Lancam Care Services Limited

Albany Park Nursing Home

Inspection report

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14 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place over two days on 11, 12 and 14 July 2017 and was unannounced.

Albany Park Nursing Home provides nursing care and accommodation for a maximum of 43 older people, some of whom are living with dementia. At the time of the inspection the service was supporting 38 people.

There was a registered manager in place. The registered manager was present throughout 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.

The communal area was unclean with heavily stained furniture. Two bedroom carpets smelled strongly of urine. Some people's bed linen had not been changed despite it being unclean.

We observed caring interactions between staff and people. However, on two occasions in the communal lounge, we observed periods of time where there was poor interaction between people and staff. Staff were often talking amongst themselves without taking to people and completing some care tasks without talking to the person.

Three staff had not been comprehensively assessed prior to employment. The home had not ensured that staff had appropriate criminal records checks in place.

There were detailed risk assessments in place that provided staff with clear guidance on what the risks were to that individual person and how identified risks could be mitigated. Risk assessments were reviewed and updated regularly.

Medicines were now safely managed. The home had employed a clinical lead who had addressed issues found at the last inspection. There were regular medicines audits completed. Staff that administered medicines had been signed off as competent and safe to administer medicines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice.

People and relatives were involved in end of life care planning. People experiencing end of life care were treated with compassion and empathy.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care.

Healthcare professionals and relatives were positive about the management of the home.

At this inspection, we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 communal lounge was not clean and furniture was dirty and stained. Some bedroom carpets smelt strongly of urine.

Some staff recruitment checks regarding criminal records checks had not been completed on commencing employment at the service.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

People were supported to have their medicines safely.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS) and how this impacted on the people that they cared for.

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

Is the service caring?

Requires Improvement

The service was not always caring. We observed staff not always promote a caring attitude towards people and completing care without talking to people when people were in the communal lounge.

People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People and relatives were encouraged to have input into their care.

End of life care was compassionate and planned according to people and relatives wishes.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

The home provided numerous activities to encourage stimulation and enjoyment.

People knew how to make a complaint. There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems in place failed to identify issues that were identified at the time of the inspection. This included cleanliness of furniture, staff recruitment and aspects relating to the quality of care.

There was good staff morale and guidance from management.

There were regular staff meetings.

Relatives and healthcare professionals were positive about how the home was run.

Albany Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11, 12 and 14 July 2017 and was unannounced.

The inspection was carried out by two inspectors and two experts 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. One expert attended day two of the inspection and on the second and third days two experts by experience made telephone calls to relatives and staff to gain their views of the home.

Before the inspection we looked at information that we had received about the service and formal notifications that the provider had sent to the CQC. This included a Provider Information Return (PIR) completed in March 2017. A PIR gives providers the opportunity to tell us about their service. Formal notifications include information that a provider must inform the Care Quality Commission (CQC) about as part of their legislative responsibility. This includes information about significant injuries, deaths and people that may be subject to Deprivation of Liberty Safeguards (DoLS).

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine care records and risk assessments, eight staff files, 13 staff supervisions and appraisals, 23 people's medicines records and other paperwork related to the management of the service. We spoke with 15 people who used the service, eight staff, the registered manager, the registered provider and 16 relatives. We also spoke with a GP, a social worker and consultant psychiatrist who were visiting the home during the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 20 September 2016 we found two breaches of Regulations 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to inadequately assessing people at high risk of developing pressure ulcers, the unsafe management of medicines and not monitoring people at risk of malnutrition. At this inspection we found that the provider had addressed these issues.

On day one of the inspection we walked around the building. In the communal lounge we observed that the carpet was dirty and stained. Seats in lounge were very soiled with food debris, spillages and other stains. The skirting board behind chairs in the communal area was rotting and coming away from the wall. Some side tables that people used to eat from were peeling leaving rough surfaces. This meant that people with delicate skin were at risk of injuring themselves. We showed the registered manager and provider the condition of the communal area. The registered manager told us that the communal room was cleaned each morning by domestic staff but not in the evenings. The provider told us that the chairs in the communal room were regularly cleaned. On the second day of the inspection the provider commenced some remedial work. We saw that the skirting board was replaced and were informed the damage had been the result of a leak which had been fixed. Some of the chairs and the tables were replaced on the second day of the inspection. However, there was still some stained and dirty furniture in place.

