Alban Quality Care Limited

Alban House Residential Care Home

Inspection report

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Ilfracombe
Devon
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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 11 and 19 January 2017 and was unannounced on the first day.

The home provides accommodation and personal care for up to 23 adults who require personal care. The home specialises in providing care to predominantly older people with mental health needs or neurological conditions such as Multiple Sclerosis.

The home consists of two adjoining properties located in the seaside town of Ilfracombe.

One of the providers was also the registered manager for 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 service was previously inspected in November 2013 when the service was found compliant in all the regulations we looked at.

The home had a relaxed and happy atmosphere. People, their relatives and health professionals all said that staff were kind and compassionate, treating people with dignity and respect. Staff knew people well and were able to describe how they supported them. A visiting professional said "The care here is very good; they have a good group of staff". People and their relatives knew how to complain, but said they had not had reason to.

Staff were recruited safely with checks carried out before they were allowed to start working at the home. Some staff were not up to date with their training. This meant that staff might not have the right skills, knowledge and experience to work effectively with people. Staff had received training to support people who had physical impairments, suffered strokes or had long term conditions including Multiple Sclerosis and dementia. Some staff had been supported to undertake nationally recognised qualifications in care.

Staff understood their responsibilities and duties in terms of safeguarding people from the risk of abuse. Staff were able to describe the actions they would take if they had a concern.

Individual risks to people's safety had been assessed and plans written to show how these were being addressed. The home had an emergency evacuation plan and had also developed individual personal evacuation plans to support each person.

Where someone was assessed as lacking capacity to make a particular decision, staff had not always followed the principles outlined in the Mental Capacity Act 2005.

People were supported to remain as independent as possible and were encouraged to do activities of their

choice both within the home and in the community. Relatives and friends were welcomed into the home and were able to use communal areas and people's bedrooms to meet in private if they wished.

Peoples' medicines were not managed, stored and administered safely because current relevant professional guidance was not being followed.

People were provided with a choice of meals which were freshly prepared. Hot and cold drinks were available for people throughout the day. People said they enjoyed the food. Where people had specialist dietary needs, staff ensured that food was prepared to meet these. Some people were at risk of losing weight. Although staff encouraged them to eat additional food, food record charts were not being used. This meant that it was not possible to see what people had actually eaten and whether they continued to be at risk.

Although maintenance of the home had been undertaken, some areas of the home were in need of redecoration and refurbishment. Some communal areas were showing signs of wear and looked 'tired.' Although there were sufficient care staff to support people's needs, there were not enough domestic staff on duty each day to ensure that all areas of the home were kept clean and free from infection. Some kitchen equipment needed replacing and some more difficult to reach parts of the kitchen required cleaning. The providers brought their dogs into the home, which people liked. However, the dogs were allowed to wander into the dining room during mealtimes, which could pose a health risk to people when eating.

The registered manager and her deputy were well known to people, relatives, staff and visiting professionals. Everyone we spoke with said they were very committed to ensuring that people were well cared for. Staff said they felt supported by senior staff and were able to raise concerns with them, both informally and during supervisions.

Although there were some quality assurance systems in place, these had not identified and addressed some issues, including building maintenance, equipment replacement, training and medicines management.

We found breaches of the Health and Social Care Act (2008) Regulations 2014.

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.

Medicines were not stored, recorded and administered safely.

There were sufficient numbers of care workers to ensure people were kept safe and had their needs met. However, there were insufficient domestic staff on duty each day to ensure the home was kept clean and infection free.

Some kitchen equipment was very worn and not functioning properly. Some parts of the home were in need of redecoration and refurbishment. There was a risk of infection from pets which were allowed in the dining room while people were eating.

People were protected from the risks of abuse by staff who understood their responsibilities. People said they felt safe and happy living at Alban House

Risks to people had been assessed. People were supported to be safe whilst minimising any restrictions on them.

Staff had been recruited safely.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff were not up to date with their training.

People were supported to maintain a healthy, balanced diet

Care records did not always reflect people's risks, needs and preferences.

Staff had not assessed and recorded people's capacity to make specific decisions. This meant they were not working within the Mental Capacity Act (2005)

People were supported to access health services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

Staff knew people very well and showed concern for their well-being. People and their families were involved in making decisions about their care.

