Albert House Residential Home Ltd

Albert House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection visit took place on 03 November 2017 and was unannounced.

Albert House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The care home is registered to accommodate 29 people across two separate units, each of which has separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of the visit there were 28 people who lived at the home.

At the last inspection in October 2016 the service was rated 'Good'. At this inspection we found the service remained 'Good'.

A registered manager was available at the home. 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 registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. Recruitment checks were carried out to ensure suitable people were employed to work at the service. Our observations and discussions with staff and relatives of people who stayed at the service confirmed sufficient staff were on duty. Before the inspection we had received concerns about insufficient staffing levels at the home. We found the provider was in the process of recruiting an additional member of care staff in response to the concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way; the policies and systems at the service supported this practice. The service had taken appropriate action where people lacked the capacity to make decisions about their care and needed to be deprived of their liberty to keep them safe.

Care plans were in place detailing how people wished to be supported. People who received support, or where appropriate their relatives, were involved in decisions and consented to their care.

Risk assessments had been developed to minimise the potential risk of harm to people who stayed at the service. These had been kept under review and were relevant to the care and support people required. Additional measures had been taken to minimise risks in response to serious incidents that had occurred in the home.

We found improvements were required to demonstrate how staff observed people after falls and documentation and to ensure people at risk of choking were adequately monitored. There was no business

contingency plan which would provide staff with guidance on dealing with unplanned events and emergencies in the home.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required.

We observed regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. Comments from people who stayed at the service were all positive about the quality of meals provided. One person said, "The food here is the best."

We found people had access to healthcare professionals and their healthcare needs were met.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

The registered manager used a variety of methods to assess and monitor the quality of Albert House. These included external audits, regular internal audits of the service, surveys and staff and relatives meetings to seek the views of people about the quality of care being provided.

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

This service was not consistently safe.

Relatives felt their family members were safe. Feedback was positive.

Staff knew how to protect people from abuse and had received training.

Risks to the health, safety and well-being of people who lived at the home were assessed and plans to minimise the risk had been put in place. However improvements were required in the risk management records.

Improvements were required to how people were supported after experiencing falls and the records related to falls.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good

Is the service well-led?

Good

The service remains good.

Albert House Residential 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 visit took place on 03 November 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert for this inspection had experience of caring for an older adult.

This inspection was prompted by two incidents which had serious impact on two people who had used the service. The incidents indicated potential concerns about the management of risk in the service. We looked at the circumstances of these two incidents and any associated risks.

Before our inspection visit we reviewed the information we held on Albert House. We had been notified by the provider of two significant injuries which had been sustained at the location as a result of people experiencing falls. We explored how risks were managed during care support. This included instances when people were supported with bath lifting equipment bath, using the stairs and in all care transfers. We also explored the environment and any measures that the provider had put in place in response to the incidents. One of the incidents had been investigated by the Local Authority Safeguarding team and the concerns regarding the service had not been substantiated.

We spoke with a range of people about the service including eight people who were using the service at the time of the inspection, three relatives and five staff members. In addition we also spoke with two catering staff, the administrator, the registered manager and the owner.

We looked at care records of five people who used the service, two care records for people involved in serious incidents mentioned above, training records and three recruitment records of staff members, external audits and records relating to the management of the service. We also contacted the safeguarding department at the local authority and made contact with contact with community based health professionals such as social workers. This helped us to gain a balanced overview of what people experienced living at Albert House.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they had no concerns about their safety at Albert House. Comments people made to us included, I would say I am safe here and quite happy, everyone is very easy to talk to.", "It is very good so I feel safe and the carers are excellent. There seems to be enough of them and they are all so helpful and easy to talk to" and "Staff are supportive and kind. I feel safe as its well organised and I don't need to worry about anything." and "I like it here where I do feel safe and they care for me very well. The staff make sure they keep everything in my room just as it always is so I have no trouble finding my way around and knowing where things are."

Feedback from the community based health professionals we contacted was very positive about the safety of the home. Comments professionals made to us included; "I work well with the staff and they seek advice if they are unsure. I have no problems recommending the home."