We also observed carpeting in two people's bedrooms which smelled very strongly of urine and emanated into the hallway throughout the days of the inspection. We showed the clinical lead one of the rooms. The registered manager told us that bedroom carpets were deep cleaned on a regular basis and that this would be addressed.

One the first day of the inspection we observed that three people's bedrooms had soiled and stained bed linen. We raised this with the registered manager who told us that staff checked people's bed linen when people got up and bedding was changed if it was soiled. On the second day of the inspection we again checked the rooms with soiled bed linen. One person's bedding had been changed. However, two people's bedding remained dirty from the previous day.

The premises and equipment used by the service provider was not clean, properly maintained and did not meet the standards of hygiene appropriate for the purposes for which they were being used. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed Disclosure and Barring Service checks (DBS) for eight staff. The DBS checks criminal records and helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups, including vulnerable adults. For most staff, the home had applied for a DBS on appointment to the post. However, for three staff members we saw that the home used a DBS from previous employers and had not applied for their own checks. It is best practice to apply for a DBS specific to the company that the staff are working for. Following the inspection we requested that the registered manager send us a list of all staff employed and confirmation of their DBS checks. This confirmed that there were

three staff that the provider had not applied for a DBS for.

Following the inspection we spoke with the registered manager to find out what action had been taken to address this. They told us that for one staff member they had applied for a DBS and this had been received. The second staff member had left the employment of the service and the service was in the process of applying for a DBS for third staff member. The third staff member was still in their three month induction period and during this time new staff did not work alone. The registered manager also told us that following the inspection, the provider was putting a system of review in place to renew DBS's for staff that had been employed for over three years.

All other pre-employment checks were in place, such as two satisfactory references from their previous employer, photographic identification and their application form. The provider had a system in place to check if people were eligible to work in the UK. We saw that where people required a visa and when this needed to be renewed was documented.

The home assessed people's potential for developing pressure ulcers by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. Where people were at risk of developing pressure ulcers we saw that they had equipment in place such pressure mattresses and cushions. Where people required turning to help prevent pressure ulcers, turning charts showed that people were being turned at regular intervals. However, for one person, we saw that there were turning charts completed during the day but not at night. We confirmed this with the clinical lead. It was unclear if the person was being repositioned at night. The clinical lead told us that the person was able to re-position themselves but would check and ensure that records reflected that the person's position had been checked during the night. There was no one in the home that had a pressure ulcer at the time of the inspection.

At our last inspection we found that food was not always being monitored for some people at risk of malnourishment. At this inspection we found that the provider has addressed this issue. There were two people at risk of malnourishment. For one person we saw that their weight was regularly checked and recorded. The person had been seen by a speech and language therapist (SALT) and there were dietary recommendations in place. Staff were aware of the person's needs. Another person was new to the service and the home was following information given when the person had been referred regarding their diet.

People told us that they felt safe at the home. People said, "To find a care home to beat this would be a hard job" and "It's a lovely home. They [staff] are all caring." Relatives were positive about people's safety and said, "Yes I do [think relative is safe]. No one comes in without signing in and the staff are very good with her", "I do feel that he is safe here and they understand all his needs" and "Yes I really do [think relative is safe]. It's just the way they have got to know her and they understand what she needs." However, despite this positive feedback, some aspects of the home were not safe.

All staff members we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us that safeguarding was, "When you make sure the person you are looking after is protected from being harmed. [I would] write it down in the log first then report and at the same time tell manager right away." Another staff member said, "Making sure the client is not being harmed in any way." Staff had received training in safeguarding during their induction when they started work and records showed that this training was refreshed each year.

Risk assessments were person centred and detailed focusing on what the risk to the person's well-being was

and how staff could work effectively with the known risk. Personalised risk assessments were seen for issues including, the use of bedside rails, swallowing difficulties, falls and behaviour that challenged. Health conditions were explained, symptoms of ill-health and relapse were detailed and action staff should take was clearly documented. We saw risk assessments for dementia associated risks such as forgetting things the person had done, isolation, non-recognition of family and hallucinations. One risk assessment stated, "If [person] has hallucinations and reports someone is in the room, to reassure them there is no one in the room. If they disagree, tell them that you have driven the person away. Focus on perception and what makes the person comfortable." This showed a good understanding of how to mitigate known risks.

