

# London Residential Healthcare Limited

# Albany Lodge Nursing Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

Our inspection took place on 6, 7 and 14 September 2016 and was unannounced. At the end of the first day we told the provider we would be returning to continue with our inspection.

At our last inspection during 24 and 25 November 2015 five breaches of legal requirements were found. This was because there had been a lack of contingency plans to deploy sufficient staff when required. Medicine procedures and records did not always keep people safe. The provider did not always consider people's mental capacity and follow procedures to make sure people were protected from abuse. Not all care and treatment met people's needs and reflected their preferences and systems and processes were not in place to identify and assess risk, health and safety and the welfare of people using the service.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. During this comprehensive inspection we found that the provider had followed their plan and the above legal requirements had been met.

Albany Lodge Nursing Home provides nursing care for up to 100 people over the age of 65, some of whom are living with dementia. It is a purpose built nursing home located over four floors all accessible by lift. At the time of our inspection 89 people were using the service. The manager had applied to the Care Quality Commission (CQC) to be a registered manager for the service.

A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

People's care records were in the process of being updated to focus on each individual. These now included details such as people's likes, dislikes, social histories and how they would like to be cared for. These were near completion at the time of our inspection. The service had also introduced bedside folders to help staff understand individual needs and preferences. These also contained essential information about people's daily care and checks to ensure people received the care they needed. However, we found some of this information was not completed at times or completed incorrectly. We spoke with managers about our concerns.

People told us they felt safe living at the service. They said staff were kind, caring and respected their privacy and dignity. Staff spoke with people in a kind and sensitive way. They were helpful and polite while supporting people at mealtimes to make sure people had sufficient amounts to eat and drink. People and their relatives were mostly positive about the food at Albany Lodge Nursing Home. Special dietary requirements were catered for and people's nutritional risks were assessed and monitored.

Staffing levels were adequate at the time of our inspection to help make sure people were safe. New systems had been introduced to ensure a flexible workforce. People, their relatives and staff told us staffing levels

had improved, however, there were still times when additional staff cover was needed. Managers were working on new ways to monitor staff numbers to further reduce the risk of inadequate numbers of staff deployed in the home.

The recruitment procedures were appropriate at the time of our inspection and any gaps in staff training had been identified.

We found improvements in the way people's medicine was being ordered and managed. People received their prescribed medicines at the right times and these were stored securely and administered safely by registered nurses.

People had access to healthcare services when they needed it and received on going healthcare support from GPs and other healthcare professionals.

The provider was aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. Improvements had been made in the way people's consent to care and their capacity to make decisions had been recorded. When a person was found to lack capacity the reasons for making decisions on people's behalf were clearly noted.

People's rooms contained personal belongings and items that were special or of personal value to them and improvements had been made in the signage used and the environment in the communal areas for those people living with dementia.

There was an activities programme at Albany Lodge. The activities staff tried hard to ensure people had the opportunity to be involved in meaningful pastimes to help stop them from feeling lonely or isolated.

Staff felt supported by managers and the provider. The provider had improved the quality assurance process in place that allowed them to identify issues and areas they could improve on.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to accurate record keeping.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

We found that action had been taken to improve the safety of this service.

Staffing numbers were adequate, improvements had been made to ensure a flexible workforce.

Improvements had been made in the way medicines were managed so people received their medicine safely.

People told us they felt safe at Albany Lodge. Staff had been trained to recognise and respond to abuse and they followed appropriate procedures.

We could not improve the rating for safe from the "requires improvement" question because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

**Requires Improvement** ●

### Is the service effective?

The service was effective. The provider knew the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. People's capacity to make decisions was recorded and when necessary, decisions were recorded when made in people's best interest.

Staff had received the basic training and had the skills they needed to deliver safe and appropriate care to people. People were supported to eat and drink sufficient amounts of well-presented meals that met their individual dietary needs.

People's health and support needs were assessed and this was reflected in care records. People were supported to maintain good health and access health care services and professionals when they needed them.

The service had undertaken improvements in the environment to better meet the needs of people living with dementia.

**Good** ●

### Is the service caring?

**Good** ●

The service was caring. Staff treated people with dignity, respect and kindness. They knew people's needs, likes, interests and preferences.

People using the service and their relatives were happy with the care they received. People spoke positively about staff and said they were kind and caring.