Due to the two serious incidents which had prompted the inspection, we looked at how are risks to people were assessed. We also looked at how people's safety was monitored and managed so they are supported to stay safe and their freedom is respected. In particular; we looked at the care records for five people to review how the risks associated with falls and the use of moving and handling equipment were assessed and managed.

We saw that each person's care records contained an assessment of the risks relevant to them; these included people's safety when being assisted with their transfers, use of moving and handling equipment, ability to safely use stairs, accessing the community, nutritional risks, and physical health needs. People who used the service had been involved in documenting what support they needed from staff in order to keep themselves safe and well. We saw that care records had been reviewed and updated when people's needs and risks changed to help ensure they received safe care and treatment.

We reviewed the actions that the provider had taken to protect people from the risk of falling down stairs. We noted that the provider had taken action following incidents which had resulted in injuries. A 'lessons learnt' report had been completed by the registered manager. This identified areas of improvement to reduce risks of falls on the stairs. In addition to the existing falls risk assessment; each individual who lived upstairs had a stairs risk assessment. Individuals had also been assessed and provided with motion sensor mats which alerted staff if they had left their bedrooms. Relevant authorisations for the deprivation of liberties and people's consent had been sought for this.

We found the lighting in the service had been improved and other hazards such as steps had been highlighted and cordons on a set of steps had been put in place to reduce the risk of falls.

In response to an incident involving a fall from a bath lift, we found care files had been reviewed. They contained details of the level of risk to people in the bath and the number of care staff required to safely support them. These records also identified if people were safe to be left on their own in the bath to promote their privacy and independence. In addition staff in the home had received up to date moving and

handling training. We found there were policies and procedures for managing falls and staff were familiar with them.

We reviewed all incidents that had happened in the home and found in all cases where a person had experienced a fall; staff had consulted a medical professional using a service called 'Telemedicine'. 'Telemedicine' is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities or out of hours. Staff had been provided with advice by the medical professionals. However we found that where staff had been recommended to observe an individual following a fall, they had not kept records to demonstrate how they had monitored the person. For example in three instances staff had been advised to observe a person over a 24 hour period. However records to demonstrate how and when they had observed the people. This lack of records of observation meant that they could not demonstrate how they had followed the advice to monitor people's welfare.

We also observed that the incident records used in the service required to be updated to ensure that they prompted staff to undertake post falls observations. They needed to remind staff to consider if an incident should be reported to safeguarding and to notify to CQC. This would ensure that the practices in the home are in line with regulations and the local safeguarding board recommended procedures for falls management. However we did not identify a significant impact on people's welfare due to this shortfall and staff had routinely reported incidents to safeguarding and to CQC. We spoke to the registered manager and the owner and they informed us they would introduce post falls observation records and would review the incident form immediately. After the inspection they sent us records to show that they had implemented the required changes.

People were provided with appropriate support to reduce the risk of choking. Care records showed risks had been identified and referrals had been made to relevant professionals to ensure staff had the correct guidance. Recommendations had been provided by the speech and language therapists and these had been shared with care staff and catering staff. However; we found one person who was at risk of choking had at times been sat alone in one area of the home during meal times. This would increase the risk of choking due to lack of robust observations. The registered manager informed us that the person had been sat in an area where they would be in vicinity of catering staff who would observe them. They informed us they would immediately review the arrangement and staff deployment to ensure meals time observations were robust. This would ensure the person is observed and would be timely supported in the event of a choking incident.

We observed people's freedom was promoted in line with their abilities and needs. We saw one person was supported to access the local community independently. The registered manager had carried out risk assessments to ensure the person was safe. Some precautions and measures were in place to reduce the risks of the person going missing or getting lost. This showed there was the service had promoted positive risk taking which enhanced people's freedom.

We looked at how the service protected people from abuse and the risk of abuse. The provider had systems, processes and practices to safeguard people from abuse. Staff spoken with expressed a good understanding of safeguarding and protection matters and had received safeguarding training. They were aware of the various signs and indicators of abuse. All staff spoken with said they would not hesitate to report any concerns to the registered manager and were confident appropriate action would be taken. Staff also told us they were aware of the 'whistleblowing policy' in place and would always report any poor practice they observed.