The home had implemented a new electronic records system that included risk assessments. We saw that there were regular reviews of people's personal risks and the system was updated as soon as risks changed or a review had taken place. Staff confirmed that they were informed by the systems internal email system if there were any updates regarding people's risk assessments that they needed to be aware of. We also asked staff if personal risks that people faced were discussed as a team to ensure that all staff understood. Staff told us, "Yes we discuss in meetings about the risks of each service user and how best to prevent it" and "We talk about it all the time. We do it in meetings or just one to one as it is needed."

We saw that each person had a personal evacuation plan (PEEP) in place, in case of a fire. A PEEP assesses how people should be evacuated if they have mobility issues and the best way for staff to support them. Records showed regular testing of the fire alarm systems and fire drills.

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

The home had several hoists for moving and handling. There were up to date records of hoist maintenance. People had individual slings based on their weight and what type of moving and handling was required. People's personal slings were stored in the person's on-suite bathroom. We observed a moving and handling procedure and this was completed appropriately by two staff with good staff communication with the person.

Accidents and incidents were documented. The incident itself and the immediate action was recorded. Incident reports also included the details of any follow-up action and people's care plans were updated if necessary.

At the time of the inspection the weather was very hot. We found that the home was cool and there were wall mounted fans and air conditioning units were being installed in the main lounge. We checked people's bedrooms when we arrived and saw that people had been provided with water and fans. People were offered drinks throughout the day to ensure hydration was maintained.

At our last inspection we found that medicines were not always being managed safely. We found that staff administering medicines had received training but had not been signed off as being competent to ensure safe medicines administration. We observed that creams and emollients, including prescription only items, were stored in open access in people's bedrooms for staff to apply at the times of personal care. Medicine administration records (MAR) were unclear. MAR charts that were hand transcribed were not always signed by a second nurse as is best practice. At this inspection we found that the provider had addressed these issues.

At our last inspection we found that covert medicines were not being appropriately managed. There was no documentation in place to ensure that decisions around covert medicines had been assessed or signed off

as appropriate. Covert medicines are where the home administers medicines without the person's consent but with the authority of the GP and pharmacist following a best interests meeting. At this inspection we found that where people were receiving their medicines covertly, this was managed appropriately with signed GP and pharmacist consent in place and information on how to give the medicines was available.

The home had a clear medicines administration policy. People's medicines were recorded on medicines administration records (MAR) and the home used a blister pack system provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicines are required. It is usually provided as a one month supply. We looked at 23 people's medicines. Medicines were given on time and there were no omissions in recording of administration.

The home had employed a clinical lead. The clinical lead was responsible for all medicines and clinical care within the home. We saw that all staff had received medicines training. Records showed that all staff that were administering medicines had been assessed and signed off as competent by the clinical lead. The clinical lead told us that currently only senior carers and nursing staff were administering medicines. All creams were now stored on the locked medicines trolley. Printed MAR charts were provided by the pharmacy to the home with each month's supply of medicines. The clinical lead showed us that where a medicine had been prescribed mid cycle this was hand written onto the MAR chart and signed by two members of staff. Where a medicine had been discontinued or the dosage changed, this was clearly documented.

Controlled drugs were checked and corresponded with the recording book. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. We checked controlled drugs for one person. Recording was correct, totals of stock were correct and two staff always signed when a controlled drug was administered.

There were records for 'as required' (PRN) medicines. As required medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious or require pain relief. For each person that had PRN medicines there was a separate sheet that detailed what the medicines were, in what event they should be given and guidance for staff on how to administer the medicine. For example, for one person that used an inhaler to help with asthma we saw that there was specific guidance for staff on when to administer the medicine.

Homely remedies were stored separately in a locked cabinet. We saw that the GP had authorised specific homely remedies to be used within the home. This included remedies for coughs, colds and constipation.

