BM Care Limited

Albany House - Tisbury

Inspection report

The Square
Tisbury
Salisbury
Wiltshire
SP3 6JP

Tel: 01747870313
Website: www.bmcare.plus.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the last inspection in May 2016 we found breaches of legal requirements. We asked the provider to take action to make improvements to key questions that relate Safe, Effective, Responsive and Well Led. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulations 9 Person Centred Care, Regulation 11 Consent to care, Regulation 12 Safe care and Treatment, Regulation 17 Good Governance and Regulation 18 Staffing.

This is the second consecutive time the service has been rated Requires Improvement.
Albany House supports up to 21 older people and some of whom were living with dementia. At the time of the inspection there were 19 people living at the service.

This inspection was unannounced and took place on 8 and 9 November 2017.

A registered manager was in post. 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.

Medicines administration systems were not safe. Procedures were not in place for medicines to be taken "when required" (PRN). Medicine Administration Records(MAR) showed people were having PRN medicines. Medicine care plans for some people included people's preferences on how they liked their medicines to be administered. Medicine administration records (MAR) charts were signed by staff to indicate the medicines administered.

Risks were not always identified and there was no guidance to staff on how to minimise potential harm to people or to help them take risks safely. Risk management procedures were not up to date. The risk assessments were not updated for people who fell frequently and there was no action taken to prevent further falls for example, referrals for specialist support such as falls clinic. Where people were refusing food and fluid there were no formal systems to assess their deteriorating health. We found monitoring charts were not consistently completed or analysed and risk assessments were not developed on supporting these individuals with hydration.

Formal arrangements to assess and monitor service delivery were not in place. Quality assurance systems were not in place. Records were not up to date and staff acknowledged that the recording of information needed to be improved. Policies and procedures were outdated and were based on legislation that had been replaced. Accidents and incidents were documented but not analysed to identify trends to help staff prevent a reoccurrence of the accident.

Where people had cognitive impairments their capacity for care and treatment was not assessed. Relatives

and friends without Lasting Power of Attorney (LPA) had consented to care and treatment. Where it was documented that LPA was in place the type was not identified. Covert medicines were being administered without the appropriate framework being in place. The staff knew the day to day decisions people were able to make.

People's needs were not assessed before their admission to the home. Care plans were not developed on how to meet people's needs and lacked person centred approach. We saw where staff had documented they were supporting people with personal care but care plans were not developed. People were not supported to develop plans about their future wishes for their end of life journey.

The staff knew the types of abuse and the expectations placed on them to report abuse. However, the training certificates showed only two staff had attended safeguarding training.

Staffing levels were well maintained but there were staff vacancies which meant agency staff were being used.

Arrangements were in place to maintain a clean environment and we found the home was free from unpleasant odours. We saw housekeeping staff maintaining the environment.

We saw good interaction between people and staff. The feedback from people and their relatives was complimentary. Staff knew how to respect the rights of people.

You can see what action we told the provider to take at the back of the full version of the report. We found breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Procedures were not always in place for medicines to be taken when required (PRN). Medicine care plans included detail on how people liked to take their medicines

Risks were not identified and action plans were not developed on minimising the risk. Member of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people.

People said they felt safe and were able to describe what safe meant to them. Staff knew the types of abuse and the responsibilities placed on them to report abuse.

Is the service effective?

Requires Improvement

The service was not effective.

People's capacity to make complex decisions was not assessed and best interest decisions were taken where people lacked capacity. Covert medicines were administered without the legal framework to make decisions of this type. Staff enabled people to make day to day choices.

The training attended by staff was limited and there were no opportunities for staff personal development.

People's dietary requirements were catered for.

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and there was a calm and friendly

atmosphere.

Staff knew how to respect people's rights to privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive

Care plans were not person centred and for some people care plans were missing for the needs that were identified.

The registered manager responded to concerns raised.

Is the service well-led?

Requires Improvement

The service was not well led.

There were no arrangements for continuous improvement. Quality assurance systems were not in place and processes for assessing the delivery of care were not in place. The views of people using the service were gathered through residents meeting.

Staff were aware of the values of the organisation. They said the team worked well together.

Albany House - Tisbury

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.

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 in Safe, Effective, Responsive and Well Led to at least good.