Before this inspection and during the inspection we had received mixed feedback from people regarding staffing levels in the home. Some people felt there were adequate staff and some people felt staffing levels were not consistent. One relative told us, "I visit [my relative] here regularly and I would not say there are always enough staff on duty but they always work hard and well."

We looked at how the provider ensured there were adequate staff to meet people's care needs. The provider monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit staffing levels were observed to be sufficient to meet the needs of people who were staying at the service. Comments from staff included, "Staffing levels are fine. If there is someone who needs additional support we usually request it and get it."

We saw the registered manager had carried out weekly audits of the call bells to monitor how long it was taking for staff to respond to people's calls for support. We found the week before the inspection 59% of the call bells had been answered within one minute. This indicated that people were not waiting for longer periods for support.

The registered manager informed us that the staffing arrangements allowed them to bring in additional care staff as required and in response to the needs of the people in their care at any given time. They also informed us that they had received feedback from people and staff regarding staff shortages and had started the process of recruiting one additional staff member each day of the week. This would ensure that people's needs would be met in a timely manner. This also demonstrated that the registered manager and the provider had responded to feedback from people and staff.

We observed the medicines administration rounds in the morning and at lunch time. We saw staff administered medicines safely and followed best practice for the administration of medicines. We looked at people's medicine administration records (MARs). Records were completed clearly and there were no 'gaps' in administration records. Handwritten medicines administration records had been checked and verified by two people to ensure the information had been copied correctly from the prescription. This meant that actions had been taken to prevent prescription errors.

Medicines audits (checks) were in place and we saw daily and monthly checks carried out by the senior staff. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to receive their medicines safely. Where errors had been found, staff had been provided with support to improve their practice.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored in a controlled drugs cupboard or secure safe, access to them was restricted and the keys held securely. There were protocols for giving 'as required' (PRN) medicines and when these medicines had been given, it had been clearly recorded. This helped to make sure that people received the medicines they needed appropriately.

We found there were suitable arrangements for the management of topical creams. Cream charts and body maps were in place. This guided care staff on where to apply the creams. Staff had recorded and signed when they had applied the creams.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around the communal areas of the home and saw the lounges, dining room, kitchen, bathrooms and toilets were clean.

Records we reviewed showed that the equipment used within Albert House had been serviced and maintained in accordance with the manufacturers' instructions. We saw that regular maintenance checks were carried out and action taken where necessary to address any issues found. However during the inspection we prompted the registered manager to cordon off a bathroom that had a faulty bath lift. They had identified the fault before the inspection and informed us that they were waiting for replacement equipment to be delivered. The registered manager took immediate action and instructed care staff to stop using the bath.

We looked to see what systems were in place to protect people in the event of an emergency. We saw there was a policy on dealing with utility failures and other emergencies that could affect the provision of care. However; we noted that there was no business contingency plan which would provide staff with guidance on dealing with unplanned events, such as emergency accommodation if people needed to be evacuated from the building for more than 24 hours. We spoke to the registered manager and they advised us that they would take immediate action to make contingency arrangements. Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear. Staff had completed training to help ensure they were able to take appropriate action in the event of a fire. Records were also kept of the support people would need to evacuate the building safely in the event of an emergency.

Good

Is the service effective?

Our findings

People received effective care because they were supported by a staff team that were trained and had a good understanding of people's needs and wishes. Comments from people included, I am happy with the skills and of the staff, they call the doctor if I need one."

All staff we spoke with told us they knew the people who used the service well because it was a small service. One relative said, "[Name removed] can sometimes change her mind on food choices, the staff will make her a sandwich and the staff promote healthy eating here."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible; the policies and systems in the service supported this practice. When we undertook our inspection visit ten people who used the service had been assessed as lacking capacity to consent to their care and DoLS authorisation requests had been made to the local authority. Authorisation had been approved for one person.

The registered manager demonstrated an understanding of the legislation as laid down by the MCA and the associated DoLS. Discussion with the registered manager confirmed they understood when an application should be made and how to submit one. They had made a number of applications to the local authority.

