Alban Quality Care Limited

Alban House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Alban House on the 2 and 23 May 2018. The first day of inspection was unannounced; we arranged the second day of inspection before we visited.

Alban House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 23 people in one adapted building.

At the last inspection in January 2017, we rated the service as requiring improvement. This was because the home was not fully safe, effective and well-led. We found three breaches of the Health and Social Care Act 2008 (Regulations 2014). This was because people's medicines were not managed and administered safely; people were not protected from the risk of infection; care was not always delivered to ensure it supported people with individual risks; parts of the home were not kept clean and infection free and systems to audit and monitor the quality and safety of the home were not robust.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Is the service safe; is the service effective and is the service well-led?

The provider submitted an improvement action plan to address these concerns, stating what they intended to do and when this would be achieved. At this inspection we found improvements had been made so all the regulations had been met in respect to the breaches found at the previous inspection.

One of the providers was also the registered manager. 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.

At this inspection, we found the registered manager did not always set a good example as a role model to staff. We also found the provider had not followed the requirements of the regulations to display the rating from their last inspection on their website. We therefore rated the Well-led domain as requiring improvement.

A deputy manager was being trained to run the home by the registered manager. The registered manager had introduced new systems and processes with the support of staff. These had helped to improve the quality and safety of the care provided. The deputy manager was very well thought of by people living at Alban House, by the providers and by staff.

Care records reflected the care people needed to support them with their risks, needs and preferences. Staff knew people really well and were able to describe the care and support they needed. People said staff were kind and helpful. Throughout the inspection we observed numerous interactions where staff showed kindness and respect to people.

Activities were offered both within the home and in the community to support people with maintaining their interests.

People said they liked the food, which was freshly prepared. Staff took time to ensure people had a meal of their choice. This included supporting people who needed help to eat and drink. People were offered drinks to keep them hydrated.

The home was clean and well maintained. There were systems in place, which staff followed, to ensure a safe and infection-free environment. People's bedrooms were individually decorated and furnished according to their preferences.

Medicines were received, stored, administered and disposed of safely. Medicine administration records and other records relating to medicines were completed accurately.

Staff were recruited safely. Staff undertook an induction to introduce them to the service and ensure they had the knowledge and skills to support people safely. Staff were supported to refresh their knowledge and skills and also take nationally recognised vocational qualifications.

The staff had been trained in the Mental Capacity Act (2005) and understood their responsibilities in relation to the Act. Staff also understood how to keep vulnerable people safe from the risks of abuse.

Health and social care professionals said staff contacted them appropriately. Where the professionals gave advice about a person's care, there was evidence that staff followed this.

There were systems in place to monitor the quality and safety of the home. This included the service improvement plan, which had been drawn up.

There was a policy and procedures to deal with complaints. People said they had not needed to complain. No complaints had been received since the last inspection.

We found two breaches of regulations; firstly, as people were not always treated with dignity and respect and secondly because the provider had not displayed their ratings from the previous inspection on their website as they are required to do. We also made a recommendation that the service should consider how to support people with dementia in terms of their environment.

This is the second consecutive time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risks of infection

Systems and processes ensured that people were safeguarded from abuse.

Lessons were learned when things went wrong. These lessons led to improvements to systems.

Risks to people were considered and steps taken to reduce the risks while maintaining people's independence as far as possible.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people and understood the support they needed.

Staff had been trained when they first joined the home and continued to receive training to keep their knowledge and skills up to date.

People were supported to eat healthy food which they enjoyed.

Where people had health needs, staff involved health professionals to ensure these were managed effectively

Is the service caring?

Good

The service was caring.

Staff showed compassion and care for people.

Staff involved people in decisions about their care as far as possible.

Staff respected people's right to privacy.

Is the service responsive?

Good

The service was responsive.

People received care which was personalised and met their needs.

Care plans were reviewed and changed when people's risks needs or preferences altered.

There was a complaints policy and procedure. No complaints had been received since the previous inspection.

Is the service well-led?

Requires Improvement

The service was not well-led as the providers were not always good role models for staff.

The providers had failed to meet the requirements in terms of displaying the previous inspection rating on their website.

There were quality assurance and safety checks and audits carried out.

Where improvements were needed, action was taken to address these in a timely manner.

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.

