Albemarle Hall Limited

Albemarle Hall Nursing Home

Inspection report

4 Albemarle Road
Woodthorpe
Nottingham
NG5 4FE

Tel: 01159607339
Website:

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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?	**Good**

Overall summary

We carried out an unannounced inspection of the service on 4 November 2015.

Albemarle Hall Nursing Home provides accommodation for older people. It is registered for a maximum of 27 people. There were 23 people receiving care and support at the home at the time of our visit.

There was a manager registered with the Care Quality Commission (CQC). They were not available at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to

Summary of findings

accidents and incidents. Numbers of staff on duty were insufficient to keep people safe, but they were recruited through safe recruitment practices. Medicines were safely managed.

People we spoke with told us they were satisfied with the skills of the staff. Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink, but their meal time experience required improvement. External professionals were involved in people's care as appropriate.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care.

People's needs were responded to. Most care records provided sufficient information for staff to provide personalised care and care plans were reviewed on an ongoing process. Activities were available in the home. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management, but had mixed feelings about whether they felt supported as the registered manager had been absent from the service for a lengthy period. By law the provider has to notify us and keep us updated of any changes to the service. We were aware the manager was absent long term. There were systems in place to monitor and improve the quality of the service provided.

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?

Requires improvement

The service was not consistently safe.

People felt safe in the home and staff were able to identify potential abuse and take action if required.

Individual risks were identified and managed. People were involved in making decisions about the risks they may wish to take in their day to day lives.

Staffing levels were identified and monitored as the provider used systems and tools to ensure they had enough staff to meet people's needs, but we were not confident the staffing levels would be sufficient to keep people safe.

Staff followed processes that were in place to ensure medicines were handled and administered safely.

Is the service effective?

Requires improvement

The service was not always consistently effective.

People received care from staff whose training and development was reviewed and updated appropriately during the course of their employment.

Staff had awareness of the Mental Capacity Act. They were following appropriate guidance to ensure people who lacked capacity were not restricted. They obtained permission before they provided care and support.

People were encouraged to be independent and where necessary they were supported to have sufficient to eat and drink, but their mealtime experience required improvement.

Staff had a good knowledge and understanding of how to meet the physical health needs of the people they cared for. Referrals were made to other healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were positive about the staff and the care they received.

People were treated with respect, compassion and in a dignified way by the staff who cared for them.

People were encouraged to form caring relationships with Staff to make sure they experienced good care.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

Staff understood what people's needs were and responded to their changing needs in a positive way, but not always in a timely manner.

People were aware of the complaints procedure. The provider responded to concerns when necessary.

Care plans were reviewed with people on a regular basis to ensure they received personal care relevant to their needs.

Is the service well-led?

Good

The service was well-led.

Systems and procedures were in place to monitor and improve the quality and safety of the service provided.

The registered manager was on a long term absence from the home.The provider had previously made CQC aware of the manager's absence. There were arrangements for alternative management cover.

Albemarle Hall 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 was 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 November 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor, who was a nurse, 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 service.

Before we visited we reviewed the information we held about the service including notifications. Notifications are about events that the provider is required to inform us of by law. We also consulted commissioners of the service who shared with us their views about the care provided.

During our visit we spoke with four people who used the service, two visitors, six members of staff, a nurse and the provider's representative.

We looked at the care plans for seven people, the staff training and induction records for staff, three people's medicine records and the quality assurance audits that the registered manager completed.

Some people were not able to express their views due to their specific needs, so we used a 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.

Requires improvement

Is the service safe?

Our findings

People were protected from bullying, harassment, avoidable harm and abuse that may breach their human rights.

People we spoke with told us they felt safe and secure in the home. One person said, "It's as safe as anything here." Another person said, "There is always someone around it is definitely safe." From discussions with staff we found they had a good understanding about how they should keep people safe. They told us they had attended training relevant to safeguarding others and were aware of the policies and procedures which they were required to adhere to.

The provider's representative told us they were aware of how to raise safeguarding issues and who was responsible for raising and escalating concerns should the need arise. They told us any concerns would be recorded on the relevant individual's file if a concern had been raised. The safeguarding referral process and relevant contact details were available in the office.

