Albemarle Court (Nottingham) Limited

Albemarle Court (Nottingham) LTD - T/As Albemarle Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected the home on 13 June 2017. The inspection was unannounced. Albemarle Court Nursing Home is owned and managed by Albemarle Court (Nottingham) Limited and it was the first inspection following the provider's legal entity change. The home is situated in the Woodthorpe area of Nottingham and offers accommodation for up to 31 people who require personal or nursing care. On the day of our visit there were 24 people living at the home.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received their medicines as prescribed, however staff had not always signed to say people had taken their medicine.

People were protected from abuse and avoidable harm and staff knew how to recognise signs of abuse and how to respond to concerns.

People's care and support was planned and delivered to protect them from harm and staff followed information in care plans.

People were supported by enough staff to ensure they received care and support in a timely manner.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions and staff knew how to act if people did not have the capacity to make decisions in line with the principles of the Mental Capacity Act 2005.

People were supported to eat and drink and maintain their health and well-being. Staff were monitoring and responding to people's health conditions.

People lived in a home where staff listened to them and were responded to by a staff team who cared about the individual they were supporting. People were supported to enjoy a social life and take part in activities they enjoyed.

People were involved in giving their views on how the home was run and there were systems in place to monitor and improve the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

People received their medicines as prescribed, however staff had not always signed to say they had been given. The mobile medicine storage trolley was left unsecure when staff gave people their medicine. People were kept safe from the risk of abuse and staff knew how to respond if they had any concerns. There were enough staff to provide safe care and support when people needed it.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision to care for people. Decisions made on people's behalf were protected under the Mental Capacity Act 2005. People's health was monitored and responded to appropriately.

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff in a way that they preferred. Staff responded to people in a kind and understanding manner. Staff respected and promoted people's independence and their right to privacy.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support and views of their loved ones were sought when people were unable to communicate their needs and preferences. People were encouraged and supported to take part in activities and follow their interests. People were supported by staff who knew how to respond if issues arose.

Is the service well-led?

Good

The service was well-led.

People were involved in giving their views on how the home was run. The management team were approachable and there were systems in places to monitor, assess and improve the quality of service provided to people.

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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.

We inspected the home on 13 June 2017. The inspection was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection visit we reviewed information we held about the service. This included the provider's registration application, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who lived at the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what it does well and improvements they plan to make.

During the visit we spoke with four people who lived at the home, three visiting relatives and a GP who was visiting the home.

We spoke with two members of care staff, the activities coordinator, the registered manager and a director of the registered provider. We looked at the care records of four people who lived at home, medicines records of seven people, staff training records, as well as a range of records relating to the running of the home including audits carried out by the registered manager and registered provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Both people we spoke with told us that staff gave them their medicines when they were supposed to. One person said, "They bring my medicine to me and stay with me whilst I take it." A relative we spoke with told us they were happy with the way staff managed their relation's medicines.

Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines, and were reviewed on an annual basis.

However, we found that medicines records were not always effectively maintained. People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. We looked at people's medicine administration records (MARs) and found seven gaps where staff had not signed to say medicines had been given to people. We checked these medicines and the number of each remaining indicated that the medicines had been given but staff had not signed to confirm they had. This increased the risk of medicines being given twice. The provider told us the issue would have been picked up in the next monthly audit. MARs should be signed at the time the medicine is given in line with national guidance.

We observed medicines being administered. We saw staff checked against the MARs for each person and stayed with people until they had taken their medicines. However, the member of staff left the keys in the medicines trolley whilst they administered people's medicines on several occasions. This meant there was the risk people could have had unauthorised access to the medicines. We brought this to the attention of the provider, who dealt with this issue immediately and informed staff that keys must not be left in the trolley.

People were protected from abuse and avoidable harm. One person we spoke with told us they felt safe, and a relative said, "I know [person's name] is kept safe here".

Staff knew how to recognise signs of abuse and report it. Staff had received training in safeguarding (protecting people from the risk of abuse) and they were able to tell us the different types of abuse. Staff knew how to escalate concerns internally via the registered manager and the provider as well as externally to organisations such as the local authority or the police. Staff were confident that any concerns they raised with the registered manager would be dealt with straight away. One member of staff told us, "If I need to, I would whistle-blow," which is a term used for employees being able to raise concerns about people's care anonymously if they wished.

The provider had an effective recruitment system in place. We looked at recruitment files of four staff members. All files showed relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, a DBS check helps employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment.

People were protected from risks relating to their care and support. Risks to people were assessed and staff had access to information about how to minimise the risks. For example, one person was at risk of developing sore skin. The risk had been assessed and there was a written plan to reduce the likelihood of the person's skin breaking down. We saw pressure relieving equipment was in place and staff supported the person to change position regularly to minimise skin damage.