### **Is the service responsive?**

Some aspects of the service were not always responsive. The service had updated most people's care plans and improvements were ongoing to make people's care more person centred, however some people's care records were not always complete or were incorrect.

Activities were available so people could be supported to follow their interests and help prevent people from feeling isolated or lonely.

People and their relatives felt able to raise concerns or complaints and knew how they should complain; the service responded to and investigated complaints appropriately.

**Requires Improvement** ●

### **Is the service well-led?**

We found that action had been taken to improve the way the service was led.

Improvements in systems to monitor the safety and quality of the service people received had been made and results were used to improve the service. People's care records were not always accurate and up to date but work was continuing to monitor staff numbers and the accuracy of record keeping.

People and staff spoke positively about the managers at the service. Regular staff and managers meetings helped share learning and best practice so staff understood what was expected of them at all levels.

We could not improve the rating for well-led from the "requires improvement" question because to do so requires consistent good practice over time. We will check this again during our next planned comprehensive inspection.

**Requires Improvement** ●

# Albany Lodge Nursing Home

## **Detailed findings**

### Background to this inspection

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

Prior to our inspection we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, previous inspection reports and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. We also looked at the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make.

Our inspection took place on 6, 7 and 14 September 2016 and was unannounced. At the end of the first day we told the provider we would be returning to continue with our inspection.

The inspection team consisted of two inspectors, a specialist advisor who was a registered mental health nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 17 people who used the service and 12 relatives. Due to their needs, some people living at Albany Lodge were unable to share their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the home manager, the nursing manager, the operational support manager and 14 members of staff. We observed care and support in communal areas, spoke with people in private and

looked at the care records for 20 people. We reviewed how medicines were managed and the records relating to this. We checked five staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

## Is the service safe?

### Our findings

At our last inspection we found Albany Lodge had suffered severe staff shortages and had found it hard to find cover for staff annual leave and sickness. We had been concerned that there was a lack of contingency planning and robust procedures that allowed sufficient numbers of suitably qualified, competent and skilled staff to be deployed at all times and to cover emergencies and routine work at the service.

Although people and their relatives thought things had improved they were still concerned as the service was short staffed at times. Four people told us they thought there were enough staff and six people thought more staff were needed. Their comments included, "I think there is enough staff", "We could do with a few more [staff]", "There is not enough, they [staff] take ages to answer the call bell" and "Not really enough staff, Sunday is terrible and night staff are very pushed."

The manager had changed the way staff were rostered so there was a more flexible staff base allowing for movement between floors. Additional staff cover was provided by those staff off duty and willing to work extra hours, the manager explained this staff pool had recently increased because the provider now had three nursing homes in the area and staff were able to work across all sites.

During this inspection we observed staff were visible and on hand to assist people when they were needed and that there was enough staff on duty to meet people's basic needs and keep people safe. Staff told us the team appeared more stable, however, there were still times when they were unable to get cover for sickness. They told us this was more frequent at weekends. Comments included, "Staffing levels have improved, it's on-going. There are days when we are short staff but we cope", "Staffing is OK, it's just trying to find cover" and "There are enough staff, its good now, there is some sickness but mostly we find cover."

We looked at staffing rotas but these did not always equate to the information contained in the staff allocation sheets or on the staff timesheet system. Often staff shortages or changes were not recorded on the duty rotas. We saw that people had dependency needs assessments in their care records but we were unable to see how this was used to calculate the numbers of staff needed on each floor. The nursing manager explained staffing numbers were assessed using both the number of residents and from the information gathered from staff on each floor during regular weekly meetings.

An on-going recruitment program had just employed eight new members of staff and we noted that two new staff members were on inductions during our inspection. To ensure there were adequate staff on duty, annual leave was monitored closely and staff numbers including any sickness was identified daily via morning walk rounds and at a weekday 10 at 10 meetings. Staff allocation sheets were completed the day before so managers could make arrangements for staff cover. We noted that the 10 at 10 meetings and allocation sheets were not available over some weekend periods. This meant there was not an easy process in place for the manager to monitor staffing numbers over the weekend and look for trends in staff absence. We discussed this with the manager who agreed to look at the way staff numbers were recorded over the weekend so that any staff shortage would not impact on people's care. Although we had seen improvements in staffing levels we could not improve the rating for safe from requires improvement

because to do so requires consistent good practice over time. We will check staffing levels again during our next planned comprehensive inspection.

