Bramling Cross Registrations Limited

Alston View Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Alston View Nursing and Residential Home (Alston View) is a care home providing personal and nursing care and accommodation to older people. At the time of the inspection, 44 people were receiving regulated activities at the home. The service can support up to 50 people. The home is a purpose-built building with two lounge areas and a dining room on the ground floor. Bedrooms are based over two floors.

People's experience of using this service and what we found
People were exposed to the risk of harm. Risks were not appropriately identified, assessed or managed in a timely way. During the inspection, we identified failings in respect of fire safety arrangements, use of bed-rails, medicines and in the leadership and governance of the service. Poor communication often meant essential safety issues and risks were not appropriately elevated and dealt with effectively.

Some aspects of staff recruitment were not completely effective at ensuring staff members were always suitable to work with vulnerable people. Some essential safety checks had not been made. We have made a recommendation about this that can be seen in the 'safe' section of this report.

Infection, Prevention and Control (IPC) processes were appropriate and we were assured about the service's ability to mitigate the transmission of infections.

Staff were competent with safeguarding processes and knew how to protect people from abuse. Relatives said their loved ones felt safe in the home and were trusting of staff and management. We observed good practices and interactions between staff and people during the inspection. The service's safeguarding processes were robust.

Staff supported people to have access to healthcare professionals and specialist support and the service worked with external specialists. Professional's views on the service were mixed but those who we spoke with at inspection said that the service was improving.

People were confident in the management team at the home and praised how approachable they were. Relatives said their loved ones were safe and praised the friendly and caring attitudes of staff and managers. We noted good interactions between people, management and staff. The service made appropriate notifications to CQC and other authorities of safety incidents to ensure these incidents received appropriate oversight.

The registered provider was responsive to concerns noted during the inspection and has started to take action to make improvements and promote safety within the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

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

Rating at last inspection
The last rating for this service was requires improvement (published 13 July 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

At our last inspection in 2021 we recommended that the provider's programme of improvements should be expanded to cover all areas of care and support to people. At this inspection, we found the provider had not acted on this and the service was now in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service and information provided to us by partner agencies. As a result, we carried out a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Alston View Nursing and Residential Home' on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches of the regulations in relation to management of risk, administration of medicines and governance at this inspection. We have also made a recommendation around the provider's recruitment processes.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority and fire service to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Alston View Nursing and Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak and to identify good practice we can share with other services.

Inspection team
The first and final day of the inspection was conducted by a single inspector. On the second day, 2 inspectors attended the home.

Service and service type
Alston View Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 25 April 2023 and ended on 3 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, commissioners and professionals who work with the service. We also looked at information we had received and held on our system about the service, this included notifications sent to us by the provider and information passed to us by members of the public.

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

We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service. We spoke with 3 relatives about their experience. We spoke with members of staff including the registered manager, deputy manager, a provider director and care workers and a member of the domestic staff. We also spoke with 5 external health and social care professionals and received their feedback of the quality of the service.

We looked at a variety of records to gather information and assess the level of care and support provided to people. We reviewed in detail 5 care records. We looked at staff rotas, risk assessments, multiple medicine records and 5 recruitment files. We also considered a variety of records relating to the management and governance of the service, including policies and procedures.

We looked around the home in both communal and private areas to establish if it met the needs of people who lived there and if it was safe.

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

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Some fire safety risks were not suitably monitored and addressed. Following visits from Lancashire Fire and Rescue in 2022, the provider had commissioned a comprehensive fire risk assessment. This assessment highlighted some areas of concern at various levels of seriousness. The expectation was that all these issues would be addressed by December 2022. Many of them were outstanding at inspection. For example, some people's fire doors remained defective. The registered manager and provider took steps to mitigate risk at inspection.

● The use of some bedrails was unsafe. They did not meet essential safety standards and this was highlighted on the second day of the inspection. When the inspection resumed on the third day, the bedrails were in the same state and the safety issue had not been addressed. Immediate action was taken by the registered manager at that stage to ensure the rails were safe to use.

● Some areas of care planning and risk assessing were disjointed. Sometimes records within the same person's care suggested risks that were not present or did not mention essential areas that staff should be aware of. For example, records wrongly stated a person had a medical device to support them with their continence.

● Records related to people's hydration were sometimes misleading. They often did not reflect a person's consumption of fluids when the care plan and risk assessment stated this was an important area in support of the person's condition. This could lead to staff being unaware of the correct position and not supporting the person effectively.

We found no evidence that people had been harmed. However, these series of risks and omissions were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Some areas of medicines administration and practice required attention. Records around the application of essential creams were inconsistent with good practice and staff and health care professionals could not be certain the person had received their medicinal creams as prescribed.

● Management and staff did not follow up prescribing and supply errors and delays effectively. This led to 1 person not receiving additional doses of their medicine for 4 weeks. At inspection, the registered manager was unaware of the issue and the matter had not been escalated by staff internally to the provider and senior management.

● There was an absence of records around reviews into some medicines that are considered 'high-risk'. This could lead to people receiving medicines that were not suitable or at a level that was unsafe. The issue around these reviews was not solely the fault of the service but there was no evidence that the service was

following up on the absence of a review.