Individual risks were identified and managed; people were involved in making decisions about any risks they may wish to take. Risk assessments were in place for falls and moving and handling. There were written details on how staff were to identify and manage any risks. The risk assessments were reviewed and evaluated appropriately.

Themes and trends for incidents and accidents were analysed and if required referrals were made to the relevant healthcare professionals, such as the falls team. These were managed to ensure they mitigated any risk to people. We looked at the records of accidents and incidents and found information was recorded appropriately. There were systems in place to monitor and address any that may occur. We saw examples of body maps, which were documents used to identify areas on the body where an injuries may have occurred. They showed if a person had a mark, such as, a bruise or injury.

We found and documents we saw confirmed safety checks for the building and equipment had taken place and were all up to date. The provider's representative told us they had a system in place to ensure all services and equipment were checked at regular intervals.

We were not confident the numbers of staff on duty were suitable to keep people safe. We received mixed comments from people about the number of staff available. One person said, "The wait depends on the time of day. It's mad in the mornings. At night, it's sometimes a long wait if I use my bell." A relative told us their family member had a pressure mat in their room. This was to alert staff when the person was out of bed or needed assistance. The family member said, "[name of person] tries to get up to go to the toilet, but staff may not be alerted if they do not stand on the mat and this sometimes results in them wetting the bed.

We observed people were waiting for assistance during our inspection. We spoke to the provider's representative who told us they used a dependency tool to assess the number of staff required. We asked them to complete an analysis to ensure there were sufficient staff numbers throughout the day, which they did.

Staff we spoke with told us there were times when they thought they needed another member of staff. They said there was always one staff member in the lounge area. The provider's representative told us they brought extra staff in when the need arose. We saw from staff interactions with people at lunch time that this was informal and showed a positive experience.

The provider had robust recruitment processes in place, which they followed to ensure they had the right staff employed. We found the service followed clear disciplinary procedures when required to do so.

People's medicines were managed and they received them in a safe way. People told us they received their medicines at regular times and were content for staff to manage their medicines. Staff we spoke with were knowledgeable about the provider's medication policy and procedure. They were able to demonstrate the process and had a clear understanding of how to administer medicines safely.

Staff followed professional guidance and medicines were stored securely and disposed of correctly. We observed staff giving people their medicines and saw that they stayed with people whilst they took all their medicines. Staff assisted in an unhurried manner and talked with people during this process. Medicine care plans we looked at described the medicines people were prescribed and Medication Administration Records (MARs) had a picture of the person attached to each record, so staff were able to

Requires improvement

Is the service safe?

make sure they were giving people the correct medicine. However on checking all records that required two signatures we found the procedure for some medicines were not being followed. Staff that had not completed relevant training in regards to administering medicines were completing the documentation as a second signature. This meant staff were signing to confirm the person had received the medicine as proscribed, but lacked the knowledge or understanding to do this. This was an unsafe practice. We spoke with the acting manager who addressed this immediately.

Requires improvement

Is the service effective?

Our findings

People received effective care, which reflected their needs from staff who were knowledgeable and skilled to carry out their roles and responsibilities.

People we spoke with told us they were satisfied with the skills of the staff. One person said, "I've no complaints [about] the staff. I can go and chat to them any time and they're happy to advise me." Another person said, "They seem to be good staff." A third person said, "The staff are ok and seem to have knowledge."

Staff received an induction when they first started work at the home and staff confirmed they received supervision and yearly appraisals. All staff we spoke with said they had received relevant training and read the policies and procedures to ensure they fully understood what was expected of them. Documents we looked at also confirmed staff had completed relevant training. There was an opportunity for staff to gain further qualifications relevant to their role. This included specialist training in areas such as, dementia, falls and end of life care.

Clinical supervision for the nurses working at the home was undertaken by the clinical lead at another location also owned by the provider. This was carried out to check and maintain their professional skills and knowledge to ensure people who used the service were cared for by staff who were using up to date nursing practices.

People consented to their care and treatment and consent was sought in line with relevant guidance. One person said, "It's really like living at home as I can ask to get up and go to bed when I want." People we spoke with told us staff asked their permission before providing any care and support. We observed staff ask people's permission before they provided care and support. We saw two staff assisting one person to move from their easy chair to a wheelchair. They explained what they were doing and gave clear instructions while they supported the person. We saw two people became agitated at lunch time. Staff deescalated the situation well and distracted them both, so they could not disturbed other dinners unnecessary.