This inspection took place on 8 and 9 November 2017 and was unannounced on the first day of the visit. The registered manager was aware of our visit on the second day.

Albany House was registered to accommodate up 21 older people some of whom may be living with dementia. Albany 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 provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by two 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.

We spoke with eight people about their experiences of care and treatment and to one relative visiting family members at the time of the inspection visits. We spoke with the, registered manager and five members of

staff. We wrote to providers for their feedback on the governance arrangements for assessing and monitoring the quality of care people received.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included eight care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we found a breach of Regulation 12 Health and Social Care Act Regulated Activities Regulations 2014. We found when required (PRN) medicines as well as prescribed lotions and creams were not recorded on MAR charts. This meant it was not clear if people had received these medicines as required. Risks to people's health and safety were not always assessed to protect them from harm. The provider wrote to us telling us how the requirements were to be met by December 2016. However, at this inspection we found no improvements had taken place.

At this inspection we found medicines were not consistently managed safely. Medicine administration procedures were not in place for medicines to be administered when required (PRN) and care plans were not developed for administering PRN medicines. The MAR charts showed staff had administered PRN medicines and had applied PRN topical creams. MAR charts showed 10 people were prescribed with PRN pain relief, one person with PRN anti-sickness medicines and to treat angina attacks for another person. Two people were prescribed with PRN eye drops. PRN topical creams were also prescribed to three people. This meant PRN protocols were not developed on how staff were to recognise when people might need these medicines.

We saw some people were self-administering their medicines. The procedure for self-administration of medicine stated "A care plan must be formulated, evaluated and reviewed at no longer that four week intervals." Care plans were not in place for people that self-administered their medicines. This meant staff were not certain if the person was administering the medicines according to the directions.

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

Medication Administration Records (MAR) charts were signed to show the medicines administered. The medicine care plan for one person stated that where people were unable or lacked capacity to self-administer their medicines trained staff were to administer the medicines. The staff that administered medicines said they had attended competency based training to ensure safe management of medicines. Training certificates showed that seven staff had attended medicine competency training in 2015. There was no evidence that staff's competency had been refreshed since then. Medicine care plans stated how people liked to take their medicines. Medicine care plan for one person stated "prefers to take her tablets on a teaspoon."

systems of managing risk were not in place. Action plans were not always developed on how staff were to manage risks. The risk procedure stated "a comprehensive plan to manage risk (including manual handling and the risk to residents) should be drawn up in consultation with the resident, their relatives and representatives: this should be included in the care plan for staff to refer to a copy should also be placed on the personal file kept in the company office. This risk management plan should be implemented and reviewed annually or more frequently if necessary." The registered manager said "We talk as a team, we had ergonomic [the study of staff's efficiency in their working environment] changes to lower the risk of falls. We

look at individuals and we are fully aware. We don't want to stop people we want them to be safe. We want to understand the risk."

People told us there were other people who fell. One person said they "I fell on my back. I shouted – I've fallen and two carers came and helped me." This person also told us another person had fallen the day before. Another person said "I slipped out of my chair this morning, they were all there helping me." Staff said there was one person who fell frequently because they often forgot to use their walking frame.

Accidents and incidents involving people were documented. Staff said all accidents and incidents were recorded. They said following an accident there was a discussion during handovers on "what would you have done differently". We saw from the accident reports that one person had fallen eight times in October 2017. Reports of GP visits showed there had been one visit relating to a fall in August 2017. Falls risk assessments dated 24 May 2017 stated this person was at high risk of falls. However, the risk assessment had not been reviewed following the falls or further action taken other than recording that a referral to falls clinic was to be considered.

People who declined food and fluid were not assessed for deterioration of their health. The Malnutrition Screening Tool (MUST) for one person dated 16/01/2017 had identified them at low risk. The Food and Fluid care plan dated 14/06/2017 stated "lost interest in mealtimes and one carer to prompt and encourage XX to eat and drink fluids. If a glass of fluid is left in front of her she will drink it with encouragement." The registered manager said food and fluid charts were kept in the bedroom. We accompanied the staff who we asked to provide us with copies of the food and fluid charts but only one chart dated 29/10/2017 was in the person's bedroom. Another member of staff confirmed they [staff] were not consistently completing food and fluid charts as this person's health care needs fluctuated. The registered manager said food and fluid charts were withdrawn because the person "started to eat and drink. I check with staff daily about people's fluid intake." However, daily notes dated 2/11/2017 stated "fluids offered but declined, checked regularly throughout this shift offered fluids but declined. For the 3pm-9pm shift staff had recorded "no food bottle of water" but the sentence was not completed. This meant there was no awareness on the person's fluid intake.