We saw people's needs and choices had been assessed and care, treatment and support delivered in line with current legislation, standards and evidence based-guidance to achieve effective outcomes. For example people's preferences, intolerances and allergies had been recorded and shared with relevant staff such as catering staff. We observed people being given choice of where to sit, and whether they needed any help.

In addition the service had considered good practice when managing people's health needs. They had been part of a pilot scheme with the local clinical commissioning group on the use of 'secure red bags' for sharing hospital transfer records also known as hospital passports. This was an initiative to improve the way services shared people's records and to reduce the risk of records going missing during a transfer between care homes and hospitals. Hospital transfer records are documents which promote communication between health professionals and people who cannot always communicate for themselves. The records we saw contained clear direction as to how to support a person and included information about whether a person had a DoLS in place, their mobility, skin integrity, dietary needs and medicines. The records also provided information about whether the person had a 'do not resuscitate order' (DNACPR) which is a legal form to withhold cardiopulmonary resuscitation (CPR). This meant other health professionals had information about individuals care needs to ensure the right care or treatment was provided.

We observed staff supported people to eat their meals. Staff offered a choice of drinks. They encouraged

individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they did not like the meals on offer. Comments about the food were good. One person who stayed at the service said, "The food is nice." Another person said, "We do have a choice and you can always chose another meal if you don't want what's on offer on the day."

Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals in order to increase their nutritional intake. There were care plans for people who were at risk of not receiving enough to eat or drink. Information in the records showed involvement from other professionals such as speech and language therapists. Where necessary people's weight was monitored and recorded.

We looked at the building and grounds and found they were appropriate for the care and support provided. We saw people who stayed at the service had access to the grounds which were enclosed and safe for people to use. In addition there were three lounges for people to make a choice on where to spend their time. There was an ongoing programme for refurbishment to ensure the adaptation, design and decoration of the service met people's needs. One person who stayed at the service said, "I can take myself away from the main lounge if I need time to myself." We observed people moved around the building freely with staff supporting them where necessary.

People were supported to live healthier lives and to have access to healthcare services and receive ongoing healthcare support. Care records we looked at contained information about other healthcare services that people who stayed at the service had access to. We noted that, in the majority of times people had been visited by GPs or dentists if they needed them. Staff had documented when individuals were supported to attend appointments or received visits from, for example, GPs. Documentation was updated to reflect the outcomes of the professional health visits and appointments.

Good

Is the service caring?

Our findings

During our inspection visit we observed people were relaxed, happy, smiling and comfortable. We confirmed this by talking with people. For example, comments included, "It's a lovely place and it's homely." A relative said, "We are given little booklets about things to help explain difficult things." Another relative said, "I know how to access advocacy services if I need to."

We observed staff engaged with people in a caring and relaxed way. For example, they spoke to people at their same level and used appropriate touch and humour.

Staff had a good understanding of protecting and respecting people's human rights. All staff had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was an extremely sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

There were arrangements to promote people's independence and autonomy. We observed people being as independent as possible, in accordance with their needs, abilities and preferences. People were encouraged to do as much as they could for themselves. For example, we saw one person independently visiting the local library. Staff explained how they promoted independence, by enabling people to do things for themselves. One staff member said, "We encourage people who have independent living skills to do as much as they can."

Staff maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering. Staff also addressed people in their preferred name. Care records that we saw had been written in a respectful manner.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the service around their own busy schedules. We observed staff welcomed relatives with care and respect. For example, they had a friendly approach and one relative said, "They always make you feel welcome and offer me a drink."

We saw people were supported to express their views on matters that were important to them and were also involved in making decisions about their care as far as possible. We spoke with the registered manager about access to advocacy services should people require their guidance and support. The registered provider had information details that could be provided to people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

Good

Is the service responsive?

Our findings

People who stayed at Albert House and relatives told us they felt the registered manager and staff were responsive and met their needs with an individual approach. Comments from people included; "I give my feedback to [name removed]", "They will help me if I need help but I want to try first." Another person told us, "They will call the doctor for me if I don't feel well, they are good at that."