People were treated with dignity and respect. People's families were able to visit when they wanted.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs, preferences and aspirations. Staff knew people well and supported them with these.

The service routinely listened to people. There was a complaints policy and procedure. People said they knew how to complain. There had not been any complaints made in the last year.

Is the service well-led?

Requires Improvement

The service was mostly well–led, but some quality assurance systems had not identified issues. Checks and audits to ensure the quality of the service were undertaken but these had not identified health and safety issues.

The home promoted a positive culture and involved people, their relatives and staff in developing the service.

Staff and people knew the providers and senior staff and said they felt they were supported by them.

Alban House Residential Care 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 and 19 January 2017 and was unannounced. The inspection was carried out by two Adult Social Care inspectors.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law. We had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed this in February 2016.

We spoke to five care staff working at the home on the days of inspection, as well as two cooks, a cleaner and both providers, one of whom was the registered manager.

At the time of this inspection, 23 people were living at Alban House. We met most people living in the home and spoke to 11 of them about their experiences.

We looked at a sample of records relating to the running of the home and to the care of people. We reviewed four care records, including risk assessments, care plans and four medicine administration records. We reviewed four staff records. We were also shown policies and procedures and quality monitoring audits which related to the running of the service.

During the inspection we met one health professional and also two visitors who were carrying out work in the home. After the inspection we contacted six health and social care professionals including GPs and district nurses at a local GP surgery. We received three responses.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

Peoples' medicines were not managed and administered safely because current relevant professional guidance was not being followed. During a lunchtime medicines round on the first day of inspection, some practices were not safe and did not follow best practice guidance. For example, some medicines were put into medicine pots with people's names on the lid. The member of staff administering the medicines said the pots were taken into the kitchen and placed on people's lunch trays so that their medicines were taken to them with their lunch. They said the lunch trays were taken to people by another member of staff. The member of staff doing the medicines round signed the medicine administration record (MAR) chart although they had not witnessed the medicine being administered to the person. This practice posed risks to people as pots could be mixed up and people could be administered the wrong medicine. There was also a risk that the medicines might not be given, medicines could be dropped or refused rather than taken. The staff member who had signed the MAR did not observe the person taking them, which is what should happen when they sign to say a medicine has been administered.

One person was receiving their medicines covertly. This is when medicines are disguised within food or drink. In order for people to receive medicines this way, it is essential that a person's mental capacity to understand that this is being done is first assessed. If the person's doctor feels it is in the person's best interests that they have covert medicines, then a best interests decision making process should be followed. The National Institute for Health and Care Excellence (NICE) guidance, Managing Medicines in Care Homes (2014) recommends "holding a best interests meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering the medicines without the resident knowing (covertly) is in the residents best interests". The documentation in the person's records to support the decision to administer covertly did not comply with the NICE guidance. Although the Covert Administration of Medication form had been signed by the person's GP, this was dated June 2016. There was no record to indicate ongoing agreement at the monthly reviews carried out since then.

In addition, the form had been amended in September 2016 as an additional medicine had been added. The form stated that an additional medicine should be crushed if the person refused to take it. Crushing medicines may alter how they work and should only be done with pharmacist guidance. However, there was no record to show that pharmacist advice had been sought. The provider's medicines policy made reference to the need to gain pharmacist/GP guidance when considering the appropriateness of crushing medicines. This meant staff were not following the provider's policy or national guidance.

There were protocols for medicines which were administered PRN (this means medicines which are given when required rather than on a regular basis). However, the reasons for when PRN medicines had been administered were not routinely documented by staff. Documenting reasons enable staff to identify any trends in relation to when, and why, people might regularly require pain relief.

When MAR charts had been amended by staff, these had not always been countersigned to ensure instructions were accurate. For example, on one person's chart the printed instruction was "0.5 mg once or twice a day when required and 1 mg at night when required for aggression". This had been crossed out and staff had hand written "0.5 mg three times a day". The entry had not been countersigned as checked by another member of staff trained to do so.

Topical creams and lotions were not recorded on topical administration records when they had been administered. This meant it was difficult to assess whether people had received their topical medicines as prescribed. The use of topical administration records is a recommendation within the NICE guidance and the NHS Devon guidelines.

