all day. We spoke with this individual who said the decision to stay in bed was theirs, due to a medical condition which made being out of bed uncomfortable for them.

The staff we spoke with had a clear understanding of people's needs and could say what individuals liked and did not like. However, we were told that any attempts to introduce changes to the way care was carried out were blocked by certain staff. The manager and head of operations were aware of the issues within the home and had an action plan in place to improve working practices. Allocation sheets had been introduced to give more responsibility to individuals and delegate care tasks to certain members of staff. Changes in work roles meant care staff were freed up from doing ancillary tasks so they had more time to focus on person-centred care.

Advocacy information was available in the service for anyone who wished additional support whilst making decisions about their care. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

The registered manager had completed audits of the care files in May 2017 and had identified a number of areas where these needed to be improved. However, the evidence we saw indicated that staff had not used the audit outcomes to develop and update the care files. This had not been followed up by the manager.

During this inspection we looked at six care files in-depth and viewed a number of other documents relating to people's care and support including food and fluid charts, positional change charts and weight records. We saw a pattern of care plans and records not being completed or reviewed. For example, in one care file the risk assessments were not up to date and the person's moving and handling risk assessment had not been reviewed since 2016. Their moving and handling care plan did not reflect their current needs as their health needs and abilities had deteriorated since 2016. Their health care plan was last reviewed in August 2016.

Another person had been admitted to the service in January 2017, but the majority of their care file was completely blank. We saw that although some risk assessments had been completed the corresponding care plans were not. There was no information on communication with others, no hospital passport, no summary sheet, no consent information and their decision making sheet was blank. Where a care plan such as the one for eating and drinking had been written, this had not been reviewed since admission; even though the person required a special textured diet and supplementary foods. Following our inspection the head of operations informed us that risk assessments had been reviewed. Nine people identified as being at risk of choking now had specific health and support choking risk assessments in place.

The quality of the recorded content of the daily records for people's care and support needed improvement. For example, in one person's file staff had recorded that "All care" was given on getting up and the next entry was from night staff saying they were in bed. No information was recorded about this person's identified needs during the day including continence, diet, activities, or positive interactions.

One person who we spoke with said they spent time on their bed because they wanted to and also because they had a small pressure sore which had a dressing on. However, when we asked the nurse on duty about the pressure sore they were not aware of this. They told us it had not been present at their last shift the week before, but the body map completed in the care file indicated it had been there prior to this date. The deputy manager was aware of the pressure sore, but could not say why the information had not been passed onto the nurse on two occasions at least when they were on duty.

The poor records and the lack of communication between the staff meant there was an increased risk that people would not receive the care and support they required on a daily basis.

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

The whistle blower alleged that nurses were carrying out clinical procedures without wearing gloves. The

evidence we saw did not substantiate this allegation. Discussion with the nurse on duty and the care staff showed that no one had ever seen this happen. We were told there were ample supplies of sterile gloves and catheterisation packs. We were given a copy of the clinical procedure followed by the nurses. We checked to see how many urinary tract infections had been recorded in the service in the last year, as this might have been suggestive of poor practices. We found only two had been noted which was an acceptable level given the size of the service.

The service had a number of people who volunteered their time and skills to carry out activities with people who used the service. We observed one volunteer working in a satellite kitchen with people who were cooking simple meals with their assistance. One person told us, "I like to do cooking- we do this mainly on a Wednesday and I do as much as I want to."

We spoke with an activity co-ordinator who told us that they did a lot of craft work, table and board games and pamper sessions with people. Outside entertainment was regularly booked to come in and on the first day of our inspection we saw that the owl and zoo man was visiting the service. At 11am there were 14 people in the activity room with the person showing off the owls and birds. At 2:30pm there were seven people and three staff in the room looking at snakes brought in by the mobile zoo man. From our observations we could see that everyone in the room was participating and enjoying the sessions. One person told us, "I get asked and I go to the activities if I want to – I like the singers when they come in." Another person said, "I have my hair and nails done and I watch the television – I would like to go out more." We checked the care files for six people and saw that some people went out with staff or family on a regular basis but others did not. When we asked one person about going on trips out they spoke about enjoying the trip out to buy Christmas presents and when we checked in another file we saw the person had only been out once in the last month.

Whilst carrying out observations of the service we noted that some people who could not verbalise their wishes to join activities were left sat in their rooms. For example, one person was in their bedroom all day during our inspection. They were sat watching one channel on the television and when we asked staff about this they said the person liked that television channel.

We voiced our concerns about this to the head of operations during our inspection. They had already identified the problem and told us, "The internal activities programme is traditional and ties in with the day service clients. Activities are more suited to people who have capacity and are reasonably mobile. I had already identified that a lack of available drivers is impacting people's ability to go out into the community, engage in external activities and go out for the day further afield. Resident holidays away from Alne Hall are not an issue and are well supported by nursing and care staff." Within a week of our inspection we received further information to show that work had been carried out by the volunteers to gather people's thoughts and wishes about trips out of the service. The service had booked trips for August 2017 that indicated every person who used the service would have between one and three trips out.

The whistle blower alleged that staff were stealing money from people who used the service and items such as perfume and jewellery were going missing. Discussion with people who used the service indicated they had no concerns about this. The complaints records were looked at and we saw that the allegations related to historical issues that had been dealt with at the time and resolved. Therefore we could not substantiate these allegations.