At our last inspection we were concerned about the way medicines were managed on three of the floors we looked at. During this inspection we found improvements had been made in all aspects of medicine management. We looked at the ordering, receipt, storage and disposal of medicine and found the procedures to be in order. We found people were receiving their medicine at the right times. All medicines were stored securely and administered by registered nurses. Where people were taking prescribed anticoagulant's (medicines that prevent blood clots), they attended their clinic regularly for scheduled blood tests to tell how much medicine they should take and when, and records confirmed this.

Protocols for 'as required' medicine were in place, giving guidance to staff on the type of medicines to give and when people needed to receive them. We found no recording errors on medication administration records we looked at and saw that daily audits identified any errors that may have occurred.

Some people using the service received covert medicines. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving them.) Most residents who received their medicine covertly had paperwork in place showing why this decision had been made, these decisions had been signed by the GP and the pharmacist. However, in two cases we did not see a mental capacity assessment or a best interest decision in place to support the decision making process. Staff were knowledgeable about how they gave people their medicine covertly for example in food or drink, however, we noted this information was not always recorded or easily accessible for new members of staff that may need to know so people could receive their medicine in the most appropriate way. We discussed this with the nursing manager who agreed they would make the necessary amendments to people's records.

People told us they felt the service was a safe place to be. One relative told us, "When I walk out of here I know [my relative] is safe, happy and well cared for."

The service had a safeguarding policy and a copy of Pan-London's "Multi Agencies Procedures on Safeguarding Adults from Abuse" was available in the office. Staff knew what to do if safeguarding concerns were raised. This included reporting their concerns to managers within their organisation, the local authority's safeguarding team and the CQC. One staff member told us, "Staff are quick to report anything, really quickly." Managers and staff we spoke with knew about the provider's whistle-blowing procedures and we saw they had access to contact details for the local authority's safeguarding adults' team. We looked at records which confirmed most staff and managers had received safeguarding training. The service was also working closely with the local authority to improve staff awareness around reporting safeguarding issues.

Risks to people were identified with comprehensive management plans. These included dependency needs, falls, continence, manual handling and nutrition and were specific to individual needs. For example, the care records of one person who was at risk of aspiration contained guidance to staff on the type of food the person should have, their sitting position while eating and how staff should best assist the person with their meals. The service used recognised tools such as Waterlow, this gives an estimated risk for the development of a pressure ulcers, and the Malnutrition Universal Screening Tool (MUST) which is a screening tool to identify adults who are malnourished, at risk of malnutrition (under nutrition), or obese. These tools helped to develop people's care plans. Risk assessments were reviewed monthly and updated with any changes in people's needs and staff shared information regarding people's risk at shift handovers. Staff we spoke with had a good understanding of how to keep people safe and the risks people faced. We heard examples of the

positive strategies staff used to manage situations where people became upset or an anxious.

The building and surrounding gardens were adequately maintained to keep people safe. The water supply and utilities were regularly inspected and tested. The service was fully accessible and of a suitable design and layout to meet the needs of people living there. The service had procedures in place which aimed to keep people safe and provide a continuity of care in the event of an unexpected emergency such as, a fire or boiler breakdown.

The service followed safe recruitment practices. We looked at the personnel files of five members of staff. Each file contained a checklist which clearly identified all the pre-employment checks the provider had obtained in respect of these individuals. Staff records included up to date criminal record checks, at least two satisfactory references from their previous employers, photographic proof of their identity, a completed job application form, a health declaration, their full employment history and proof of their eligibility to work in the UK (where applicable).

## Is the service effective?

### Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the process of assessing people's capacity, the decision to act in a person's best interest and details of any applications for DoLS were not always clear or were sometimes missing.

During this inspection we found improvements had been made to people's records and these now included information about people's consent to care and if they had the capacity to make decisions. When people lacked capacity to make certain choices we noted records were kept of most decisions made in people's best interest. Where applications had been made to the Local Authority for DoLS the manager of the service kept detailed records of those applications that had been sent, those returned to the service and those authorisations due for review.