Medicines were not always stored safely. Liquid medicine bottles had not been dated when they were opened. This meant there was a risk that out-of-date medicines could be administered. We identified a bottle of paracetamol liquid with an expiry date of November 2016 which meant it was 42 days out of date. When we showed this to the deputy manager it was immediately disposed of.

There was a fridge for the storage of insulin. However, the fridge was not kept locked and although the temperature was checked, the thermometer in use only recorded the current temperature. The fridge was also used to store food products. Good Practice Guidelines produced by NHS Devon for care homes, which the registered manager said they referred to, states that minimum, maximum and current temperatures of the fridge should be monitored. In addition, the guidelines state the fridge should be locked. After the inspection we were informed that a new fridge/freezer had been purchased and this was being used to store the insulin. We were informed that there was no lock on the fridge and milk was still being stored in the fridge.

In addition, topical creams and lotions were not stored safely because they were stored in communal bathrooms, rather than in people's bedrooms. This meant people living at the home could have access to a topical cream or lotion which was not prescribed for them.

Although staff had access to a British National Formulary (BNF), a pharmaceutical reference book, this was out of date as it was the 2011 edition. This meant that they could be referring to information that was no longer current guidance.

Medicine administration audits provide checks on whether staff are administering the correct medicine, recording it correctly in the MAR charts, storing medicines safely and disposing of out of date medicines. Medication audits were not routinely carried out. However there was a monthly check of the stocks of medicines undertaken.

A training matrix showed only seven care staff had completed medicine administration training, three of whom had not undergone the training in the last year. We asked how often staff competence to manage medicines was assessed. The deputy manager said that staff competence had not been assessed since 2015, but that a programme of reassessment was planned.

People were not protected from the risk of infection from animals. For example, on the first day of inspection, two dogs owned by the provider were at the home. The dogs were observed entering the kitchen on three occasions, although staff did shoo them out when they saw this happen. During the lunchtime, one dog was observed licking dirty plates which were on a trolley waiting to be taken to the kitchen to be cleaned. There was no evidence that there had been a risk assessment undertaken about whether the dogs posed a potential infection control risk to people by being allowed in the dining room.

Staff said although the dogs were not supposed to be in the kitchen or dining room but they sometimes came in. We discussed this with a senior member of staff, who said they would take action to ensure dogs were not allowed in the kitchen or dining room.

Infection control audits were not being carried out. The registered manager said the building was "checked visually" on a daily basis but there was no record of issues that had been identified or actions that had been taken.

Care was not always delivered to ensure that it supported people with individual risks. For example, staff described one person who was at risk of being underweight. Although staff had monitored the person's weight each month, the care plan did not include information for staff to know what they needed to do to ensure the person was supported to gain weight. There was also insufficient detail to ensure that actions taken were having a desired effect. For example, staff said they gave the person extra snacks during the day and encouraged them to eat these. However, the care records did not provide sufficient detail to be able to determine what the person had eaten during the day. On one occasion we observed the person had been given a snack but had not eaten it. This meant that the person was at risk of continuing to be underweight.

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

Risk assessments were in place to support people to be as independent as possible. A health professional commented that a care plan they had looked at, had documented evidence of skin, swallowing and hoist transfer assessments. They said this addressed risks to the person and met their physical needs.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, some people were able to go out into the local community independently. These protected people and supported them to maintain their freedom.

The local pharmacy providing medicines to the home last undertook a monitoring visit to the home in April 2016. They had not identified any concerns.

Medicine errors, such as medicines not being given were reported. Staff said that medicine errors were discussed as a team to ensure all staff could use them as a learning experience. Where errors were identified, action was taken to keep the person safe.

Medicines which required a higher level of storage were stored safely. Medicines that were no longer required were disposed of safely.

There were enough care staff on duty to meet people's needs. A senior member of staff described how they ensured they had sufficient staff on duty with the right skills on a weekly basis when they were drawing up the rota. The registered manager said they did not use any tool to determine staffing levels. However they described how they talked to staff to decide whether people's needs had changed which would require a change in staffing levels.