The GP notes for one person dated 27/10/2017 stated they were to be referred for district nurse input as red area was forming on their ankle. It was recorded that the person "says her legs and feet are painful." A member of staff said this person was seen by the district nurse," there is a dressing on the wound and an air flow mattress in place". The registered manager said they had placed the dressing on the wound as instructed by the GP. However, care plan and risk assessment was not in place for preventing pressure ulceration.

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

Staff told us they had attended training in moving and handling. The certificates for this training listed the names of four of the nine staff with caring roles as having attended the training. This meant not all staff supporting people with mobility needs had attended moving and handling training. A member of staff said equipment was available for helping people with transfers. Another member of staff said there were people with mobility needs and assessments were in place for safe moving and handling techniques. Moving and handling care plans were in place for one person which stated "requires support from one to two staff for standing" and the person was to use a wheelchair for long journeys. The equipment to be used for transfers, the size and the colour of the slings were detailed in the care plan.

Personal emergency evacuation plans (PEEPS) held in care records were not always completed and for some people the plans were incomplete. For one person the PEEP did not contain any information other than a tick in the box to answer "yes" to the question "Does the Service User use any mobility aids?" This meant staff were not given the guidance needed for the safe evacuation of the property in the event of an emergency.

Procedures and systems to protect people from abuse and from avoidable harm were out of date and staff had not attended safeguarding from vulnerable adults from abuse training. The Albany House procedures including the safeguarding of vulnerable adults procedures were outdated and related to legislation that had been replaced. The training certificates showed two of the nine staff with caring roles had attended safeguarding of vulnerable adult's from abuse. The registered manager did not initially agree that only two staff had attended safeguarding training and checked the training certificates. This registered manager arrived at the same conclusion that only two staff had attended the training in April 2016.

People said they felt safe living at the home. The staff we spoke with knew the types of abuse and the expectations on them to report allegations of abuse.

The staff we spoke with had a good understanding of prevention and management of difficult behaviours. A member of staff said there was one person who at times presented with aggressive and physically challenging behaviours. They said there was involvement from community specialist in mental health care needs and distraction techniques such as reassurance was used to prevent behaviours from escalating. Staff knew the triggers for the person becoming verbally and physically aggressive. For example, the person disliked noise and when personal care was needed they became verbally and physically aggressive. Staff said when the person became aggressive they persuaded this person to return to their bedroom and offered refreshments as "a cup of tea often calm them." The behaviour care plans for this person stated "suffers from periods of paranoia and delusions disorders. Can be antisocial and finds it difficult to cope in communal areas. Responds better on a one to one basis. Encourage to participate in social activities." Daily reports showed at times this person threw items and shouted to gain staff attention. Documentation also confirmed staff were following guidance to distract the person by offering refreshments.

The registered manager explained for this person community specialists were involved and had requested antecedents, behaviour and consequence (ABC) charts to be completed for two weeks. They said this person was unable to "articulate that personal care was needed." ABC charts in place showed the person mainly shouted to gain attention from staff.

There was no system to determine the number of staff needed to meet people's needs. The registered manager said "we look at what we are doing time and management but not formally recorded. The staff work hard and spend adequate time amounts of time speaking to people during tasks but additional time outside of tasks is limited. We need more staff. The "owners" were made aware of the need for more staff and would [owners] see the need once explained."

The comments from people about the staff included "Wonderful, but I don't think there are enough. The girls in the morning are very busy and rushing around." The registered manager said there were 33 vacant night time hours and 16 vacant day time hours. This registered manager said "currently night time cover is done by one carer and agency. They said the same agency staff was used" to maintain continuity of care to people. The staff we spoke with said there was sufficient staff on duty throughout the day although there were vacant hours.