The first inspection day took place on 2 May 2018 and was unannounced. The first day of inspection was carried out by two Adult Social Care inspectors 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.' Their area of expertise included mental health and autism.

The lead inspector returned to the service on the 23 May 2018 to complete the inspection and feed back to the management team. We gave the provider notice we were returning for the second day of inspection.

Before the inspection we reviewed information held on our systems, this included notifications we had received from the service. A notification is information about important events, which the service is required by law to send us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection, we asked staff in the local authority as well as health and social care professionals about the care provided at Alban House. We received two responses.

During the inspection, we met and spoke with both the providers, one of whom was the registered manager. We also talked with the deputy manager, a member of administrative staff, six care workers, a maintenance member of staff and two housekeeping staff. We spoke with 16 people living in the home. During the inspection we met and spoke with a visiting social care professional and a relative of a person living at Alban

House.

We reviewed four people's care records, five medicine administration records, two staff records, staffing rotas and staff training records. We also reviewed records of audits and checks carried out in the home.

Good

Is the service safe?

Our findings

People said they felt safe at Alban House; comments included "Yes, perfectly safe"; "Staff look after me so I am safe" and "Safe here, not anxious about anything."

At the last inspection in January 2017, the service had been found to require improvement in the Safe domain as people were not protected against the risks associated with the unsafe use and management of medicines. The home was not following current relevant professional guidance relating to the management and administration of medicines. We therefore found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulations 2014). At this inspection, medicines administration systems and practices were safe and the requirements of the regulation were met. The medicines policy had been updated in December 2017 to reflect current best practice.

At the time of our visit two people living in the home were being given covert medicines. Staff had followed the correct processes to assess each person's understanding about their medicines. A best interest decision had been made which was fully documented. The records showed staff had involved family members as well as professionals responsible for the person's care, before making the decision.

An independent mental capacity advocate (IMCA) had been involved for one person who did not have any family members. The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions. This includes making decisions about serious medical treatment options. The medicines administration record detailed how the covert medication was to be given; this had been signed by the person's GP, a pharmacist and the deputy manager. Dates on which the covert medicines would be reviewed by the GP had been recorded. Reviews are important as a person's condition/mental state may change and covert medication should only be given when necessary in the person's best interests.

One person had been risk assessed as able to administer their medicines on their own. Two people were administered insulin by a district nurse who visited the home each day; staff said they tested each person's blood sugar levels every morning to support the district nurses. An external organisation also undertook checks on the blood sugar machines to ensure they were functioning and accurate.

Staff recorded accurately when medicines were administered on medicine administration record sheets (MARs). Allergies had been noted on the front sheet of the MARs along with a current photograph to aid recognition.

Medicines that are given on an 'as required' basis are known as PRN medicines. There were records of who had received PRN medicines; this included the reason why the medication had been given. This helped staff to identify trends and patterns; staff used these to consider actions which may be needed to reduce PRN usage. For example if the PRN was for pain relief it may mean a person needed referral to their GP or dental appointment.

We asked staff how they would know if a person, who was unable to communicate verbally, was in pain. Staff said they always considered the person's body language and behaviour. For example if the person was holding a particular part of the body, grimacing when touched or if there was a change in their behaviour. Staff described how one person, who was unable to communicate verbally, kept holding their hand against their mouth. This had helped staff establish the person had toothache; staff had therefore provided pain relief and arranged a dental appointment.

There were systems in place to ensure medicines were reviewed by the person's GP on an annual basis or more often if necessary.

Medicines were stored safely. The storage room did not have the daily temperature recorded but deputy manager said they planned to do this. The medicine fridge had a padlock and the temperature was checked and recorded on a daily basis. Storage room temperature control ensures that medicines are stored at optimum temperatures.

Medicine bottles and eye drops in the medicine trolley had been labelled with the date of opening. This is necessary as some liquid medicine when opened, should not be used beyond a set time.

Medicines which required greater levels of security were stored safely. Records for these medicines had been appropriately audited and were accurate.

Monthly medicine audits were undertaken to ensure MARs were accurate. Checks were also carried out to ensure creams, liquid medicines and lotions were in date. Where issues had been identified, action had been taken. The home also had an annual audit undertaken by the dispensing pharmacy; the most recent audit had been in June 2017. This audit had not identified any major issues.