People's rights were protected under the Mental Capacity Act 2005. 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 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.

We found that relevant authorisations for DoLS had been applied for and the relevant guidance followed. We saw people had the freedom of the home and were able to come and go as they pleased. Staff respected people's human rights and put appropriate measures in place when a person lacked capacity.

We found staff were following relevant guidance relating to DoLS referrals, which had been put in place with the local authority to support people, whose liberty may be restricted when their behaviour became challenging. Staff described training they had attended for MCA and DoLS and demonstrated they had a good understanding of these areas. They were able to identify who applications for DoLS had been made for and the reasons behind these referrals.

People were supported to eat and drink sufficiently to maintain a balanced diet. One person said, "It's excellent. I have no complaints whatsoever. There are two things to choose from and they've never failed me yet." Another person said, "I prefer plain wholesome stuff – not foreign things. They ask me what I want and if I'm not keen, they'll do me a special." Other people told us they had no worries about the food or with getting sufficient food.

Staff told us they encouraged people to eat and drink regularly. One staff member told us most people went into the dining area to eat. They said, "We support and assist those people who prefer to stay in the lounge. We make sure they are comfortable." They were able to identify the people who required different cutlery and who required assistance when eating and drinking. All staff talked about how they monitored what people ate on a daily basis. They told us they completed food and fluid charts for those people who they felt were at risk of malnutrition. One staff

Requires improvement

Is the service effective?

member told us they reviewed people's eating habits and were alert to any changes which may trigger them to monitor the person's daily intake of food and drink. Another staff member discussed the process of reporting any concern to the nurse on duty or making an appropriate referral, for example, to the Speech and Language team (SALT). However we did not see any drinks available in people's rooms. We discussed this with the nurse and they told us they would address this.

People were supported to eat and drink to maintain a balance diet. We reviewed five sets of documents and we felt confident the recording systems were being used to monitor people's weight effectively to help identify patterns of change in weight that could be an indicator or an health issue. We saw where relevant food and fluid charts were required they were in place and there was evidence that dieticians had been contacted when needed. We found care plans in place for special dietary requirements. This information was well documented for staff in the kitchen to make sure they were aware of people's dietary requirements and food allergies.

People's dining experience required improvement. Five people were in wheelchairs and staff looked challenged when manoeuvring people into the dining room and moving the dining chairs so they could get the wheelchairs in position at the table. This process was disruptive to people already seated and distressing to the people in the wheelchairs. However, staff did explain what they were doing.

The tables were covered with tablecloths and as people were seated they were given a napkin and cutlery. We also saw a range of different drinks on a trolley, but people were given a drink chosen by staff, they did not ask people which drink they would like. We saw six people were given a clothing protector for their clothes, but none of the people were asked if they wanted one. However we heard the member of staff discussing with people what they were doing and why.

There were two choices available on the menu and staff offered people assistance with their meal if required. One member of staff provided a person with one-to-one assistance and supported them with their eating and drinking, whilst overseeing others. A second member of staff entered the dining room and made sure everyone had a drink and we saw them encouraging people to eat. We found limited interaction between staff and people other than staff prompting and assisting with the process of putting food on a person's fork.

People were supported to maintain good health and wellbeing as they had access to healthcare services and received ongoing support. People told us they could see a doctor anytime they wanted one. One person told us that staff were very good at referring people to the doctor and other healthcare services, such as chiropodist or optician. A relative said, "The way [name of person] had recovered so well after being at deaths door, speaks volumes."

One person required turning or moving every two to three hours. We looked at the person's care plan and it told us the person was immobile and required repositioning and checking every two to three hours. This person was not moved or repositioned during our visit. There was a risk this person would develop skin sores as they were also doubly incontinent. We saw little interaction from staff with this person. This showed staff did not always respond effectively to people care needs. Another person's care plan noted that due to them being unable to use the nurse call bell they would receive hourly checks/safety rounds. We saw evidence that this person was being checked on an hourly basis.