Records showed that the home completed a dependency assessment for each person on a monthly basis and submitted it to the provider. This was analysed and the registered manager informed if they were above or below staffing requirements. We looked at the last two months dependency assessment results and saw that staffing was above required levels. The registered manager told us that if necessary, extra staff would be put in shift. For example, two people required one-to-one care during the day and these staff were extra to the usual staff allocation. We received mixed feedback when we asked people and relatives if they felt there were enough staff on duty. People said, "Yes it is good enough for me, they look after me" and "I think so. It is not too bad." Relatives commented, "Yes. There are always enough staff on the floor" and "There have been times in the past [where there were not enough staff] but I haven't noticed a lack of staff recently."

All bedrooms and bathrooms had a call bell system in case people required help. Inspectors checked the response times when call bells were used during the inspection. Two staff responded to an active call bell

within one minute. We asked people if their call bells were answered in a timely manner. People told us, "Not long. A few minutes unless it is mealtimes then it can take long time", "Not too sure as I have never timed it. But they always do come. I am extremely happy" and "During the day they are alright they come within like 10 minutes." Relatives said, "When I am around they come pretty fast like five minutes" and "They are usually always fast to get here. He says around 10 minutes unless its lunch time then it could take some time."

Good

Is the service effective?

Our findings

At our last inspection we found that records did not show how the home supported nurses with their continuing professional development (CPD) and revalidation which are part of the requirement of registration for nurses with the Nursing and Midwifery Council (NMC). At this inspection we found that the provider had addressed this issue. Nursing staff were being supported when their revalidation was due by the clinical lead. There were records to show that the clinical lead ensured that nursing staff were appropriately registered with the NMC.

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures, medication training and manual handling. The registered manager told us that new staff worked with more experienced staff for the first three months of their employment before being able to work alone with people. One staff member said, "Yes I did [have an induction] It was really helpful. They talked me through all the tasks I would have to do and helped my understand how to do it better. Yes, I am able to work on getting a NVQ (National Vocational qualification)."

Staff told us and records confirmed they were supported through regular supervisions. The registered manager completed supervision for the clinical lead, cooks, domestic staff and heads of care. The clinical lead completed supervisions for nursing staff and heads of care supervised care staff. We looked at supervisions from February and May 2017 for 13 staff. Supervisions were detailed and covered areas such as, appearance, work ethic and standards, training, communication, planning, working relationships and recordkeeping.

All care staff had received an annual appraisal in August 2016 where they had been employed for one year or more. However, we saw that no nursing staff had received an appraisal since August 2015. This was raised with the registered manager who told us that this had been identified and we saw that appraisals were booked in for July 2017. This was also confirmed by the clinical lead.

Records showed and staff told us that they were provided with training to enable them to carry out their role. Training records showed when staff had completed training and when they needed to refresh specific training such as, safeguarding, manual handling and health and safety. Training had been booked up to December 2017. Additional training included, a virtual dementia tour to help staff understand what is like living with dementia, training from a Tissue Viability Nurse (TVN) on pressure ulcer management, hospice delivered end of life training and diabetes. We saw that staff were able to request training if they felt it was necessary to their role. For example, one nurse requested training for syringe drivers, a method of administering medicine during end of life care. Training records showed that this training was provided shortly after the supervision.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. There were DoLS authorisations in place for people where appropriate. Where a DoLS had been granted there were timescales for review documented. The registered manager had informed CQC of all applications and authorisations as per their regulatory requirements.

Staff were able to tell us the procedure if a person were unable to make decisions regarding their care. Staff understood what best interests meetings were and under what circumstances they would be necessary. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. One staff member said, "It [MCA] is to do with the how to help people that don't have capacity to make decisions. We have meetings that inform us of the people that have capacity."

The kitchen was clean and well maintained. There were daily temperature checks completed in fridges and freezers which were clean and well stocked. Opening dates was recorded and use by dates also noted. The kitchen also had a large range of herbs and spices to ensure that food was well seasoned and appetising.