We saw that there was a copy of the provider's complaints policy and procedure on display. People who spoke with us were confident about discussing any issues or problems they may have with staff and managers. We saw one complaint received in July 2017 from a person who used the service. They had asked

if they could move rooms as the one they were in was too noisy at times. The manager said they were looking at this, but as the service was full it was not easy to accommodate the person's wishes.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2016 we identified a breach of Regulation 17 – Good governance. We found that effective management systems were not in place to assess the quality of the service and to evaluate and take the necessary steps to improve the quality of the service. We asked the provider to take action to improve the service. At this inspection we found evidence to indicate there was insufficient progress to meet this breach of regulation.

The service had a manager in post registered with the CQC. There was also a deputy manager/clinical lead, nurses and team leaders who made up the junior management team. All of the management team were new to their management roles within an adult social care setting and lacked experience and knowledge of their management roles and responsibilities. This had been recognised by the head of operations and action was urgently underway to put in additional support from more experienced individuals employed by the provider.

However, this lack of experience, training and development and a past history of management problems meant the service was disorganised with some staff resistant to change. This was adversely impacting on people who used the service. Care was task based and was not person centred. The voices of the most vulnerable people who used the service were not listened to/heard and their needs were not being met.

Where audits were being carried out by the manager the findings, which showed improvements were needed, had not been acted upon by the staff and the manager had not followed up on this. There was a lack of provider and manager oversight of risk factors including accidents, nutrition, moving and handling and documentation. In turn this meant that little action had been taken to mitigate the risks to people who used the service of receiving non-compliant care and treatment by the manager.

The manager did not complete monitoring of clinical outcomes such as weight loss to ensure referrals and interventions were appropriately dealt with by the team. At the end of our inspection we asked the manager to complete an up to date audit of weight loss and gain for people who used the service. This was sent to us within the given timeframe and we were told that as a result of the audit four people had been referred to the dietician.

The service delivery for each individual had not been assessed or planned appropriately to meet their needs and preferences. There was no evidence that people and their families had been involved in their care. This had led to people being socially isolated with a lack of access to the community, activities or opportunity to develop and maintain friendships/relationships. Some people were seen to not have any stimulation or meaningful engagement.

The provider had carried out an audit of the service when the new manager came into post. The manager had then been given monthly action plans to carry out improvements to the service, but we found little evidence of progress being made.

We found there was a division between the staff in the service, with a lot of staff "Unhappy and fed up of the service going nowhere". Staff told us, "Staff morale is really low", "When we try to speak to the manager, they put their hand up and say 'Stop right there'. They do not listen to us" and "We feel threatened and intimidated by the management team." However, other staff said, "The manager is lovely, understanding and listens" and "The tensions in the staff team are down to the team leaders who are fighting against each other."

We found during this inspection that staff supervision, appraisals and development through structured training and support was not taking place. The staff lacked the knowledge and skills to recognise risks to people's health and safety and their working practice did not always protect people who used the service from risk of harm.

We saw that the manager and head of operations had organised staff meetings to try to speak with staff about the issues identified in the service. However, staff told us they did not attend these meetings because, "Meetings are one-sided" and "We are told in no uncertain terms what is happening. Staff thoughts are not sought and there is a 'them and us' mentality in the service." One member of staff told us, "There is no conversation about work, it is more dictating and ticking boxes." However, when we asked staff why they had not used the complaints procedure or the external help line to voice their concerns to the provider, they were unable to provide us with an answer.

We asked people if they had any meetings to voice their opinion of the service. They told us, "No meetings or surveys" and "Sometimes I have been to a meeting. They ask us if we are happy." This person could not say if any suggestions had led to improvements as a result of this consultation.

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

Within a week of our inspection we received an action plan from the head of operations and the manager setting out the improvements needed to meet the breaches of regulation. This plan also included timescales for compliance. We have also received weekly updates from the head of operations evidencing the progress they are making within the service.

Information was sent to show how urgent action had been taken to improve the catering choices within the service and that consultation with people had taken place with regard to changes to meal time arrangements. Staff had been redeployed from activities and maintenance to facilitate trips out on two afternoons each week and work was on-going to increase this with input from volunteer drivers.

We have received information that people's need assessments and risk assessments have been reviewed and updated by staff. Copies of bedrail risk assessments and moving and handling risk assessments are now in people's bedrooms. New moving and handling aids have been ordered for several people following the review of the PEEPs. Several people have also been referred for fitting of new slings. The nurses have been given a dead line to review, rewrite and update the care files for people who use the service and this is being monitored by the management team. The deployment of staff in the service has been addressed through additional training and use of the allocation sheets. The service is also recruiting for additional nurses, a driver for activities and a therapy assistant.

The local authority commissioning team and the clinical commissioning group have been monitoring the service and people who use the service have been reassessed regarding their needs. We have received positive feedback from the commissioning teams about progress within the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people who used the service had care and treatment that was personalised specifically for them. The provider failed to ensure that people received the support necessary for them to understand and make informed decisions about their care. Regulation 9 (1-3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and mitigate the risks to the health and safety of people who used the service. The provider failed to ensure that staff providing care to people who used the service had the competence, skills and experience to do so safely. Regulation 12 (1) (2) (a-c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy enough qualified, competent and experienced staff to enable them to meet the regulated requirement. The provider failed to ensure that staff employed received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (1) (2) (a-b)

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to have systems and processes established and operated effectively to ensure the service was assessed or monitored for quality and safety in relation to the fundamental standards. This led to multiple breaches of regulation in relation to staffing, person centred care and safe care and treatment. The provider also failed to do all that is reasonably practicable to ensure safety and quality, use information to improve the service and mitigate risks. Regulation 17 (1) (2) (a) (b) (c) (d) (f)

The enforcement action we took:

We have issued a warning notice against the provider in respect of a breach of Regulation 17: Good Governance.