One relative said "I am visiting [my relative] and I am sure this is the best place for her. I have no complaints and have never made one. I think that, generally, there are enough staff. I would not say I am really involved in her care plan but I have confidence in the staff, I do like them and the management and I have attended the meetings."

We looked at care records of five people to see if they received personalised care that was responsive to their needs. The care records had been developed where possible with each person and their family where appropriate, identifying what support they required. People and their relatives told us they had been consulted about support that was provided before using the service. They told us they sat down with staff and the registered manager regularly to discuss what had gone well and what could be improved.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified, for example, people who required assistance with moving, people who were at risk of falling and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who stayed at Albert House.

The provider had been responsive to the needs of people who lived at the home. For example the registered provider had responded to people's feedback about increasing staffing levels and the need to highlight and adapt areas of the building that could expose people to risks.

People were supported to maintain local connections and important relationships. People were also actively encouraged and supported to maintain local community links. We saw evidence of various activities including day trips to the theatre and the local community.

People we spoke to knew how to make a complaint or raise concerns and felt comfortable to do so if they needed to. We saw people were encouraged to do so, and were confident to speak up. The service had a complaints procedure which was made available to people on their admission to the service. Copies were on view in the service and had been written in an easy read format to enable people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

At the time of the inspection we saw records to show how one complaint had been received and dealt with. The process followed showed that concerns and complaints were used as an opportunity to learn and drive continuous improvement.

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example there was a policy which guided staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. Some of the care staff had received training in supporting people towards the end of their life. The service was working closely with the local clinical commissioning group to ensure all staff received the training. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Good

Is the service well-led?

Our findings

There was a registered manager employed at Albert House. Staff we spoke with told us they felt the registered manager worked with them and supported them to provide good quality care. We only received positive comments from staff and relatives and they included, "[Registered manager] listens to you and is approachable. Her door is always open we know we can make suggestions and feel listened to." Also, "The place is well organised and managed very well." One relative said,"There is a really good atmosphere here and enough activities for [my relative]. I rate the staff and the management very highly and I have done a questionnaire but have not yet been to any of the meetings."

Staff we talked with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager was experienced and had an extensive health and social care background. The registered manager had worked at the home for a long time. They were, knowledgeable and familiar with the needs of the people they supported. Care staff had delegated roles including medicines management, infection control and catering duties. Each person took responsibility for their role and had been provided with oversight by the registered manager who was in turn accountable to the registered provider.

Staff and service user meetings were held on a regular basis. We confirmed this by looking at minutes taken of meetings. In addition staff and 'relative/family' surveys were carried out regularly. The registered manager analysed any comments and shared them with registered provider who had acted upon them. Feedback we saw demonstrated people felt the service was of a good quality. We saw people and staff were consulted on the daily running of the service and any future plans. The registered manager regularly attended regional meetings at the company's head office to share good practice.

The registered manager and provider had auditing systems to assess quality assurance and the maintenance of people's wellbeing. We found regular audits had been completed. These included medicines, the environment, care records, accidents and incidents and infection control. Any issues found on audits were quickly acted upon and lessons learnt to improve the care the service provided.

The provider had sought support from an external care consultant who undertook quality assurance inspections in the home. These audit visits provided support with ensuring compliance and analysing information in the service such as accidents and incidents, as well as monitoring that the service was complying with regulations and quality requirements with other regulatory authorities. They also drew actions plans for the registered manager and monitored that these had been completed in a timely manner. The registered manager met with the owner on a monthly basis to discuss the quality of the service, progress and future plans. This also gave them the opportunity to discuss areas of concern and to share updates in requirements or any developments or changes in regulatory requirements.

We saw evidence to demonstrate that the service had adopted to keep up with best practice. This included using technology to access medical advice over the internet, nominating care staff as champions in various

areas of care practices for example moving and handling, safeguarding, infection control, dignity and dementia champions. These staff would attend multi-disciplinary meetings with other stakeholders such as the local Clinical Commissioning Groups and share information and best practice with other staff in the service.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and the people in their care were safe. These included social services, healthcare professionals including General Practitioners, specialist nurses, dieticians and best interest assessors. The service also worked closely with the local special schools and local adult education providers to ensure people living at the home have a contribution in their local community.