There had been no medicine administration errors in the previous six months. Staff were able to describe what would happen in the event of an error; this included checking the person's safety and sharing learning to reduce the risk of recurrence.

Staff were trained to administer medicines and were observed and 'signed off' as safe before being allowed to administer medicines on their own. A master signature list of all staff who dispensed medicines was up to date; the list included the newest member of staff who was able dispense medicines. A master signature list help to identify which staff member dispensed medicines in the event of a query. Staff had annual medicine administration competency assessments and random spot checks were also undertaken.

At the last inspection in January 2017, the service had also been found to require improvement in the Safe domain as infection prevention and control systems were not sufficient to keep people safe. This was breach of regulation 15 of the Health and Social Care Act 2008 (Regulations 2014). At this inspection, the requirements of the regulations had been met.

The home was clean and odour free. This included bedrooms, communal areas, the kitchen and laundry area. Staff understood and followed good hand hygiene practices. Toilet areas had good handwashing facilities and signs to show how to wash your hands.

Personal protective equipment, including disposable aprons and gloves, were available through the home and staff were observed using, and changing, aprons and gloves appropriately.

Staff followed safe practices when cleaning. For example there was a 'spills kit' to deal with various spills

and liquids. There were different coloured cloths and buckets to clean different areas of the home. There was clear information for staff regarding what colour cloth and bucket to use in what circumstance. Harmful substances, such as cleaning fluids were clearly marked and were locked away in a cupboard.

The home has a comprehensive management of infection prevention and control policy. The home had not had any outbreak of infection in the previous six months. The registered manager also kept a file that contained information staff needed if there was an outbreak of Norovirus, flu, chest infections, scabies, clostridium difficile or MRSA.

People were protected from the risk of abuse by staff who knew how to identify signs of abuse. Staff had completed safeguarding vulnerable adults training and were able to describe what actions to take if they had concerns. Staff said they would report concerns to the registered manager or their deputy. Staff were also aware of how to report concerns to the local authority safeguarding team if necessary.

The deputy manager had worked with the local authority to resolve issues relating to concerns about one person's finances.

Care records contained details about the risks to people which made them vulnerable. This included assessment of the risks to their physical health; for example hydration and nutrition needs assessment (using a tool called MUST), risks to skin integrity (using a tool called Waterlow) and their risk of falls. Care records also included risk assessments for using bed rails. Where a person was identified as being at a higher risk, there were care plans which described how to keep the person safe whilst maximising their independence

There were sufficient staff to meet people's needs and keep them safe. The deputy manager was responsible for drawing up the rota of staff at work. When planning the number of staff needed she took into consideration the dependency level of each person as well as what activities each person was involved in. For example staffing levels varied during the day to take into account supporting people to get up in the morning. One member of staff said they now started earlier in the morning to support night staff as some people liked to get up early. The home had increased the number of cleaning staff to support the improvements in infection prevention and control.

There were systems in place to review incidents and accidents when they occurred. Reviews considered how to reduce the risk of a recurrence.

Good

Is the service effective?

Our findings

At the last inspection in January 2017, the service had also been found to require improvement in the Effective domain. This was because staff were not all up to date with their training, people's capacity to make decisions had not been assessed and recorded and care records did not always reflect people's risks, needs and preferences. At this inspection, these issues had been addressed and the service was now effective.

We checked to see whether the provider was working within the requirements of the Mental Capacity Act (2005). Best interest meetings had been held where there were concerns about a person's ability to make a specific decision. Meetings had involved, where possible, the person, their family, staff and professionals.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for a DoLS authorisation had been made for 15 people living at Alban House. None of the applications had yet been authorised. There were systems to show when the application was made. The deputy manager said they monitored the applications to check that they were still needed. This meant they kept under consideration, any changes to a person which might lead to the application being amended or withdrawn.

Wherever possible, people's risks, needs and preferences about their care had been initially assessed before they came to the home. Care plans had been developed taking into account how to support people to meet these needs whilst supporting them to be independent. For example, one care plan described how the person was at risk of falls; it also described how the person still enjoyed being mobile. The care plan included information about how to keep the person safe while not restricting their mobility. This included what staff needed to do, such as ensure the person had the correct mobility aids. Staff were able to describe what actions they took and were observed carrying these out. This helped to reduce the risks to the person of falling.