People were living in a safe, well maintained environment and were protected from the risk of fire. We saw there were systems in place to assess the safety of the home such as fire risk and the risks of legionella which is known to cause respiratory diseases. Staff had been trained in relation to health and safety and how to respond if there was a fire in the home. Doors leading to stairwells were locked to reduce the risk of people falling down the stairs and people were able to move between the floors of the home via passenger lifts.

People received the care and support they needed in a timely way. We saw there was always a member of staff available if people needed support. On the day of our visit we observed there were a number of staff readily available to meet the requests and needs of people.

The provider told us staffing levels were increased based on the number of people living at the home and the level of support they required. Staff we spoke with said they felt there were enough staff to meet the needs of people who lived at the home and keep them safe.

Good

Is the service effective?

Our findings

People were supported by staff who had completed training to meet their needs. Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support the people who lived at the home. We saw records which showed staff had been trained in various aspects of care delivery such as safe food handling, moving and handling people and infection control. Training was also given in relation to the individual needs of people.

The provider made sure people were supported by staff who had the skills and knowledge they needed when they first started working in the home. Staff were given an induction and worked alongside a senior carer until they had completed their mandatory training and felt comfortable supporting people on their own.

Staff had undertaken national qualifications in care and the provider told us that new staff were completing the care certificate. The care certificate is a nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. Staff we spoke with were knowledgeable about the systems and processes in the home and about how to provide safe and effective care.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision with management and were given feedback on their performance and we saw records which confirmed this.

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 were supported to make decisions about their care on a day to day basis. We observed people decided how and where they spent their time and made decisions about their care and support. We asked one person who made the decisions about their daily life and they said, "I can do what I want. I do have help to get dressed, but they (the staff) ask me what I want to wear each time. Sometimes I can't be bothered to choose, but they always make me look nice."

People were supported by staff who had a good knowledge and understanding of the MCA. The staff and manager we spoke with had a good level of knowledge about their duties under the MCA and how to support people with decision making. People's support plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's

decision had been made which ensured the principles of the MCA were followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider 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 provider and registered manager had made applications for DoLS where appropriate. For example, one person had been assessed as requiring support from staff if they went out into the community and they were not free to leave the home alone. There was an up to date DoLS authorisation in place for this person. The provider had also made further DoLS applications for other people to ensure that they were not being deprived of their liberty unlawfully.

People had their nutritional needs assessed and were supported to eat and drink enough. We spoke with people about the food and they told us they had enough to eat and we observed people had access to food and drinks when they wanted. We observed staff regularly offered drinks and snacks to people on the day of our visit.

People were supported with their day to day healthcare. People were supported to attend appointments to get their health checked. We saw that if people were unable to attend appointments, the provider had arrangements in place for health professionals to visit people at the home. One person we spoke with said, "I have seen the GP when I was poorly and I also see the Chiropodist." A relative said, "I regularly see the GP and the district nurses visiting here."

Staff sought advice from external professionals when people's health and support needs changed. For example staff had involved an occupational therapist for one person when their mobility had changed and we saw that the therapist observed how staff supported the person and commented, "The actions taken by staff is appropriate."

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home. One person said, "I like living here." We saw staff were kind and caring to people when they were supporting them. People looked relaxed and at ease with staff . We observed one carer chatting with a person for 15 minutes and the interaction seemed to comfort the person as we could see them smiling.

Staff we spoke with told us they enjoyed working in the home and one person said, "Everyone is nice here." Observations and discussions with staff showed that staff clearly knew people's needs and preferences. People's care plans documented their preferences for how they were supported along with their likes, dislikes and what was important to them. For example, one staff member said, "[Person's name] likes to sit by the window so they can look out." We saw that after lunch the person was assisted to sit by a window.

People we spoke with told us they got to make choices for example about when and where they ate, how they spent their time and what activities they did. We observed people's choices were respected on the day of our visit.

We saw people decided what to eat for lunch and options were written on a board. Staff told us the menu was on a five week rota but people could choose other meals if there wasn't anything they wanted. A relative told us, "I have never heard [person's name] complain about the food and they wouldn't keep quiet if there was a problem." The relative went on to joke about having to buy their relation a larger pair of trousers since they moved into the home as the food was so good.

People had opportunities to follow their religious beliefs. Some people had visits from members of their faith and arrangements were made for some people to attend their local place of worship.

We spoke with the provider about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. The provider told us no one in the home was using this service but information was available for them should this be required. We saw that the information was accessible and displayed on the wall within the home.

People were supported to have their privacy and were treated with dignity. We observed people were treated as individuals and staff were respectful of people's preferred needs. We saw that staff knocked on people's bedroom door before entering and they protected people's dignity when assisting them to transfer using a hoist. Staff sought the permission of the person they supported before they did things for them.