Cleaning responsibilities were identified in cleaning schedules which staff signed to say when tasks had

been completed. Cleaning rota dated 29/05/2017 to 05/06/2017 listed the rooms cleaned and included comments from staff such as cleaned windows in conservatory. Shampooed carpet and changed curtains. There was cleaning rota for night staff which included the tasks to be completed such as the catering areas and the laundry. We found the home clean and free from unpleasant smells.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we found a breach of Regulations 11 and 18 of Health and Social Care Act Regulated Activities Regulations 2014. We found people had not always been consulted about consent to their care and treatment and there was no evidence of signed consent. Mental capacity assessments were not always completed where people lacked capacity to consent to their care and treatment. We also found there was a lack of opportunity through staff supervision to review individual personal development and progress. The provider wrote to us telling us how the legislation requirements were to be met by from September 2016 onwards. However, we found improvements had not taken place.

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 told us about the day to day decisions they made. Their comments included "I just tell them I'm going out. I've walked up to the shops and done a bit of shopping." "I let someone know and then definitely go." "I can go out if I want to. I can catch the train to Salisbury. I just tell the staff first". People were not empowered to make complex decisions. The staff we spoke with knew the day to day decisions people were able to make. A member of staff said people were consulted about the assistance needed and made decisions about meals, activities and times to wake and retire. Another member of staff said "I will ask people if they want help with personal care. People make daily decisions such as "what they wear, going out and meals".

The staff lacked an understanding on when to assess people's mental capacity. The training certificates in place showed that in 2015 three of the nine staff with caring roles had attended Mental Capacity Act training. Staff confirmed that where people had cognitive impairments mental capacity assessments were not completed for complex decisions. There were no formal assessments of capacity for people with cognitive impairments regarding living at Albany House, nor accompanying best Interest decision leading to applications for continuous supervision.

People were administered with covert medicines. We saw recorded for one person "XX has been taking her prescribed medicines covertly". A member of staff said the GP had instructed staff to disguise medicines for one person in porridge. The medicine procedure for covert medicines stated "residents who do not have capacity to accept or refuse medicines should be assessed individually by the home [registered] manager and in conjunction with the GP, consultant, family and social worker." The GP had recorded in the October 2017 Medication Administration Record (MAR) "add to normal food and drink". Staff had also recorded in the daily notes that there was a conversation with the GP and with a Care Liaison officer and permission to administer medication in food or drink was given and "preferably in cold or luke warm." There was no formal covert medication protocol for the most recent prescription to be administered covertly. Mental capacity assessment with accompanying best interest decisions for covert medicine was not in place. The registered

manager said the pharmacist was consulted and advise was to disguise the medicine in porridge at tepid temperature." This meant staff were not following procedures and frameworks to take best interest decisions were not in place

The care records for one person stated their closest relative had Legal Power of Attorney but the type was not detailed and copies of the order were not held at the home. We saw documentation which indicated the person had been diagnosed with dementia in 2008. However, in February 2015 a friend had countersigned with the person consent for care and treatment. Consent to care included chiropody treatment, assistance with personal care and GP examination and treatment. Also to share information.

This was a repeat breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

Mental capacity assessments were completed by GP's where Do not attempt Resuscitation (DNAR) orders were in place. The GP had recorded in the DNAR orders the rationale for the decision to allow natural death and detailed the individuals such as relatives and staff involved in the decision.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. A member of staff said some people left the home unaccompanied by staff. However, DoLS authorisations had not been sought for people that were subject to continuous supervision.

Staff were not fully supported to keep their knowledge updated and in line with best practice. . The staff we spoke with said they had attended essential training in Health and Safety, Safeguarding of vulnerable adults from abuse, first aid, moving and handling. However, the training certificates in place did not support that all staff had attended appropriate training to deliver effective care and support. For example, four of the nine staff with caring roles had attended Health and Safety training and four staff had attended Life Support training. A member of staff said they had gained vocational qualification to level three and five.

Staff were not supported with personal development through one to one supervision and annual appraisal. Staff told us one to one supervision meetings were not taking place. A member of staff said there was "no formal supervision but there were opportunities for ad-hoc meetings with the [registered] manager. It's an open door policy for anything we need". Another member of staff said "in five years I had one supervision."