Staff rotas showed there were usually a senior care worker and five care workers on duty in the mornings at the home. During the afternoon and early evening, there were usually four or five staff on duty. The number of care staff on duty during the day and evening was sufficient to meet people's needs during the day. Throughout the inspection, care staff were observed working in a calm and unrushed manner. Staff spent time with people and helped them with their care needs as well as activities of their choice. A health

professional said "There always seems to be enough staff. I never have any trouble finding a member of staff when I come here". Another health professional commented "I always make an appointment to visit and am welcomed when I do so. I am allocated a key worker to discuss [person'] care and observe numerous staff at the home attending to care of others. I visited once during the end of morning personal care and there were two carers attending [person's] needs as I would expect given [person's] high level of need." However another health professional commented that they sometimes found it hard to locate a member of staff when they arrived at the home.

At night there were two staff on duty, one waking and one sleeping in. Staff said some people required re-positioning in bed during the night which required two members of staff. They said that this meant the sleeping in member of staff was always woken at least once. They also described how some people also needed help to go to the toilet during the night and others liked to have a hot drink in the middle of the night. Staff said they were expected to undertake laundry and cleaning duties as well as some preparation for breakfasts. They said this meant they were often very busy. A senior member of staff said that they were monitoring the staffing levels during the night. They said they were considering whether two waking staff were needed.

There were parts of the home and equipment that were not clean or well maintained.

Rotas showed that domestic staff worked in the home on five days a week between 9am and 2pm. On one day a week there were two staff on duty, but on the other four days there was one cleaner. On one weekday and one day at the weekend, there were no domestic staff on duty. Care staff said that on the days when no domestic staff were working, the care staff "picked up" any necessary cleaning duties. One member of staff said "We keep an eye out and do what we can, but if we're busy with residents, things might get missed". Staff said some areas of the home were not always cleaned even though they needed it. After the inspection the registered manager told us that in addition to the weekly staff, every two months, one of the domestic staff was employed for two days for three or four weeks to undertake a deep clean. This included shampooing carpets.

Staff described the cleaning schedule saying that cleaners cleaned all the communal toilets each time they were on duty. In addition, they cleaned the bedrooms and communal areas on two of the four floors. On the next day when a cleaner was in, the other two floors were cleaned. This meant that some areas may only be cleaned every two or three days.

On the first day of inspection, when a cleaner was not on duty, there were areas of the home which were not maintained and kept clean to ensure people were protected against the risks of infection. Some people's bedroom floors and some communal areas had debris on them which needed sweeping or vacuuming. A chair in one person's room was stained and had food debris on it. Staff said these areas would be cleaned when the cleaner was next on duty. In two of the communal toilets there was faeces either in or on the toilet. We informed staff of this and the toilets were immediately cleaned by the care staff.

In addition to care and domestic staff, the home employed two cooks. One or other of the cooks would work each day from 8am until 1pm. Once a week, one of the cooks worked until 2pm which they said was to undertake additional cleaning in the kitchen. However, they described how this was not sufficient time to ensure deep-cleaning of the kitchen and the equipment in it was carried out regularly and thoroughly. Although work surfaces and the floor were cleaned every day, some areas of the kitchen were visibly dirty. For example a refrigerator had a stained back panel. Some equipment in the kitchen was covered in greasy dirt; this included two fridge thermometers, a window net and radio.

Equipment in the kitchen, including three refrigerators and freezers, were showing considerable signs of age and wear. One freezer had a cracked lid, which meant there was a risk of germs being trapped as it could not be cleaned properly. A chest freezer had a build-up of ice in one corner. Staff said this was an ongoing problem and they were concerned that it was because the seal on the freezer door was no longer functioning

It was not possible to assess whether food was being kept at the correct temperature to ensure it was safe to consume. Two digital thermometers used to check refrigerator temperatures were on top of a fridge. The thermometers were not recording accurate temperatures. For example one thermometer, which had its probe against the back panel inside the refrigerator, was displaying a temperature of 6.1oC. However the back panel of the refrigerator was covered in ice, which meant the temperature should have been on or below zero. The other temperature probe was not in the refrigerator, but was recording a temperature of 6.9oC, although it was in a very warm environment.