People were supported and encouraged to maintain relationships that were important to them. No one told us of any concerns about being able to visit the home. One relative said, "I visit several times a week, I always get offered a drink and the staff are a nice bunch."

Good

Is the service responsive?

Our findings

People and their relatives were involved in planning and making choices about their care and support. We saw that where people were able, they had been involved in planning their care and had signed their care plans. A relative we spoke with told us they felt involved in their relation's care and support and that staff kept them updated about any changes. The relative said, "If something happens before I come again, they (the staff) will phone me." We saw in people's care plans that staff had recorded people's preferences and how they would like to spend their day.

People were supported by staff who had information about their support needs. People were assessed prior to admission to check that their needs could be met with the staffing and facilities at the home. Care plans were written to give staff the information they needed to meet the needs of the individual. People's care records also contained a 'snap shot' of their support requirements which gave staff an overview of the support people required. For example, when people had difficulties in communicating verbally their care plans provided information as to the approaches staff should take to ensure they were given choices and their understanding was maximised.

We saw that the registered manager and the provider's care consultant completed a full review of each person's care on a regular basis. Care plans were adjusted to meet people's changing support needs, so that staff had access to up to date information to ensure they responded appropriately to people's needs.

People were supported to follow their interests and take part in social activities. The provider employed a dedicated activities coordinator who was responsible for engaging people in activities they enjoyed. A relative said, "The activities coordinator does a really good job, and keeps the people ticking over." We observed the activities coordinator interacting with people in a friendly manner and provided them with individual activities which people enjoyed. For example, we saw a person reading a motor cycle magazine, another was provided with a book about Britain, two people were completing a jigsaw, and two other people were trying to solve a Rubik's cube.

People knew what to do if they had any concerns. The people and relatives we spoke with told us they would speak to the registered manager if they had a problem or concerns. The provider told us, they spoke with people and their relatives when they visited the home to get feedback about the care, which also gave people the opportunity to discuss any issues they had.

The registered manager told us they had not received any complaints in the last 12 months and so we were unable to assess how well complaints would be responded to. However, staff were aware of how to respond to complaints and the registered manager had systems in place to deal with complaints if they arose. There was a complaints procedure on display within the home so that people would know how to escalate their concerns if they needed to.

Good

Is the service well-led?

Our findings

There was a registered manager in post and people knew who the registered manager was and we saw they responded positively to her when she was speaking with them. We found the registered manager was clear about their responsibilities and they had notified us of significant events in the home.

In addition to the registered manager, a director of the registered provider also worked in the home on a daily basis and was involved in the running and overseeing of the care and quality. A relative said, "I always see the director walking around the home and he often meets me at the front door when I come to visit."

People told us they were happy living in the home and a person said, "I like it here." Relatives also commented positively on the care and we saw in a recent thank you card that a relative described the home as, "First class." We saw that staff worked well together.

People, their relations and other visitors were given the opportunity to have their say about the quality of the home. There were meetings held for people who lived at the home so the provider could capture their views and get their suggestions and choices. We saw that quality surveys were sent to people, their relatives and visitors every year. The results of these were analysed and shared with people and an action plan was put into place for any areas which needed addressing. For example, one person commented that they felt people could do with lap tables beside the chairs in the lounge. We saw on our inspection that the provider had acted on the feedback and purchased more lap tables and people were using these to rest drinks and magazines on. We saw that the feedback was positive and people who completed the surveys were happy with the quality of the service provided.

People lived in an open and inclusive home. A relative said, "I think the management team are very approachable here," and that they would be available anytime they wanted a chat. Staff also had the opportunity to raise any issues or concerns at their regular staff meetings and the provider also used these to share important updates. For example, there had been a recent national news coverage regarding people using flammable skin creams and fires. We saw that the provider had communicated this to staff and reminded them of the risks especially for people who smoke so that staff could ensure the safety of people. Staff we spoke with told us they felt the home was well run. In the annual staff survey, 95% of staff said the management team were good or very good.

People could be assured that the quality within the home would be monitored. There were systems in place to monitor the quality and safety of the home. We saw that accidents and incidents were reviewed to see if there were any trends or patterns and whether any action needed to be taken. There were audits carried out on care records to ensure these were up to date. The registered provider also carried out audits in relation to the environment and the safety of the home. A weekly spot check took place that looked at care plans, the kitchen, and people's rooms to ensure standards were maintained between full audits. The director told us that the issues we raised about the gaps in people's MAR charts and key's left in the medicine trolley would be communicated to staff to remind them of the importance of following safe medicine administration as it would reduce the risk of it happening again.