This was a repeat breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

People's physical, mental health and social needs were not holistically assessed before their admission and there was limited ongoing assessments and reviews of needs. A member of staff said the registered manager had a meeting with people who wanted to move permanently to the home. Another member of staff said "care plans for new people. We should be doing them now. Usually we let people settle in for a week to get used to their likes and dislike."

The admission assessment for one person admitted on the 20/9/17contained minimal personal information such as personal contact details, GP information, next of kin. There was no care plans contained in the folder. It was also noted that the first entry by staff about this person occurred on the 28/09/2017 eight days after their admission. The care records for another person showed their date of admission was 23/10/17 and

personal information was also minimal. The reason for admission was "additional personal care now required". There was no care plans to explain the support required. This meant staff were not provided with information on the needs of people and guidance on how to meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

While people's dietary requirements were catered for feedback from people about the quality of the food was varied. One person said the quality of the food was variable but "we do get nice homemade cake at 3.30pm". Another person said, "Yesterday we discussed lunch at the table and would have given it 6 out of 10." Other comments from people we spoke with included "It's mostly frozen and then microwaved. We don't have much fresh veg." "No, we get choice for supper only." "No choice at lunchtime," "You can ask for something else but there's not a lot of choice." "I've put on weight" and another person said there was "Plenty" of food.

People also told us the menu was detailed in the white board by the hatch in the dining room. They also told us there was sufficient food and fluids. The registered manager told us the post for a cook was vacant and they were covering these duties while the recruitment checks for the new cook were in progress. We saw there was a range of fresh and frozen vegetables and fresh fruit. There were also adequate supplies of frozen mean and tinned foods.

People were supported with ongoing their healthcare. A member of staff said there were good working partnerships with GP and community specialists. They said the GP made non urgent routine visits to the home weekly. We saw there was involvement from healthcare specialists such as the mental health care team and there was documentation on the outcome of their visits

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. The comments from people about the staff included "Very good, very chirpy." "Excellent. All are very kind, thoughtful and caring." "I can't speak highly enough of them all." All the staff, including the housekeeping and maintenance are first class." "They help me with anything." "Generally speaking staff are pleasant and helpful."

The wishes of the resident is an absolute paramount in what they [staff] do." "I can't speak highly enough of the home." A relative told us about the how they were helped to celebrate a family member's significant birthday. They said the staff "asked me what we wanted to do. They threw a party for everyone in the home." They decorated the conservatory nicely. The staff rallied round, and made a very nice cake for her."

A relative with a family member of their end of life pathway said staff were delivering "the most wonderful care. I can't thank them enough. There is a living will. The care she is getting is amazing nothing is too much trouble. Beyond what you could expect. They [staff] let me in and out. I can sit with her for as long as I want. They put cream on her face, Vaseline on their lips and they are careful about her pressure areas. They are so good and caring".

We saw good interactions between staff and people. At lunchtime we observed nine people having lunch in the dining room. There was quiet music playing and we saw staff take their time to speak with people. Some people were having conversations with each other. When people were speaking with staff we saw staff take their time and discuss their issues and concerns.

People felt they mattered. The comments made by people included "The wishes of the resident is an absolute paramount in what they [staff] do" and "I can't speak highly enough of the home." A member of staff said "I have a good rapport with people and we tell people they matter." Another member of staff said "we ask people for feedback and talk to people about their family we share information" about our interests. People feel able to approach staff." The third member of staff said "we talk to people. They like staff with a smile on their face. I treat them [people] like my mum."

People were supported to express their views. A member of staff said feedback from people was received during three monthly residents meetings. Another member of staff said at "residents meetings problems are discussed and suggestions for improvements are gained". Records of residents meetings showed these meetings were three monthly and at the recent meeting people discussed themed evenings, menus and birthdays.

People's rights were respected by the staff. A member of staff gave us examples on how people's rights were respected. This member of staff said "doors are shut during personal care and people are not left exposed. I leave people if they want to be left alone and some people don't like night checks." The care plan for one person with spiritual needs stated "devout Catholic and will attend church services held at the home. XX is able to continue to practice her religious beliefs."

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found a breach of Regulation 9 Health and Social Care Act Regulated Activities Regulations 2014. We found People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. Information within care plans was sometimes contradictory. The provider wrote to us telling us how the legislation requirements were to be met by mid-October 2016. However, we found improvements had not taken place.