Staff told us they had received enough training to care for people and meet their needs. Staff told us about their inductions when they first started working at the service and the program of on going training they received. The nursing staff we spoke with told us how the service was supportive with their nursing revalidation to maintain their registration with the Nursing and Midwifery Council (NMC).

The provider had a training and development programme that included a structured induction and mandatory learning for all new staff. The induction incorporated the Care Certificate which is a set of standards that have been developed for support workers to demonstrate that they have gained the knowledge, skills and attitudes needed to provide high quality and compassionate care and support. It covers 15 topics that are common to all health and social care settings and became effective from 1 April 2015.

An electronic training and development plan was used to monitor training provision for the staff team and identify any gaps. We noted those areas where gaps in training had been identified. Training had been booked for staff to address these gaps, for example, infection control training had been booked for October 2016. The service worked closely with the local authority care home support team to provide training to staff and we saw they had recently attended a relatives meeting to speak about the dignity and choice training they were offering. Staff were encouraged to undertake their NVQ (National Vocational Qualification) now

replaced by QCF (Qualification and Credit Frame) and we saw 20 staff had recently enrolled. The nursing manager spoke about future training that had been booked to help empower staff. They also explained how they were working closely with outside organisations such as the London Ambulance Service to help with workshops to inform staff about subjects such as hospital transfers.

Staff told us they had regular supervision and appraisals, we looked at records and spoke with the nursing manager about a recent local authority inspection where it had been identified that some supervisions were too generic. Plans were in place to improve the supervision process, by incorporating competency checks, reflection and training.

Most people told us they enjoyed the food provided to them and knew there was a choice of food available. When asked for their views comments included, "I have a choice of two things", "[Food] is not too bad but sometimes I don't like it", "Not too bad, if I don't like it I don't eat it" and "I don't eat much but the puddings are nice."

We spoke with the head cook who explained how they catered for those people who required a fortified diet or those that preferred finger food to snack on at intervals throughout the day. They told us how they tried to make pureed meals more appetising for people by keeping each food type separate on the plate and using moulds so food would be in different shapes, such as a carrot or a butterfly and we observed these being used at lunchtimes.

Our observations on one dementia unit, during lunch showed that people's needs were met and staff worked hard to achieve this. One person was sitting in an armchair and seemed to be waiting longer for their lunch than other people. A member of staff explained that this person took a long time to eat their lunch and staff could spend more time attending to them, after people who ate quicker, with less support required had been served. This enabled staff to provide the level of support the person needed to enjoy their lunch, at their own speed. Staff provided meals and support for people in a skilled and caring way. They made sure that people got the meals they wanted and had enough to eat. There was some spare ice cream and one staff member said, "I know who would like that." They asked the person who said they would like it. Although staff were aware of the size of meal portions people preferred they also asked them again to make sure. One person said, "You couldn't have got more in it." They were referring to their pudding and smiled.

The care plans contained sections for health, nutrition and diet. These included completed and regularly updated nutritional assessments and weight charts. There was also information regarding the type of support people required at meal times. Staff said any nutritional concerns were raised and discussed with the person or their family and their GP if necessary. Nutritional advice and guidance was provided for staff as part of their training. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. People were regularly supplied with drinks to keep their hydration levels up and encouraged and supported to drink.

People had access to health care services and received on-going health care support where required. The nursing manager explained people were registered with one of six GP's who covered the service. GP contact numbers and the days they visited were available on each unit to help staff coordinate care for people. Various methods were used to exchange information including daily 10 at 10 meetings, weekly nursing forums and staff handovers at each shift. We saw that the outcomes of GP consultations and medicine reviews were recorded. There were also records made of follow up actions required such as referrals to other health or social care professionals such as dieticians, speech and language therapist and the tissue viability nurse. People were supported to keep well and had access to the health care services they needed. We spoke with a healthcare professional who regularly visited the service. They told us that the management

team and staff were very supportive of the work they did with people who used the service.

During our last inspection we made recommendations that the service referred to current best practice guidance around making the environment friendlier for those people living with dementia because we were concerned that the signs, environment and decoration may not help to meet the needs of people living at the service. Since our previous visit improvements had been made, clear pictorial signage had been introduced in communal areas as well as people's private accommodation. An example of this was the pictorial signs outside toilets that enabled people to recognise what they were. The signs were also used on the doors of people's en-suite bathrooms. There were also pictorial menus to enable people to choose what they wished to eat.