Records confirmed that people were offered a choice of two dishes for lunch and evening meals. The evening meal consisted of soup and sandwiches and a hot meal option. People were asked their menu choices the evening before and their choices recorded. Where people did not want the choices on offer, they could have an alternative. We saw that one person requested ham, egg and salad. People told us, "Yes, there is plenty of food" and "Of course I do [think there is enough food]. I can eat when I am hungry."

Where people required specialist diets, this was documented in their care plans. On the first day of the inspection we taste tested pureed and fork mashable foods that people with swallowing difficulties would be eating. The fork mashable food was an appropriate consistency, appetising and well presented. The pureed vegetables were of an appropriate consistency. However, the pureed meat was not the correct smooth consistency required for pureed food. The registered manger also tested the foods and told us that the blender in the kitchen had broken the previous day and that a new one had been ordered immediately. Kitchen staff were using a hand blender that was not able to adequately puree meat. On the second day of the inspection we were informed that a new blender had arrived. We again tested the pureed meat and found that whilst this was more pureed, it appeared that a liquid had been added to it. This made the meat runny and unappetising. We discussed this issue with the registered manager who told us that the regular chef had been on leave the week of the inspection and said that they would review the consistency of all specialist diets and gain further training around appropriate consistencies of pureed food.

We observed breakfast on the first and second day of the inspection. People ate breakfast in their rooms. Where people required help with eating we saw that staff were patient and people were fed at an appropriate speed that allowed people to enjoy their meal. Staff talked to people as they were feeding them to explain what they were doing or engaged in general chat. Breakfast was not rushed and there was a relaxed atmosphere as people were eating. We observed one staff member offer to help a person cut their food and then sit and chat with them while they ate. People told us that they had a choice of what they

wanted for breakfast. One person said, "I love my eggs. I always have eggs but I could have anything I wanted." Relative's comments regarding the food included, "Excellent. Freshly cooked and good variety. I can't fault them", "Mum eats it all. She has never complained about the food" and "He gets a good breakfast and a good dinner. He eats everything."

People's personal files had details of healthcare visits, appointments and reviews such as dentists, doctors and opticians. Guidance given by professionals was included in people's care plans and updated if necessary. People were able to access healthcare with support from staff where required. Staff said that they knew about people's individual healthcare and how to refer people to the appropriate healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought that staff were kind and caring. People told us, "I would say they are very friendly and amazing at what they do. I can't fault them" and "Yes I think they do [care]. They are pretty friendly and easing going. Just very busy." Relatives commented, "Very caring and helpful. Positive and respectful", "They are pleasant and welcoming and always ask about things, show an interest" and "Yes I would say they are. The conversations I have seen have always been pretty friendly and they know what is happening". However, relatives also said, "They spoil [person] quite a lot. Night staff are not very helpful and can be too busy to accommodate" and "Not overly [caring] they just do what needs doing and never sit and chat."

During the morning of the second day, around lunch time, we saw that there were six carers and 19 residents in the communal lounge. Staff spent most of lunch talking amongst themselves with very little interaction with people. The television was on although no-one was watching it. We also observed five people in the lounge area in the afternoon of the second day of the inspection. We saw staff present and walking through the room. However, we found that caring and personalised interactions were lacking. We saw staff assist people by removing bibs and clearing crumbs off people without acknowledging the person. We observed a staff member remove a table from a person, then another staff member would place the table by the person again, another staff member would come along and remove the table without speaking to or acknowledging the person. Staff spoke amongst themselves without involving people.

We also observed some caring interactions throughout the inspection between staff and people. Staff greeted people warmly and asked how they were. Staff appeared to know people well and asked about their families. For one person with dementia, we observed a staff member reacting with patience and caring when the person was repeating the same questions. We asked people how staff treated them if they became upset or anxious. People told us, "Someone will sit with me and will try and make me feel better" and "Someone will make sure I am alright. I guess they always try and help."

We asked people if they felt that staff treated them with dignity and respect. People told us, "Very respected they talk to me in a nice kind way" and "I would say they respect me. They treat me like family." However, another person said, "Not always." Relatives commented, "With the interaction I have seen they are always friendly and [show] respect to him. They understand his needs better than anyone and have been very good to him" and "I think they are [respectful]."