Care plans described the person's history and background which helped staff to work with them more effectively. For example, one member of staff described how they would talk to a person about their earlier life and family which helped the person to remain calm and content.

When staff started working at Alban House they completed an induction programme which was aligned to the Care Certificate. The Care Certificate is a national set of minimum standards designed by Skills for Care that social care and health workers that should be covered as part of induction training of new care workers.

Staff refreshed their knowledge and skills at regular intervals. This helped them to ensure they remained knowledgeable about national guidance to support people effectively. Staff were also supported to undertake nationally recognised qualifications in care.

Staff were provided with specialist training so they were able to support people with particular needs. For example staff received diabetes care training from an external organisation to help them understand how to support people with diabetes effectively.

Staff said they received regular supervision from the deputy manager. This was confirmed by records of supervision meetings. Supervision provides an opportunity for staff to reflect on their performance and identify any training needs they might have. Staff also had an annual appraisal each year. The deputy manager said she was supported and mentored by the registered manager, which they found very helpful as she was planning to become the registered manager of the home.

People were supported to have sufficient to eat and drink. Meals were freshly prepared by a cook who was familiar with people's likes and dislikes. A variety of different meals had been prepared for lunch during the inspection. Staff said this was common practice as people did not all want to eat the same meal. The meals looked appetising and people were clearly enjoying their food. Most people ate their lunch in the dining room. However some people preferred to have their meal served in their bedroom or in the lounge.

People said they really enjoyed the meals at Alban House. Comments included "Ooh yes, I like the food.", "Yeah, especially when (staff member) is on" and "I like the food, don't I."

We observed two people being assisted with lunch in the lounge area. A staff member was supporting both people. With one person, they explained what food was on the plate and encouraged them to drink. We observed caring, kindly and unhurried interactions with the staff member asking the person "Would you like me to cut that up for you?" and "Would you like to hold the spoon?" This helped the person to be supported while remaining as independent as possible. The other person did not appear to be interested in eating. The staff member spoke kindly to them offering alternatives and encouraging the person to eat something.

Staff worked effectively with each other, ensuring key information was passed on to the staff coming on the next shift. Staff also worked with health and social care professionals to deliver care and support. For example one health professional commented "Although I have only been in a few times, the resident is clearly well looked after; staff know her well even if they have been off for a few days…Staff are able to show me, they are always helpful and good. They keep us informed and have taken ownership of their role. They alert us appropriately if they have a concern about anyone with diabetes or if anyone shows signs of a pressure sore."

People were supported to maintain good health as staff contacted healthcare professionals when necessary. This included the person's GP, dentist, optician as well as hospital services as required. One person's care record had evidence that a speech and language therapist had been involved in the person's care when staff had identified they were at risk of choking. Advice about how to support the person to eat and drink safely was in the care record. Staff were able to describe what foods the person could have and how these should be prepared. People said they were able to see health professionals when they needed to; one person commented "If I ask the management and they draw conclusions, will get to see a doctor, doctor comes here."

People were able to choose wall colours for their bedrooms and were encouraged to bring items of furniture, ornaments and pictures to make it more homely for them.

Adaptations had been made to the home to ensure that it met people's needs. For example although the home had four floors, it was accessible as a lift had been installed to support people who were unable to use the stairs. The back garden area had been made more wheelchair-friendly as it had wide paved areas with

raised beds.

As well as the main lounge, there were two other communal areas where people could sit if they wished; both of these were close to the main entrances. The dining room was large and airy providing plenty of space for people to move around. However, the home did not follow best practice when supporting people with dementia. For example, people with dementia can find it easier if the home uses visual aids to support them to identify things. These could include the use of coloured crockery, signage with symbols to identify toilets; coloured toilets seats and rails in bathrooms. If aids are not used, people may become confused and anxious when carrying out everyday tasks.

We recommend that the service finds out more about environmental improvements, based on best practice, in relation to specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

Throughout the inspection we observed numerous affectionate, kind and considerate care interactions. Staff clearly knew the people who lived in the home well and treated them with respect and compassion. Staff stopped what they were doing and chatted to one person when they were approached. They took time to have a conversation with the person, before carrying on with the task they had been involved in.