Staff we spoke with confirmed they had referred people to the relevant healthcare professional if and when the need arose. In one person's file we looked at we saw evidence that staff had contacted the falls and bone nurse when the person had had a fall. There were appropriate care plans in place for people who lived with diabetes or epilepsy.

Good

Is the service caring?

Our findings

People were supported to develop positive caring relationships with staff, other people and their families. People told us they were treated well. One person said, “If I have any issues with the way staff are toward me I will tell them. There had been an occasion, but I sorted it and we are fine now.” Other people told us the care was, “10 out of 10” and ,”Staff are just nice to deal with.”

We observed staff being kind and respectful to people. We heard conversations and observed interactions between staff and people. We saw staff spoke with people in a polite and kind manner, using their preferred name and conversing with them well. This showed staff were compassionate and caring towards people.

People received care and support from staff who knew and understood their life history and preferences. Each person had access to a keyworker. This is a dedicated member of staff who liaises with the person and the family to ensure they are involved in all aspects of care. Discussions with staff showed us they were knowledgeable about the people they cared for. Evidence in the care plans showed that people’s religion, age, disability, gender and belief had been explored and any preferences adhered to.

People were supported to express their views and be actively involved with decisions about their care and support. Relatives confirmed they felt informed about their family members’ care and were involved in care reviews. One relative said, “They tell us everything.” We could not tell if people had been fully involved with their care planning, as the plans were not person centred. The care plans did show how the person wanted to be cared for. We observed staff communicating with people and giving an explanation and time to make a decision when asked. We saw staff communicated with people effectively, no matter how complex their needs were.

There were no details or information available for people about an advocacy service or how they should access this service. An advocacy service is used to support people or have someone speak on their behalf. Advocates are trained professionals who support, enable and empower people to speak up. The provider’s representative told us they had worked with advocates in the past. They told us about one person who had been supported in making certain decisions, but they had no leaflets or literature to share with people. The nurse told us most people had relatives to support their decision making. This meant people may not be aware this service was available for them. The provider’s representative told us they would look at what information could be available for future reference.

People were treated with dignity, respect and their independence was promoted by staff. People told us they felt they were respected by staff and had their privacy maintained. One person said, “Staff are just nice people to deal with.” Staff described how they made sure they respected people and their preferences. For example they told us about people who liked to listen to religious services and how they respected their choice to do this. Staff also told us they had received training in relation to dignity and respecting people. We noted there was one member of staff who was a dignity champion. This meant they would share good practice with other staff. We observed staff being respectful and caring. Staff were aware of the importance of spending time with people and were generally concerned for people’s wellbeing.

Requires improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People told us staff did not always respond in a timely manner. One person said, "I have been waiting to go to the toilet for some time, they take ages." We observed this person had been waiting for assistance. However, we also observed staff attending to other people when they required assistance or support. This showed us they did respond, but not always promptly. People's care and support was written in individualised plans of care that described how staff should care for the person and what they needed to do to provide personalised care.

We saw where a person was assessed as requiring the use of equipment this was in place. We found where a person was at risk of falls they had been referred to the falls team. The falls team had advised the use of a floor sensory mat and sensory beam to alert staff if this person was mobile in their bedroom. This was to make sure staff responded to the person if they had a fall. We also found if a person was identified as needing transfer by hoist this was done. Pressure cushions were being used and we saw evidence that 'at risk' people had air flow mattresses in place.

Initial assessments had taken place. People who were able, and their relatives when appropriate, were actively involved in care planning. One person told us they had been visited by the home before they were transferred and their needs had been discussed before they arrived at the home. This was to ensure they received the care and support they wanted.

People were supported to take part in activities. One person said, "There's a bit of activities in the main room. I'll dance with one or two ladies. Sometimes things are a bit last minute though." This person went on to tell us about accessing the garden of the home, "A few of us use the garden, but we don't do anything out there, just sit." Another person told us they had been asked for ideas of what people wanted to do. They said they had made some suggestions, "We could do with a quiet area so I can read, it gets so noisy in here." A third person said, "We play bingo and I like the music. We're very happy with it." We observed some group activities and one to one interaction taking place by a designated member of staff. We felt they tried to engage with people individually as there was a wide range of people with different levels of capacity. We were not confident that all the activities were suitable for all people in the home.