Some communal parts of the home were 'tired' looking and were in need of redecoration and refurbishment. Skirting boards and door frames were scuffed, and laminate flooring in some rooms had holes or tears. A pressure relieving cushion in the lounge had a tear in the plastic cover. In one of the communal bathrooms, carpet tiles were badly fitted, coming up at the edges and visibly dirty. In a communal toilet the wallpaper was peeling and ripped in places.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about cleanliness and infection control with a senior member of staff. They said they were considering whether if they had two waking night staff, additional cleaning could be undertaken by them both in the kitchen and in communal areas. We asked staff what actions they had taken about their concerns regarding the equipment. They said they had raised concerns with the provider about the refrigerators and the freezers as they did not think they were fit for purpose. A senior member of staff said they would discuss the concerns with the provider.

After the inspection we contacted the Environmental Health office. They said they had last rated the home in 2015 when it had achieved a level 5 Food Standards Agency (FSA) rating. However they said they would pass the concerns to the FSA inspector who would be inspecting within the next two months.

After the inspection the provider sent us information about the actions they had taken following feedback during the inspection. They said they had reviewed the cleaning staff levels. They said they now had domestic staff on duty from Monday to Saturday. They also said they had reduced the care hours to have one of these staff doing cleaning. Other actions included installing paper towel dispensers, and replacing a refrigerator, a freezer and digital thermometers for the refrigerators.

During the inspection, the home was undergoing an upgrade to their fire alarm systems. This was carried out by an external contractor. Contractors were observed warning people that they were testing the alarms at appropriate times to ensure people knew they did not need to respond to the alarms. Maintenance staff were also undertaking repair work to walls and ceilings associated with this. This was carried out with regard to people's safety.

There were supplies of personal protective equipment (PPE) including gloves and aprons available for staff to use throughout the home. Staff were observed using PPE appropriately.

There was a separate laundry area with washers and dryers which were used by care staff and cleaning staff. Soiled laundry was separated and dealt with appropriately. Clothing items which had been cleaned and dried were placed in a shelved storage area before being returned to people.

People said they felt safe and happy living at Alban House. A relative commented that they felt the home was "always safe."

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or safeguarding concerns. Staff said they had not seen any evidence of abuse. However they were able to describe what actions they would take if they had a concern about a person being abused. For example a member of staff said they would always alert the senior staff or the provider. They said they had confidence that action would be taken. They said they also understood that if they had a concern they could report it directly to the local authority who had responsibility for safeguarding vulnerable adults.

The registered manager confirmed that there had not been any safeguarding concerns but they understood their responsibilities if they had an issue reported to them.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Each person had a personal emergency evacuation plan (PEEP) which described the support required if they needed to be evacuated in an emergency. The PEEP provided good information about the person. This included their mobility, their ability to see and understand what was happening. It also described special considerations which needed to be made to support them in an emergency including what assistance they would need and any specialist equipment required. PEEPs were reviewed regularly and were up to date.

People were protected against hazards such as falls, slips and trips. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends.

Health and safety audits were undertaken on a regular basis. All audits were completed and any actions required to address issues had been carried out. Equipment was regularly maintained and there were service records for equipment such as hoists. In addition fire safety checks had been completed and individual fire risk assessments had been produced for people using the service.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.
Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure people were suitable to work with vulnerable adults. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

Training records showed that not all staff had completed or refreshed training in order to ensure they had the necessary up-to-date skills to undertake their roles. The registered manager said a senior member of staff was checking staff records to identify "any gaps" in their training. They said this would then be addressed with the members of staff. After the inspection, a senior member of staff said they had updated the training matrix to reflect some training which staff had attended but which had not previously been recorded. They sent us an updated training matrix. However although some training had been added for some staff, there were still staff who were not recorded as having completed the training needed to ensure they remained up to date with current practice. For example, eight staff had not received first aid training, 11 staff had not completed food hygiene training and four staff had not refreshed their food hygiene training for over 2 years.

After the inspection, the registered manager said they were ensuring staff were completing theory based training. They also said they had booked a manual handling trainer to deliver a practical course in late March 2017.

Most staff had been at the home for a number of years and had been supported to undertake a national qualification in care. A health professional commented "[Registered manager] encourages staff to progress and develop their skills." The training records showed about half the staff had a nationally recognised qualification in care.