People's right to dignity and privacy was not always respected as people were weighed in a communal dining area. For example, we observed two people being weighed on weighing scales towards the end of a lunchtime when other people were in the room. We discussed this with the registered manager who said they would move the scales to a private space.

People said they liked living at Alban House. Comments included "I think this place is as perfect as it can be, in general there are details that need improving, but they are of no consequence." People are really sweet here, do have differences with staff, but everyone has that don't they….Get really fed up with them towards the end of the day but I love the morning."; "Quite happy."

Staff were observant of people's needs, for example they noticed someone has something stuck in teeth and helped them to sort it out. They asked another person if they were alright. They helped the person who wanted a different pair of shoes.

There was an unhurried atmosphere that gave people the opportunity to be as independent as they chose to be, whilst having staff support them unobtrusively. For example, one person liked to be useful in the kitchen. Staff welcomed them into the kitchen, where they buttered bread; an activity they enjoyed doing.

Staff were able to describe people's communication preferences both verbal and non-verbal. Some people in the home were not able to communicate verbally. Staff described how they interpreted people's facial expressions, body language and other non-verbal communication when supporting the people. Interactions between people and staff showed staff understood people and were able to interpret non-verbal communications including physical responses.

Staff showed compassion and kindness to people, treating them gently and with consideration. One person who was able to communicate verbally, said "Staff are very good, they are always around to help."

People were supported to express their views and be involved in decisions about their care and support. Where possible, people were involved in decisions about their care and how they would like care provided. For example, staff said some people were early risers while others preferred to stay in bed until later. People were able to also choose where they ate their meals. For example one person said they would prefer to have lunch served in their room, rather than eat in the dining room. Staff arranged for a tray to be taken to the room to meet this request.

Staff respected people's individuality and treated people equally. Staff were respectful of people's privacy

and dignity. Staff were discreet when talking with people about their personal care needs. Staff knocked on bedroom doors before entering and supported people to have private time in their bedrooms.

Staff described people's history and backgrounds and knew about their families. People's relatives were encouraged to visit whenever they wanted. One relative commented "I call in whenever I want, staff are always welcoming." Staff also supported people to stay in touch with their families. For example, one person was supported to regain contact with a loved one who they had not been in touch with for an extended period of time. Staff said they had helped the person to make contact and both the person and the relative had been delighted to be reconciled.

The home used technology to support people. For example there were IT facilities which enabled people to contact friends and family via the internet.

Special events such as birthdays were celebrated which helped the person feel cared for. Staff also arranged events such as a celebration barbeque for the royal wedding and a visit by an ice-cream man. Staff members on their day off would often support people to go out on trips to places of interest.

The providers and several staff described how they tried to make Christmas Day a joyful occasion. The deputy manager explained that most staff, whether or not working, would call in. The deputy manager described how she had worked on Christmas Day as they felt it was important for both people and staff to see them. The deputy manager said she had dressed up in a Christmas outfit so she could hand out presents as part of the fun. She said this helped to make it feel special to people, some of whom had little or no contact with family or friends outside the home.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs and preferences. People said they received care which was focussed on their individual needs. This included following interests and activities they wanted to do. For example one person said "In the evening I make my meal at the end of the day." "Going shopping tomorrow, get lift usually, get taxi back…suits me doing that, being independent."

One person's daily notes said they enjoyed watching snooker on the television; when we visited their room the snooker was on the television. Another person's care plan said that they liked to use a magnifying glass; when we met with the person they had a magnifying glass next to their chair.

Wherever possible people were involved in developing and updating their care plans. Care plans set out clearly the support people required and how this should be delivered. For example care plans described the support needed with personal care, social activities and general living activities such as eating, going out and contacting authorities. The plans also held information about relatives and professionals involved in the person's care. This included their next of kin, their GP, dentist and other health professionals.

People's care plans were reviewed on a regular basis. The frequency of review was decided by the deputy manager, who explained that some people's needs and risks were more variable so needed closer monitoring. One person with complex care needs had the care plan reviewed on a monthly basis; two people other had the care plan reviewed on a three monthly basis. These reviews ensure that care is in accordance with the person's current presentation.