People told us they received care that was responsive to their needs but records were not clear on how their needs and preferences were being met. "This is Me" documents about the person's history, family contact and interests and hobbies were left blank for some people. The Past History section of the care records for some people included their interests, past employment, family network and important family connections. This meant overall staff had little information on developing person centred care plans. A member of staff said there was a keyworker system (staff assigned to work with specific people) and this role included consulting people about their wishes and keeping records up to date.

.A member of staff said a standardised care planning documentation was used. They stated the staff were "struggling" with developing person centred care plans and they were finding this activity "overpowering". I say once you've done one it gets easier." However, care plan documentation relating to people's health and physical needs as well as their mental, emotional and social needs were incomplete for some people. Another member of staff said they had attended training in developing care plans but that completing documentation was "time consuming". Another member of staff said that care plans are "our downfall. There are time restraints."

Care plans were not person centred on how people wanted their care to be delivered and lacked detail on the care the person was able to manage for themselves. Care action plans on how staff were to meet people's care needs were brief. For example, the mobility care plan for one person dated 30/05/2017 stated " XX requires assistance from one member of staff with a frame and is able to take a few steps only. Mobility varies from day to day and sometimes needs full support". The medicine care plan for another stated "likes to have medicines with fluids. Does not remember to take medicines and requires the support of the staff due to memory loss. The care plan was reviewed in October 2017 and "no change" was recorded. However, the care plan lacked detail on the support needed from the staff. The daily notes for another person indicated that staff had assisted them with personal care. However a care plan for meeting personal care needs was not in place.

People's accessible information needs were assessed but lacked detail on how staff were to assist them. One person was assessed "registered blind" with hearing impartments due a medical condition. The care plan stated "XX can see shapes but finds it difficult to make out details. XX also hard of hearing and wears hearing aids in both ears. Needs support to change batteries." Staff reviewed the care plan on 25/07/2017 and documented "staff to knock loudly before entering and announce themselves. Staff to speak loud and close to her ear. Person is able to recognise colours. Uses adapted cutlery and will need assistance with cutting their food.

Some people and their family were involved in planning and making decisions about their end of life care. The GP notes indicated that one person's health was deteriorating and the staff had made the GP aware that a Do not attempt resuscitation (DNAR) order was in place. However, care records were not clear on the decisions reached regarding the priorities of care for this person. Staff said they had attended end of life training. Training certificates in place indicated that five of the nine staff with caring roles had attended End of Life training. A member of staff said "every effort was made to support people whose wishes were for their end of life care to be provided by the staff at the home".

Staff said there was a verbal handover about people's current needs when they arrived on duty. The daily records were varied in quality, with some language use that was not very person centred and the entries contained task focussed details. For example, staff mainly recorded the well being of the person for example, a description of the person's mood, the meals eaten, where the person spent their day and their sleep patterns.

This was a repeat breach of Regulation 9 and 17 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

People were supported to maintain links and relationships with family and friends. A relative said "they are very good. They know I come most days, so something minor they let me know when I come in. [registered manager] has phoned when [person] had a fall."

People were supported to take part in social activities. We saw three entertainers visiting the home at different times of the day. On the first day of the inspection we saw five people in the lounge with an entertainer playing the piano. We saw four people had a song sheets and were joining in. The registered manager told us the "lady has been visiting for a long time and is well liked by the people at the home". There was also entertainment in the afternoon by a band playing musical instruments and on the following day there was a guitarist playing to the people in the lounge.

One person told us there were "plenty" of activities. Comments from other people included "There is a person who does sewing and embroidery." "Everything is geared for women, pretty hopeless for me." Lots for things going on." "There are social things to go to if we want to according to our interests." "We have had the chance to interview girls from a local school who were studying for their Duke of Edinburgh Award." "At Christmas we have visiting singer which we can join in with, as well as our monthly communion service by the local parish priest.

People we spoke with said the staff listened to their concerns. A relative said "they [staff], without prompting or complaints, have replaced [person] chair for a more comfortable one."