A health professional commented "The staff are well trained and knowledgeable." Another health professional when asked whether staff had the skills, knowledge and training to support people effectively, commented "From observed care delivery I would say they do."

New staff were supported to complete an induction programme before working on their own. The registered manager said recent new appointments had already got a level two qualification in care. However they said they were aware of the need to ensure an induction for unqualified staff was aligned to the nationally recognised Care Certificate. The Care Certificate was developed by Skills for Care. It is a set of 15 standards that all new staff in care settings are expected to complete during their induction.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to feel supported in their work. One member of staff said "I have supervision from time to time but if I need support, [registered manager] or [the deputy manager] are always there to help". After the inspection, a senior member of staff said they were reviewing the supervision policy and would consider whether changes to the way supervisions were carried out was necessary.

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 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.

The principles of the MCA were not always being followed with regards to people who may have lacked capacity to make certain decisions. Where people were considered by staff to lack capacity to make a certain decision, staff had not completed the two stage assessment of capacity relating to that particular decision.
Although staff had some understanding of the MCA, records did not show evidence that they had followed it. For example, some people had generic mental capacity assessments within their care plans. These did not relate to specific decisions at a specific time as they should do. There were no records of best interests decisions having been made following these assessments so it was not clear what the assessments related to.

A health professional commented "In relation to care of the resident I see, lack of mental capacity has been identified. From the staff I work alongside, they are aware and demonstrate knowledge of capacity and implications for care delivery and decision making."

However, care records did not contain information about how the MCA had been applied to individual decisions. A senior member of staff said they would take action to ensure that records reflected people's capacity to make particular decisions.

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body, although they said they were all waiting to be assessed.

Staff supported people who could become anxious and exhibit behaviours which may challenge others. For example one person who was anxious was supported by staff who distracted them by suggesting they went for a walk. This helped to allay the person's anxiety.

Some areas of the home were in need of redecoration. Although some work had been carried out to redecorate some areas, some parts of the home had walls and paintwork which was chipped and damaged. Flooring in the dining area was damaged.

A health professional commented 'The environment would benefit from refurbishment throughout'
Another health professional fed back that 'an area for potential improvement, which is management of the entrance to the property. Obviously some [people] come and go and some are housebound. No reception system operates which is fine for a property of this size, but I often find it really hard to announce my arrival to see [people].' and am often wandering around trying to find a member of staff. A visitor bell or similar at the entrance by the signing in book would likely benefit visitors like myself who need to locate staff to enable care of residents.'
However, a visitor to the home said "Although the fabric of the building is old, there is an ongoing maintenance programme." They added that it was "a comfortable, homely place not regimented." and was

"lovely and warm." Another visitor said "because of the layout of the building, moving around could be a challenge, however the lift is always working."
After the inspection, the registered manager described how they "sat down at the start of each year and decided on the priorities for making improvements." They said they built this into their business plan. They described how in 2016, they had undertaken improvements to the paths in the back garden to make the area more wheelchair friendly; a new fire alarm system; a bathroom which had specialist equipment to support people to take baths more easily and redecoration of a bedroom.
The staff were all aware of people's dietary needs and preferences. Staff said they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. On both days of inspection, we observed lunch being served. People were offered a wide choice of both main course and dessert. A person who was at risk of choking had been assessed by speech and language therapist who had recommended they were supported to have a soft diet. Staff were able to describe how food was prepared to meet the person's needs. For example they described how the person had sandwiches for lunch which had to be cut into small squares.

People said the food was good and they were always offered a choice. However one person said there was not enough fresh fruit. A visitor commented "The food smells lovely and home cooked." A health professional fed back 'there was always a welcoming smell of food and from my observations, the residents were well fed. Menus were on show in the dining room and assistance with meals for those residents needing it.'
Staff were aware of people's allergies to certain foods, for example they described how one person could not have shell fish.

Hot and cold drinks were offered at mealtimes and throughout the day to ensure people remained hydrated.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People were referred appropriately to the health professionals if staff had concerns about their wellbeing.

A health professional said staff contacted them in a timely manner with any concerns that required a clinical review. They commented "The deputy manager is really on the ball, she alerts us quickly if she wants us to see someone".