The deputy said that as well as regular reviews, they would update risk assessments and the care plan if a person's needs suddenly altered. Where people's needs had changed, the records showed that new risks had been assessed and actions taken to address the changes. For example there was evidence that people had been assessed for the risk of falls, choking and malnutrition. Actions to address the risks were described in the care plans.

For example one person required a special soft diet following a speech and language assessment. There was a list of what savoury and sweet foods they could have. This makes it easier for staff to follow external professional instructions.

On the first day of inspection, one person's care plan described that the person was to have two hourly repositioning and their incontinent pad changed. The person was being nursed in bed due to immobility and complex care needs. We asked the provider where we would find the repositioning chart as we could not find it in the person's room. They replied that there was not a repositioning chart, but the staff did do this. This meant that we could not see any evidence that two hourly repositioning was actually taking place.

By the second day of inspection, the deputy manager had contacted the occupational therapist, who had arranged for some equipment to be provided to support the person when moved. The deputy said repositioning charts were being implemented following the advice of the occupational therapist and the

inspection feedback.

The service were working to implement the Accessible Information Standard (AIS). The AIS is a framework put into place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can understand information they are given.
People's communication preferences were known and understood by staff. Some people had limited or no verbal communication. Staff described how they communicated with each person individually. Staff spoke with one person, who they said understood but would not speak very often. Staff were able to understand what the person wanted by watching the facial expressions; this allowed them to communicate with the person effectively.

People were supported to do activities they enjoyed both in the home and in the community. For example one person enjoyed going out each afternoon. A taxi was arranged for the person who was able to go out on their own.

Other people spent time in the home and the garden. One person said they liked to sit outside and watch the home's chickens that were usually about. Staff ensured the person was dressed appropriately for the time of year; they also ensured the person was happy to remain outside by checking with them every so often. Staff also said they sometimes took their breaks in the garden so they could chat to the person.

There was a programme of activities which people could choose to join in with. This included visits from local zoos so people could pet the animals, visits from musicians and singers. Staff also spent time with people on a one-to-one basis reading the paper to them or giving them pampering sessions. One relative commented that there were times when there was nothing going on in the afternoon, which meant people were just sitting in the lounge without anything to do. The deputy manager said they were looking at more ways to engage with people in activities. However she said that staff did spend time with people doing activities "which they think is just what they should be doing, so they don't record it." Throughout the inspection, we observed this occurring; for example a member of staff spent time reading the paper with one person, talking about headlines to try to involve the person. This included talking about a photo of the prime minister on the front page, explaining what the headline was about and talking about the necklace Mrs May was wearing. When the person did not appear interested in that, the care worker then went to another article about animals which appeared to interest the person more.

There were opportunities for people, relatives and friends, to raise issues, concerns and compliments. For example, there were minutes of resident meetings where people could discuss issues which were important to them. Staff said there was a resident meeting due to happen the week after the inspection. People were made aware of the complaints process when they started their package of care. There had been no complaints made since our last inspection. People and relatives said they had never needed to complain. One person said "If I need something sorted, they will do it."

The home supported people at the end of their life. At the time of the inspection there was no-one receiving this type of service in Alban House. However, the deputy manager described how a person who had been resident was nearing the end of their life in hospital. The deputy manager described how they were still involved in caring for the person, by visiting the hospital on a daily basis to make sure the person had everything they needed. The deputy had also contacted relatives to ensure they were aware of how the person was.

The home had also provided care and accommodation for people who were admitted for end of life support. The deputy described how they had admitted one person in the last week of their life, as they had

not been able to be supported at home. The deputy said this had involved collecting the person from their home, helping to get articles they wanted to have with them, contacting relatives and liaising with the health professionals involved in the person's care.

Relatives had sent cards thanking staff for the care which had been given.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in January 2017, the service had been found to require improvement in the Well-led domain. This was because systems to audit and monitor the quality and safety of the home were not robust. Issues such as the cleanliness of the home and the medicines administration and management had not been identified. We therefore found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).

At this inspection, we found that the auditing and monitoring of the service were far more robust, so the breach of regulation in respect of the concerns identified had been addressed and the requirements of the regulation were met.

However, we found there were other issues related to the provider's responsibilities.

There was a registered manager who was also one of the two providers. A registered manager is a person who has registered with the Care Quality Commission (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 2008 and associated Regulations about how the service is run.'