People told us that staff asked for consent before completing any care tasks, such as personal care. One person said, "Yes, they always say what they are doing and if I am okay with it." Relatives told us, "They always ask and talk to her" and "Yes, they always close her door when helping [relative]." A staff member said, "The way you talk to the service users and making sure to always be friendly and respectful. Knock on the door instead of just walking in and making sure there is no one around when I am helping them get changed." One staff member said, "When we go in we ask them do you want to have a shower or a bath, we ask them what they want to wear and we ask them what they want to eat. We don't just walk in and assume what they want. We have a set plan which is created by the families and duty manager which we follow

when they are not able."

Staff had received training in equality and diversity. One staff member told us, "Yes I did get trained for it. It just means make sure to treat everyone equally. It doesn't matter where they are from or what their background is." Staff we spoke with were positive about working with people from different cultures and faiths. One staff member said, "It's about the care and the resident's needs."

We saw that relatives were involved in planning people's care and this was documented. People told us, "My children do that" and "It is this folder I have saying what I need and how they will help me." Relatives were positive about their involvement in people's care and said, "Yes, from the start. We have regular meetings and they definitely listen", "We went through everything together" and "So far they have been very good. Everything was discussed."

There were appropriate arrangements in place for end of life care. There was guidance for staff on working with individuals at the end of their life with dignity and respect and ensuring the person's wishes were carried out. Decisions and what the person or relatives wanted were detailed in people's care plans where end of life care had been identified.

Relatives were able to visit whenever they wished. We observed people visiting throughout the inspection. For one person, we saw that their relative was visiting early in the morning so that they could help with the person's breakfast.

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred. There were comprehensive records of people's backgrounds and personal histories which staff were aware of when we talked to them. Care plans had a section called, 'Things I like.' This detailed what people enjoyed doing. For example, one care plan noted, 'Irish folk music, spending time in the pub, socialising'. Another care plan said, 'Loves makeup and looking glam. Likes reminiscence, karaoke, quizzes and exercise.' Where people had a diagnosis of dementia, care plans noted how this affected them. One care plan talked about how the person had been a van driver and when they thought about their van and keys they become upset. Care plans had detailed information on people's health conditions and anything that staff needed to be aware of.

There were regular reviews of people's care. Care plans were reviewed each year and relatives told us that they were involved in reviews and their opinions listened to. Where a person's care needs may have changed, we saw that care plans were updated to reflect any changes. One staff member said that care plans were reviewed, "As often as it is needed. Sometimes people's health can deteriorate quickly so their plan changes."

Each person's bedroom had a board that noted what people liked to be called, what their favourite things were and what they did not like.

We asked relatives if they felt that care was delivered in a personalised way. Relatives were positive about the service treating people as individuals. Comments included, "They talk to them all, calling them by name and most show an interest in what they are doing or saying", "They always ask. They know her likes and dislikes and always refer to her by her name. Always respectful" and "They always talk to her, call her by her name. They have got to know how she likes things done."

People's waking and sleeping preferences were noted in their care plan. On the first day of our inspection we arrived at 6.15am People were still in bed and we observed that people were able to wake up when they wanted. There was a very relaxed atmosphere throughout the home in the morning. A person told us, "I can wake up when I want." A relative said, "They respect what he asks for, he's never forced to get out of bed. They respect his decisions." One person's care plan noted, "[Person] prefers to stay up all night. Prefers to stay up listening to music and singing."

The home had an activities coordinator that worked 10.00am until 4.00pm weekdays. People were positive about the activities provided by the home. People commented, "I like to go to all the activities they are good and something to do" and "I went to exercise one today it was not bad. I'd like do some more but it depends on my mood." Relatives told us, "They are always trying to get him to go on activities and last week they planned a trip out." Activities provided included, arts and crafts, singing, gentle exercise, memory group and day trips.

The home had a complaints procedure. A poster of the complaints procedure was clearly displayed on all floors of the home. This provided people and relatives with information on how to make a complaint.

Relatives said that they knew how to make a complaint. The home had received four complaints in the past six months. The outcome and any actions taken were documented. We asked relatives if they were confident that complaints would be listened to. Relatives told us, "I am confident any complaint would be dealt with", "Mum has had a few bruises because her skin is very delicate. If I notice any new bruising the staff will look at the body map and respond" and "Yes they would."