Feedback from health and social care professionals included 'I am overall impressed with the care provided at Alban house. The carers report concerns to us in a very timely manner. One carer is always present when we are attending to a resident so information is communicated well.' and 'They contact me between visits or telephone reviews should there be cause to do so and if I ask for a specific activity to be organised I have every confidence it will be done.'

Good

Is the service caring?

Our findings

Throughout the inspection there were positive caring interactions between staff and people using the service. The atmosphere was relaxed and friendly. People's care was not rushed enabling staff to spend quality time with them. We observed one member of staff sitting on the floor in the lounge playing dominoes with one person; they were laughing and joking together. Staff treated people with kindness and respect. For example, staff were overheard asking people "Can I help you?", "Would you like me to walk with you?" and "Where would you like to sit?"

The home was spacious and allowed people to spend time on their own if they wished. For example as well as a large lounge area, there was two other separate seating areas which people used during the inspection when they wished to have a quiet time or wished to see visitors privately. Some people chose to remain in their rooms while others chose to go to communal areas, including the lounges, dining room and garden. People's bedrooms were personalised and people had their own belongings and furniture with them if they chose to.

A visiting professional said "The care here is very good; they have a good group of staff". A health professional commented 'On the occasions I have visited, the residents always looked happy and well cared for.'

Staff knew people well and spoke about their personal life stories. We observed staff engaging in conversations with people rather than just passing them by. However, care records did not contain very much detail about people's life story or their personal preferences. Senior staff said they were reviewing care records and would consider how they could incorporate more personal information about people.

People's dignity was respected by staff. Staff took time to ensure they understood what a person wanted before helping them achieve this. Where a person required personal care, staff were discreet when discussing this with them.

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. Staff knew, understand and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. For example, a professional commented that the person they visited had been supported to go to church when well enough. Records showed that a local minister had also visited the person.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Staff knew people's individual communication skills, abilities and preferences. For example, one person was not able to verbalise their preferences. Staff described how they would talk to the person and would use the person's gestures and body language to understand what they wanted. We observed staff using these skills when working with the person.

Good

Is the service responsive?

Our findings

Staff knew people really well and responded to the needs promptly. For example where one person had been identified as gaining weight, care records showed a health professional had been contacted for support and advice on what to do. There was evidence that the changes recommended by the health professional had been carried out. The health professional commented "Weight is also monitored on a regular basis and they have contacted me about concern with weight gain."

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and provided information about people's preferred daily routines. Staff were able to explain how each person was supported as an individual. For example they described how one person liked to spend time outside in good weather while another person liked to sit in a particular chair in one of the lounges.

Where people required support with their personal care they were able to make choices and be as independent as possible. Care plans described how people liked to receive personal care and what time they preferred to get up and go to bed, for example one care plan described how the person liked to go to bed after 9.00pm. Care plans also described personal preferences, for example one person's care plan described how they liked to 'wear lounge pants and pyjama shirts for comfort.'

People's equipment needs were reviewed regularly and as required. Where an issue such as additional equipment was required, staff took action to address this. A visitor commented "If they need equipment, they get it. They don't just make do."

Care plans reflected people's choices in terms of their activities. For example, one person chose to go to a community activity each weekday which was provided by an external organisation. They showed us photos and video footage of some of the activities they were involved in, which included horse riding, which they clearly enjoyed. A visitor commented "[The providers] are always very responsive. [Person] is always ready when we pick them up. Any problems are sorted out quickly and appropriately."

One of the care staff took responsibility for organising activities. They described how they organised group activities which people joined in. These included board games, quizzes and keep fit. They also arranged visits from outside organisations including visits from singers and a local zoo which brought zoo animals into the home. This had been very popular with some people at Alban House and therefore staff had organised for this to be repeated. Staff said they also arranged trips out for groups of people to local places of interest and for meals out. Some people were able to go out independently, which staff would arrange transport for if necessary. One person was supported to go to a community group on five days a week, where they did activities including horse riding, swimming and gardening. Another person visited a club each afternoon where they met with friends. Staff ensured that people who spent long periods of time in their bedroom were also supported with activities. For example, they described how one person liked to have they nails manicured, which staff did for them.