The registered manager did not always act as a good role model for the staff. For example, we observed the registered manager, towards the end of a lunchtime, where they were working with people in the dining room. The registered manager used patronising and inappropriate language when talking to one person. They spoke loudly about the person's weight in front of other people living at the home. We discussed this with the registered manager during the feedback session at the end of the inspection. They acknowledged that it had been inappropriate but it was not intended to be disrespectful or unkind to the person. However, since the person did not have good verbal communication, they were not able to respond to the comments made by the provider or indicate whether they found them acceptable or not.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The providers were also very negative about the CQC's inspection process, saying that they "jumped through the hoops" but did not believe that the inspection system was of value or fair. They showed an overly challenging and dismissive attitude to the inspection team when asked to provide evidence. We explained that providers have an opportunity to feedback about the inspection report before it is published. We also explained that if they did not believe a rating to be fair they could challenge it after publication, if we had not followed our policies and procedures when carrying out the inspection. However, they continued to demonstrate a negative approach in front of staff. This did not demonstrate a positive example to staff.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A requires providers to display the ratings the service is given within 21 days of inspection. Ratings must be displayed

conspicuously and legibly at each location delivering a regulated service and on the website, where there is one.

The home had been rated as requiring improvement overall at the last inspection in 2017. Three of the domains, Safe, Effective and Well Led had been rated as requiring improvement. Two of the domains, Caring and Responsive had been rated as good.

We checked the home's website before the inspection. The website was not displaying the previous inspection's rating as it was legally required to do.

The website stated "A Good Responsive and Caring Service" It also stated "The Care Quality Commission is responsible for the registration and inspection of social care services in England. In their recent report on care at Alban House, they determined that the things that really matter we do very well. Our caring service and responsive service was graded as 'Good'." This information was misleading, as it made no mention of the domains that had been rated as requires improvement. It also implied that some domains were more important than others, whereas the CQC does not differentiate the domains in terms of importance.

This is a breach of regulation 20A of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

There was a hyperlink on the web page to the last inspection report on the CQC website.

We discussed the web page with the providers. They agreed to change the web page. By the second day of inspection the web page was meeting the requirements of the legislation.

Staff said they were happy working at Alban House; they felt supported and valued and that there was good team-working and an open culture at the service. Staff commented: "We all support each other; [deputy manager] is always really good." The deputy manager showed great sensitivity and understanding of some members of staff who had difficulty with the written word.

The deputy manager said that she felt supported by the registered manager. She described how the registered manager had coached and mentored her to ensure she had the skills and knowledge needed to manage the home in the registered manager's absence.

There was a governance framework which identified how the safety and quality of the home was monitored. A service improvement plan described where improvements were required; the plan also recorded the actions that were needed to make the improvements. Actions were time defined and identified who was responsible for completing them. The service improvement plan also described when actions had been done. The providers said they monitored the service improvement plan and discussed it regularly with the deputy manager to ensure that it remained focussed on where improvement was needed and where improvement had been made.

Audits and checks were carried out to monitor the quality and safety of the service. Checks were completed on fire equipment, water safety, building maintenance, medicines administration and care records. The deputy manager had worked with another member of staff, who had taken on responsibility to improve medicines management; there were robust systems in place to ensure that medicines were checked when received as well as when administered. Staff took responsibility to monitor and ensure the quality of care records. Staff said they completed a daily checklist to ensure all daily records were completed and up to date. Staff were observed undertaking the checks and then filling in the checklist.

The home had an open culture of learning and improvement. Staff described how they were able to make suggestions to improve the care for people. New systems had been implemented to support the care staff provided.

Resident meetings and staff meetings were held regularly. Staff said meetings were useful as they were used to both provide information for staff and enable staff to be involved in making improvements.

The service work in partnership with other agencies; this included working with health and social care professionals as required. A health professional commented "Staff are helpful and keep us informed." The deputy manager had worked closely with the local authority's quality assurance and improvement team (QAIT). A member of the QAIT team provided positive feedback about how the service had worked with them on improvements.

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 10 HSCA RA Regulations 2014 Dignity and respect The service was not always caring as the registered manager did not always treat people with dignity and respect. People's privacy and dignity was not maintained as people were weighed in a communal area in front of other people.