We also saw compliment cards from relatives and healthcare professionals. One relative wrote and praised staff for going 'beyond the call of duty' on recent day trip to Southend. A healthcare professional praised service for promptly following up on recommendations made. We also saw thank you cards from relatives around how the home had supported their relative at the end of their life.

People's rooms were personalised where they wished. People were able to bring items of furniture to the home when they moved in which helped bedrooms feel more familiar and homely. We saw that bedrooms had personalised items such as photos, ornaments and bed spreads.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found some areas of the home that were not always well-led. An infection control audit completed on 3 July 2017 noted that all furniture was, 'Of good use and clean'. However, the cleanliness of the furniture at the time of the inspection indicated that furniture had been stained for a considerable amount of time and that the audit had failed to identify this.

The registered manager completed a fortnightly report that was given to the provider. This looked at various areas of the home including maintenance, health and safety, any safeguarding issues, staffing and clinical care. Following this the registered manager held management meetings that addressed any outstanding issues. However, this process had failed to identify that three staff had not received all appropriate employment checks by the provider and the home had not applied for criminal records checks for these staff. Whilst the provider took steps to address this issue following the inspection, adequate systems should be in place to ensure that staff recruitment includes applying for a relevant criminal records check.

At the time of our inspection there was a lack of management oversight in the communal areas. Staff had received training in dignity and respect but were not always putting this into practice when in the communal areas. This had not been monitored by the home to ensure quality of care and that people were always being treated with dignity and respect.

However, we received positive feedback when we asked relatives if they felt the service was well run and if management was available if they wanted to talk to them. Relatives comments included, "You can talk to her whenever you want, always available" and "[The registered manager] is very helpful." Staff were positive about the registered manager. Comments included, "She is nice. You can sit down and talk to her and she is always around to talk and she wants to help yes" and "I can always talk to [the registered manager], she takes time to listen." A healthcare professional told us, "Care has always been brilliant here. Do make a special mention of [the registered manager]. She is organised and is changing things for the better."

Relatives told us that they felt that the home provided a good quality of care and said, "I believe they saved her life. [Relative] was very ill last year and I had to insist [person] was brought back to Albany Park. They have given her the care needed", "Yes ten out of ten. I would recommend them and have done" and "I honestly do. She is always happy. So many staff to look after her and she is well cared for."

There were regular audits of various aspects of the home. Medicines audits were completed monthly. There were also weekly medicines audits that checked four people's medicines each week in rotation of room numbers. We looked at the most recent ten weekly audits and found that where any issues were identified, these were documented and signed off when addressed. The clinical lead told us that any issues were discussed with staff and at staff meetings to ensure best practice was being followed. There was also an external pharmacy audit completed in May 2017.

Records showed that a catering audit had taken place in July 2017.There were audits that checked the stocks of personal protective equipment (PPE) such as, gloves and aprons. All audits completed looked at

actions required from previous audits and commented if the noted action had been completed.

We reviewed accident and incident logs. It showed that the manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report and record accidents and incidents.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training.

There were records of regular staff meetings that allowed staff to discuss care needs and development of the service. Staff told us that they could talk to the registered manager at any time.

The home completed an annual survey with relatives and people that used the service. The most recent survey from 2016 was available for people and relatives to read. Questionnaires were sent out and results collated into a short report. The survey was positive and noted any leaning for the home. The home was in the process of starting the 2017 survey.

Healthcare professionals that we spoke with were positive about the management of the home and guidance that staff received regarding referrals and care and treatment provided by them. One healthcare professional commented, "Communication wise, [the registered manager] is always ready when I visit and knows what she is doing. Overall, it's just great."

Services that have been given a rating following an inspection are legally obliged to display their rating on their website, if they have one, and at the registered location where care is provided. The provider showed us their new web site which was under construction. The provider was aware that their ratings must be displayed on their website when it was completed.

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 15 HSCA RA Regulations 2014 Premises and equipment The communal area was unclean. Chairs were unclean and stained. Carpeting in two rooms smelled strongly of urine and bed lined was not always changed when unclean. 15(1)(a)(e)