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we found a breach of Regulation 17 Health and Social Care Act Regulated Activities Regulations 2014. We found the service did not effectively assess, monitor and evaluate the quality and safety of the care provided nor did it effectively evaluate and improve its practice. The provider wrote to us telling us how the legislation requirements were to be met by October 2016. However, at this inspection we found no improvements had taken place.

At this inspection we found arrangements were not in place for assessing and monitoring the quality of the service. The registered manager said "I speak with the residents that are able to and we respond to their feedback. We have bought an audit tool for care plans. The paper work is not there for us to audit. Medicines audits tool not yet used. Infection control done through cleaning schedules". A member of staff said infection control, medicines and care planning audits were the responsibility of the registered manager but these audits were "not happening". They said the providers were good and came to the home regularly. The provider "sometimes looks at the care plans and speak to people, they are good and get us what we need". This meant the delivery of care was not assessed and reviewed.

The registered manager said "there is no specific overarching system for assessing patterns and trends. I don't identify patterns and trends. I look for timelines, and room checks for hazard." Accident reports in place showed three people had fallen in October 2017 and one person had fallen six times that month. However, the falls were not analysed. The registered manager said there was a medicine review and they were considering referrals to falls clinic.

Systems were not in place to improve, innovate and ensure sustainability. The registered manager said there were "no plans." The senior XX and I need training. I think it's [training] is adequate but the level for the senior XX and I is not appropriate. We need to implement it [learning] and then get staff on board. We need them to be more confident about records."

This was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

A registered manager was in post. People we spoke with knew who the registered manager was. The comments from people we spoke with included "[Registered Manager], she is excellent. Very approachable." "The only person we know to be in charge is [registered manager], the manageress." "She's here all hours." The relative of one person told us"[Registered Manager] has been here quite a while; it [the home] seems quite stable. There's not much staff turnover and they can recruit local people."

The registered manager explained they were "contracted to work office hours or as the service requires" and "mostly worked supernumerary but will cover hands on if needed". They said there were challenges in the recruitment of appropriate of staff and "having to cover different roles such cooking." They stated that "there are problems with getting agency cooks and having to be on call 24 hours". It was explained "I was called in at the weekend to cover waking night staff. I arrived at 2:30am and went home at 8:30am.

The provider wrote to us telling us about their visits to the service and stated visits to the home were undertaken on 4 November, 7 October, 9 September, 1 July, 17 June, 28 May, 13 May and 22 April 2017. They said during our visits the feedback from people, their relatives and staff was gained. They stated in writing that maintenance records, duty rota, petty cash register, food storage, environmental sanitation and security among other things" were checked during the visits. The provider also told us there was regular contact "almost daily" with the [registered] manager to "discuss and assist with any issues that arise at the home. I am taking steps to review the practices and procedures at Albany House by delegating responsibilities to one of our senior carers (who has the required qualifications to be manager) to be the compliance officer / deputy manager."

The Statement of Purpose dated 30 November 2006 detailed the aims and objectives of the home which included "provide a homely, safe and caring environment for older people". A member of staff said "we make sure people have a quality of life. Help people to live their life as best as they can. We help people through it and not to change their life."

There was open communication with people who use the service, those that matter to them and staff. The registered manager told us how they ensured the views of people was gathered to improve services. They said time was spent "speaking to people and to the staff. I look at staffing levels and I know by looking at daily notes. I walk around."

Team meetings were held but were not regular. A member of staff said they had attended team meetings. The records of team meetings showed three meetings had taken place since April 2017. A member of staff told us that at the November 2017 meeting the agenda covered new standards, on call systems and Christmas arrangements.

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 9 HSCA RA Regulations 2014 Person-centred care People's care needs were not assessed when they were admitted to the home. Care plans were not developed on how to meet people's needs. Where care plans were in place they did not always contain people's preferences, the care they were able to manager for themselves and how staff were to support them to meet their needs..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not always been consulted about consent to their care and treatment and there wasn't evidence of signed consent. Mental capacity assessments were not always completed where people lacked capacity to consent to their care and treatment. Relatives and friends without legal powers gave their consent to care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were not developed for when staff were to administered medicines prescribed to be taken when required (PRN). Risks to people's health and safety were not always assessed to protect them from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not fully supported to keep their knowledge updated that was in line with best practice. Staff were not supported with personal development through one to one supervision and annual appraisal.