We found no evidence that people had been harmed as a result of these issues. However, this series of omissions were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been trained on the safe administration of medicines. A senior member of the care staff told us they took the administration of medicines seriously and said it was an important part of their care and support of people. They said their competence in this area had been checked in the past.

Staffing and recruitment
● Sometimes the provider did not always follow safe recruitment procedures. Checks with previous employers in health and social care had not always been completed in some of the recruitment files we considered.
● Checks such as those into identity, right to work and criminal records had been made.

We recommend the provider reviews its recruitment processes to ensure they are compliant with legislation and best practice.

● There were enough staff employed. One person we spoke with told us they did not have to wait for staff to support them. Rotas and our observations at inspection supported this position.
● During the inspection, the provider representative and manager told us an immediate safety review of all staff employed would be actioned and CQC kept informed of developments.

Learning lessons when things go wrong
● Areas of concern were not always elevated to the registered manager and provider. This hampered the opportunity to learn lessons from incidents.
● The registered manager had developed a system to review some accidents and incidents so that lessons could be learned. We noted this included looking at all falls for trends and themes.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for people using the service and staff. We were told all people living in the home had been vaccinated against COVID-19.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
We were assured the provider was facilitating safe visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the home. The registered provider had a system for responding to and reporting abuse. A relative told us they felt the home was a safe place for people to live and they had no concerns around any abuse or neglect.
● Staff told us they had received safeguarding training and were aware of the importance of reporting abuse. They said they were confident about intervening when abuse may be suspected and were sure the registered manager would act appropriately in these circumstances.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered provider did not always understand risk and regulatory requirements. They did not appreciate the significance of ensuring environmental safety concerns were the primary responsibility of the registered provider and had allowed the issues highlighted in the 'safe' section of this report to develop over a period of time. At inspection, the main provider representative was unaware of the current position around fire related safety improvements and there was no effective plan of action in place to deal with the issues and the management of risk in the meantime.
- Although the registered provider had arranged 'mock' inspections of the service, by an external organistion and a provider representative, these had not been effective in establishing the breaches of regulation seen in the 'safe' section of this report.
- Staff and health care professionals told us that communication was an issue in the home. We saw evidence of this during inspection when we asked for bed-rail safety issues to be addressed on the second day of inspection. When we returned a week later, the issue remained and we noted confusion around the issue between management in the home and some staff members. In addition, the registered manager was unaware of the substantial omission around a person's medicine until inspection. Although we noted the matter had been considered by a senior member of staff, they had not escalated the concern and there was a missed opportunity to learn lessons from the incident.
- There was limited evidence of provider led checks and audits. For example, staff recruitment files and employment processes had not been considered by anyone other than the registered manager.
- Following a change in the structure of senior management at registered provider level, we received some assurances that auditing systems within the service were in the process of being reviewed. However, these needed to be consistently implemented and the scope wider ranging so that they addressed the concerns related to safety within the home.
- We identified issues pertaining to the provider's responsibility for fire safety and delays in their actions. We liaised with Lancashire Fire and Rescue Service to ensure appropriate actions were taken to comply with fire safety legislation and people were safe from fire.

We found no evidence that people had been harmed. However, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. Any processes that were in place, were not effective to ensure compliance with essential safety requirements. These series of issues are a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visits, the registered provider confirmed they were working with the company who supported them with fire safety to ensure all areas of concern were rectified. The registered provider liaised with CQC and the fire service on this. They told us they were committed to making improvements to ensure they provide a high-quality service within the home.
● The registered manager said the recent change with senior management had affected some checks and responsibilities within the service. However, staff members commented that the changes were generally positive and had led to stability within the service

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was clear about their role and responsibilities, including under the duty of candour. They had notified us of significant events, as required, and had been open and honest with relevant people when incidents occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● During the inspection visit, we saw positive and caring interactions between staff and people who lived at the home. People told us they were happy with the care and confirmed they received person-centred care. Relatives confirmed that they were happy with the care provided to their family members.
● The registered manager was open and honest about the failures seen at inspection. They said they were already undertaking a number of changes to improve the service and were committed to working in partnership with other agencies to make the required improvements to ensure the home was safe. They provided us with assurances that immediate improvements would be made within the service.
● We saw evidence of partnership working with health and social care professionals to meet people's needs. During the inspection we were approached by a health care professional who said they had been completely supported during their visit and had no concerns around the patients they had considered. Another said, "I am seeing the 'green shoots' of improvement in this service. It is starting to be more effective in the care and support of people and the registered manager must take some credit for this." Some health care professionals were critical of the service and stated that poor communication was the main factor in matters not being addressed effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were involved in how the service was managed. Relatives told us that the service engaged in regular communication with the home. We saw evidence of positive engagement between the management team, relatives and people who lived at the home.
● Staff we spoke with told us they felt listened to and were supported by the management team within the home. Staff members raised concerns about a lack provider led input and that they were not aware of who they should approach at a provider level if they had any concerns.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care planning risks were not considered effectively and fire safety concerns had not been addressed. Records around medicine's administration were disjointed and medicines issues had not been elevated appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider's oversight of the service was ineffective. Systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. Any processes that were in place, were not effective to ensure compliance with essential safety requirements