This staff member told us each person had a 'This Is Me' section in their care plan, so staff were aware of the person and their past. There were also several people living with dementia who had a laminated pictorial file of photos and notes on their life, supplied by family, which remained in the lounge and was used by staff to stimulate people's memories and conversations. During our visit a visiting entertainer came to provide a relaxation session. No staff came in to watch or engage with the activity, which was a missed opportunity for them to interact with people living with dementia. In the morning there was very little quality time spent with people by the care staff, which meant people were left alone with no one sitting or talking to them. Staff did not seem to have enough time to engage fully with people. The staff that did appeared focused on the task in hand. This meant they only spoke or made contact with the person if they required assistance. In the afternoon it was a little more relaxed and several staff sat chatting with people for short periods.

People felt they were listened to and the service learned from people's experiences, concerns and complaints. People we spoke with told us they felt able to raise any concern or complaint. One person said, "I'd see a senior person first, no problem." Another person told us they would speak to the nurse. Staff told us they listened to people's choices and everyday decisions.

A policy and procedure was in place to monitor concerns and complaints. The provider's representative told us they had received no complaints within the last 12 months. Documents we saw confirmed this.

Good

Is the service well-led?

Our findings

People commented that they thought the home was well run, but the management were not very visible. One person said, "The manager is usually in the office – she's not seen much in the home. We were given a survey last year which we filled in, but never heard anything about it again." One person said, "It's definitely well run. All the time opinions are being bounced around. They do listen." Other people told us they could talk to anyone, but felt they did not get feedback when they completed surveys or were asked their opinions.

Systems were in place for people and their families to feedback their experiences of the care they received and raise any issues or concerns they may have. People told us they had attended meetings for people who used the service. We saw feedback regarding a carpeted area in the home. People and their relatives told us they had made suggestions for the flooring to be changed due to concerns that the pattern made it confusing for people living with dementia. We saw recorded in a staff meeting that discussions had taken place about the feedback from people who used the service and their families. The provider took action and changed the carpet. This showed they listened when people raised concerns.

People were able to voice their views through completing a quality questionnaire. We saw positive comments regarding the care people received. People had commented on the quality of the activities and the action was for management to discuss with the staff member responsible. It was not clear if this had taken place. There were also comments from relatives and people who used the service regarding a request for fresh fruit and vegetables to be made available. We saw this had been acted on and fresh fruit was available in bite size pieces on the drinks trolley.

The service was not always following CQC requirements including submission of notifications. We found two incidents that had not been reported to CQC. After discussion with the provider's representative we found this was an oversight and not normal practice. Other notifications including safeguarding had been dealt with appropriately and they had been reported to the local authority and CQC when required. We spoke with healthcare professionals who worked with the home. They told us they could see improvements.

We saw minutes of team meetings where the provider's representative and nurse in charge had shared information, explained changes and reviewed practices. These records supported what staff told us.

We received mixed feedback from staff about support from management. Some staff members felt the management was not approachable. Other staff told us it depended who was in charge. We found the registered manager had been on long-term sick leave and was not available in the home at the time of our visit. The provider had previously made us aware of the manager's absence. The provider's representative told us they had made arrangements for alternative management cover as they were responsible for the running of the home in the temporary absence of the registered manager. They told us people and staff were encouraged to actively be involved in developing the service. They said day to day needs of people were monitored and people were encouraged to be open and transparent, this was work in progress.

The provider's had put a system in place to make sure quality monitoring was completed. Systems in place monitored the quality of the service provided. Audits were completed by the provider's representative and senior managers assessed, monitor and improve the service where necessary. We saw that where improvements had been identified plans were in place to take action to make changes. We saw how checks were made to the environment and to equipment to ensure it remained safe and suitable. We spoke with the person responsible for carrying out the day to day repairs and checks. They told us that they had the resources to do their job to ensure that the home was well run and fit for purpose.

We found regular complaints audits took place to address areas of concern and lessons they could learn were discussed in team meetings. We looked at the processes in place for responding to incidents, accidents and complaints. We found that incident and accident forms were completed and actions were identified and taken.