The dining area on the second floor had a sensory area with flower troughs, artificial grass and a water feature that provided a tranquil atmosphere for people using the service and there were plans to introduce a similar feature for people on the first floor to enjoy. One of the sitting rooms was also used for sensory sessions for people using the service. The sessions took place in a manageable group size so that staff could give people the support they required and enhance their experience. The sitting area had arm chairs arranged in a semi-circular way. This enabled people to identify that there were other people present and took into account their limited lateral and peripheral vision. This was further supported by chairs that did not have large wing backs. This meant people could be more aware of other people sitting beside them. There were activities and aids available that stimulated people to take part in doing things they had previously done on a daily basis. For example, in one lounge there was a clothes line with pegs that people could hang clothes on and dish towels for washing up.

## Is the service caring?

### Our findings

People told us staff were kind to them and listened to what they had to say. One person told us, "[Staff] are extremely caring, it's a friendly and kind environment". Another person said, I like it here, it's pretty good". All the relatives we spoke with had concerns around the number of staff on duty and felt there could be more at times but they all spoke positively about the staff who cared for their relatives. Comments included, "Patience and care have been applied to [my relative]", "[Staff] who work here are very good" and "All the nurses are excellent, some staff are angels."

We observed staff over all floors of the service and found the staff approach to people was friendly and caring. Staff were polite, encouraging, treated people with respect and addressed them in the way they preferred. They were attentive to people's needs and there was a lot of laughter and good natured banter during our visit. We observed staff used clear speech and explained to individuals what was happening. One person became agitated and started to shout and pull at their hair, staff promptly responded by reassuring them and rubbing their back. This had a positive impact for the person who visibly relaxed once they had the staff member's attention.

Staff spoke about people in a caring way, they told us, "I like to talk to the residents and their family, it's very interesting. I like to visit and chat and make sure they are safe. I like to think I've done my best today", "I like my residents, it's my passion of caring for them. I like to come to work" and "The best thing is the residents, when they are happy to see me."

People had comfortable accommodation that offered privacy and comfort, and those who chose to had personal possessions and family mementos displayed in their rooms. Staff respected people's choice for privacy as some people preferred to remain in their own rooms and not to participate in planned activities. People told us staff respected their privacy and dignity and gave us examples of how they did this. We observed staff respecting people's privacy and dignity during our inspection, for example, a screen was used while staff transferred one person using a hoist in a communal area. Staff explained the ways they respected people during personal care and the nurses we spoke with explained how they observed staff to ensure they maintained people's dignity and were respectful while assisting people throughout the day.

People's care records included information about how people preferred to be supported with their personal care. For example, what time people preferred to get up in the morning and go to bed at night and whether they preferred a shower or a bath. Staff knew people well and were able to tell us about people's individual needs, preferences and personalities. One member of staff told us how they talked to and reassured one person when they became angry or upset. Other members of staff told us how they referred to the new bedside folders when people were new to them to find out the information they needed to know to care for that person.

Albany Lodge had recently passed a reaccreditation from the National Gold Standards Framework Centre in End of Life Care. This is a system of training and accreditation in end of life care which enables front line staff to provide a 'gold standard' of care for people nearing the end of life. We looked at examples where people's

end of life care needs were considered and recorded and staff had worked with relevant professionals to make sure people's wishes were respected. Information and requests from people and their relatives were recorded including information about people's religious and cultural beliefs, where they wanted to be and who they wanted to be with them. One relative who also worked at the service told us how their family member had been a resident and had been very happy. They explained when they passed away how staff had helped with the funeral arrangements and had a gathering at the home after the funeral. They told us, "They really helped me, fantastic... [The managers] often ask how I am, I don't think they could do any more."

## Is the service responsive?

### Our findings

At our last inspection we found people's care records contained information regarding their health needs and any associated risks but there was very little information about the individual, such as life histories, likes, dislikes and social interaction needs so people did not always have care or treatment that was personalised specifically for them. This meant that it was hard for staff to react effectively to people's needs, distress and any aggressive behaviour that people may display, outside of their physical needs.