A health professional commented "[Registered manager] has assessed and accepted people at short notice that the [health and social care team] have needed to place in a crisis situation and always has their best interests at heart." Another health professional commented that the home offered "very person centred care for a very diverse population of [people]." They also described staff as having an amazing commitment to one of my patients who has severe dementia, is frail and vulnerable ….focused on providing quality care."

Feedback from another health professional included '[Registered manager] takes [people] to their appointments if no other family or transport option, and can use an adapted van for shopping trips which I feel is wonderful for [people]. I also like the fact there are home pets there, and residents and family alike seem to love this.'
There was a complaints procedure in place, but we were told that no complaints had been received in the last year. A senior member of staff said any complaints and concerns would always be taken seriously and used as an opportunity to improve the service. A relative said they knew how to complain but they had "no complaints at all."

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Health and safety audits were undertaken. For example there was a regular audit of the building safety and the equipment such as fire equipment. However health and safety audits had not always picked up issues, such as the poor state of some kitchen equipment, including refrigerators and freezers. Audits had also not identified that there were infection control issues. These included inaccurate refrigeration temperatures; areas of the building where there was damaged such as the dining room floor and some communal areas; areas where cleaning had not been completed, for example some parts of the kitchen and some people's bedrooms. The registered manager said they were in the home every day and monitored the cleanliness of the home. However they said they did not undertake formal audits of the home's cleanliness.

Although the registered manager said they talked to staff to decide if there were sufficient staff on duty, they had not identified that there was an issue with the number of domestic staff required to ensure the home was kept clean and free from infection. The registered manager had also not identified that medicine administration was not been carried out in line with national guidelines and staff training not being up to date.

Although the registered manager said that a senior member of staff was in the middle of undertaking a review of staff training, this had not been kept up to date prior to this review. This meant that some staff had not refreshed training within the recommended timescales.

This is a breach of regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The provider information return described 'We encourage our staff to voice their concerns or ideas to improve the service. We have an open door policy. Owners are in the home most days, and regularly lead the morning discussion.' Staff and visitors confirmed that both the providers were regularly at the home and were involved in its running. Comments included "[Providers] always looking for ways to improve." and 'The owner/manager is no-nonsense in her approach and fiercely protective of the people who live there and is a passionate advocate for them in their care needs."

Health and social care professionals as well as staff, visitors to the home and family members all described the providers and staff as committed to the care and welfare of people living at Alban House. Comments included 'There is very clear leadership from [registered manager]. She encourages staff to progress and develop their skills and she enables residents to make choices.' And 'I look forward to visits to Alban House because they make you feel welcome and are enthusiastic about providing a high standard of personalised care.'
The registered manager was supporting a care worker to develop the skills and knowledge required to

enable them to become the registered manager. A member of staff described the registered manager as "a really good mentor", explaining that they were also being supported to achieve a qualification in management.
The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

The registered manager and her deputy regularly worked alongside staff which gave them an insight into how staff worked with people. For example, during the first day of inspection, the registered manager supported people at lunchtime, working alongside staff. We observed the registered manager discussing the care of one person with a member of staff, giving advice on how to manage a particular situation.

A health professional commented "…[Registered manager] checked that care staff had completed the tasks allocated to them." Another health professional commented that there was clear leadership "from the manager or her deputy."
The registered manager and her deputy kept up to date with current practices and national guidance. For example, they described how they were involved in local manager networks and also attended dementia care home network group meetings.

The registered manager and her deputy had recognised the challenges of improving the service. For example they were working to improve the care records and were therefore undertaking a review of all the current care plans to address areas of concern.

People, their relatives and staff were empowered to contribute to improve the service. Minutes of staff meetings and resident meetings showed that they were able to discuss the home and suggest ways to improve it. The provider valued feedback and acted on their suggestions. For example staff described how they had suggested having a small trolley which had toiletries and confectionery which people could buy.

People benefited from staff who understood and were confident about using the whistleblowing procedure.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Peoples' medicines were not managed and administered safely. People were not protected from the risk of infection. Care was not always delivered to ensure that it supported people with individual risks. Regulation 12 (1) (2)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were put at risk of infection as some parts of the home were not kept clean and infection free. Regulation 15 (1) (a)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to audit and monitor the quality and safety of the home were not robust. Regulation 17 (2)(a) (b)