During this inspection we found improvements had been made and were ongoing. The service was in the process of updating people's care records, making them more person centred and reflecting individual preferences. We viewed some improved care records and noted people and their families had been involved in the planning of care and helped contribute towards people's likes and dislikes. For example, one person liked to wear a certain make of face cream, and another person liked staff to leave the bathroom light on during the night. We noted the new system in place had a clear structure for regular reviews. At the time of our inspection some people's records had not been updated or staff were in the process of gathering further information. The nursing manager confirmed they were overseeing the introduction of the new care records and hoped they would all be complete by the end of October 2016.

On the dementia floors we noted some people had little or no personal information recorded, the manager explained it had been difficult to gather this information from relatives or when there were no relative. We discussed other sources of information that was readily available that could be used such as staff knowledge. For example, one person spoke to us in detail about their past life and working history but none of this was recorded in their records. The manager agreed to discuss this with staff with a view to recording staff knowledge in addition to that already provided.

The nursing manager had also introduced bedside folders for each person using the service. These contained information that was useful to staff and included a brief summary of people's specific needs and preferences, their diagnosis and where possible people's history and interests. People's mobility was noted together with guidance for staff on how to transfer when necessary. Also within the files was important information about day and night checks conducted by staff, details of personal care received and when appropriate turning charts and details of meals and drinks. Staff we spoke with all told us they found the new bedside folders useful. One staff member told us, "The bedside folder has everything there, we can read it and get to know the person...it's really useful when we move between floors." Relatives we spoke with also found the information useful. However, three relatives said they had concerns that staff were not completing the records appropriately. We saw examples where one person's hourly checks recorded them as sleeping solidly for 12 hours one night; they were due their medicine in the evening and could not have been asleep to take this. We checked the person's medicine records and confirmed the medicine they needed had been given as prescribed in the evening. This indicated that the hourly night check had been incorrectly completed. Two people's turning charts were not completed or were not clear. We saw gaps in people's logs for personal care, for example one person had gaps on two days indicating that no personal care had been received that day. One relative spoke to us after our inspection and explained how their relative's personal care log had been pre populated in advance, they explained to us they felt unsure that

any personal care had been given as items ticked as done such as cleaning and fitting dentures had not been completed. We spoke with the manager and showed examples to them, they told us they were aware there were still issues with the new system and they were working hard to address issues with care staff. We were concerned because these records did not accurately reflect the care given to people so could not be relied upon to give the information relatives, staff and managers needed to ensure people received the care they needed when they needed it. The failure to record accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed three activities coordinators with the view to having two on duty throughout the week. Over the three days we were at the service we observed the activities and entertainment provided for people, these included a visiting musician, singing and dancing. One day was quite warm and the entertainment moved into the garden area where people sat in the shade and enjoyed a cup of tea and an ice cream. We were told one to one time was given to those people who were unable to or did not wish to leave their rooms.

People told us about the activities at the service and the things they liked to do, one person said they liked to play dominoes and go into the garden while another told us they liked to listen to music and play cards. People spoke of outings they had enjoyed and birthday parties, one person told us how staff helped them read their prayers.

Two people told us they preferred not to get involved in the activities and two other people told us of things they would like to do such as going into the garden and swimming. One relative we spoke with explained they would like to see staff engage with people more they said, "[Staff] need to increase peoples mobility and keep their mind stimulated as well as their muscles active." We spoke to the manager who agreed to look at ways to further improve the quality of people's lives when they were at risk from social isolation and did not wish to or were unable to leave their rooms.

People were able to maintain relationships with people that matter to them. Many relatives we spoke with visited the service on a regular basis, all felt there was no restriction on them doing so. One relative told us how they had met all the staff caring for their relative including the night staff, they said, "There are no restrictions on visiting, I sometimes leave at 9pm and I walk in at any time."

People we spoke with told us they or their relatives would complain or comment on issues they were not happy with. One relative told us "I feel I can speak to anyone about concerns...we were not happy with [my relatives] first room so they moved her". We spoke with the manager and nursing manager about the number of complaints the service had received, both felt these had reduced in recent months. We looked at the process for recording, logging and acting on complaints and found clear procedures were in place. The manager said they tried to deal with issues as soon as possible and we saw records of conversations with relatives and action taken by the service to address issues and concerns raised. The nursing manager confirmed that any lessons learnt from complaints were discussed with staff to reduce any likelihood of the same happening again. Complaints were also logged and monitored at provider level.

## Is the service well-led?

### Our findings

During our last inspection we found that although regular audits were undertaken to assess internal standards at the service, not all audits identified problems or issues so it was hard to see how managers could monitor progress and improve standards. We were also concerned the provider had not introduced sufficient emergency measures to ensure people's safety during periods of staff sickness and absence.

During this inspection we saw improvements had been made. For example, at the last inspection we saw medication errors had not always been identified, during this inspection we noted daily audits were completed with any errors being identified, acted upon and flagged for future learning. The service had recently instructed a new pharmacy to work with them and commissioned a full medicine audit to identify any further issues that needed addressing. We had sight of the audit and the recommendations made. The manager was due to have meeting with the pharmacist to discuss the way forward shortly after our inspection.

We saw the managers had looked at ways to address the staffing shortages that had previously occurred because of staff absence. The nursing and home managers explained how annual leave and people's sickness were managed more effectively and that a new system of staff allocation had been introduced so all floors would be covered by a more flexible staff base. Feedback from relatives and staff suggested that system was working however there were still times when staff cover was limited especially over the weekends. We discussed this with the manager who agreed to review the management information available to him over weekends so he could better monitor staff shortages.

Since our last inspection the service had restructured its management team and had employed a new home manager to work alongside the existing nursing manager. The home manager had applied to the CQC to become a registered manager. People we spoke with and their relatives knew who the new management team were and were positive about the changes made so far. Comments included, "The managers are lovely people, always very agreeable", "I would rather speak to managers as changes happen from in house...I'm impressed with the changes I've seen", "The manager has done a marvellous job and helped improve staff, they are more friendly and there is more cooperation" and "[The manager] is such a lovely man and [the nursing manager] gives the place a buzz."

A program of regular audits were undertaken by the managers to monitor people's health needs these included information about wound management, bruises, skin integrity, falls, hospital admissions, call bell audits, and analysis of accidents and incidents. Weekly clinical review meetings were held to discuss identified risks and trends with clearly identified actions and the person responsible for completion. The nursing manager explained how these meetings were inclusive of all care staff not just nurses with the aim to empower all staff to be responsible for peoples care and to feel confident in reporting any issues or changes in peoples care needs.

Staff told us they felt supported by the management at Albany Lodge and that they had seen improvements. Their comments included, "Staff support is now good,[the nursing manager] is an absolute star", "[The

nursing manager] is always there for the staff, anything you don't know [either manager ] will help, I find them very approachable" and " Staffing is improving, [the managers] are bringing in more staff but I don't know if this will help."

Relatives' meetings were conducted periodically to gain the views of people and their relatives. We saw records of these and noted where concerns or suggestions had been raised they had been addressed. For example, relatives suggested their family members might enjoy music in one of the lounges; this was later actioned by the manager. One relative told us about a relatives meeting they had attended where an outside speaker had spoken about up and coming training in dementia, they told us, "I really hope this will improve staff attitude and knowledge."

Regular staff meetings were held. Senior staff including nurses, housekeeping and maintenance attended a daily meeting with the manager. This provided the opportunity to discuss the needs of people who used the service, share information, raise any concerns and identify areas for improvement. Staff meetings helped share learning and best practice so staff understood what was expected of them at all levels. Minutes from the staff meetings covered information such as infection control, medicine administration, staffing issues and catering.

All accidents and incidents which occurred in the service were recorded and analysed. This enabled the service to identify any patterns or trends in accidents. It also gave an indication of where people's general health and mobility was improving or deteriorating.

Registered persons are required by law to notify CQC of certain changes, events or incidents at the service. Our records showed that since our last inspection the registered provider had notified us appropriately of any reportable events.

Both managers and their staff had worked hard to make improvements at the service the results of which could be clearly seen during our inspection. However, both managers acknowledged that there was still work to be done and improvements to be made especially in areas around record keeping and the monitoring of staff numbers. We could not improve the rating for well led from requires improvement because to do so requires a registered manager to be in place and we also need to see consistent good practice over time. We will look at well-led again during our next planned comprehensive inspection.

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 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Records were not always complete or accurate in respect of each service user. Regulation 17 (2) (c)
Treatment of disease, disorder or injury	