

London Residential Healthcare Limited

Albany Lodge Nursing Home

Inspection report

201 St James's Road, Croydon, Surrey, CR0 2BZ
Tel: 020 8684 4994
Website: www.lrh-homes.com

Date of inspection visit: 24 and 25 November 2015
Date of publication: 14/01/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

Our inspection took place on 24 and 25 November 2015 and was unannounced. At the end of the first day we told the provider we would be returning the next day to continue with our inspection.

At our last inspection during April and May 2015 the provider met the regulations we inspected.

Albany Lodge Nursing Home provides nursing care for up to 100 people over the age of 65, some of whom are living with dementia. At the time of our inspection 89 people were using the service. A manager had been appointed and was nearing the end of the process of applying to the Care Quality Commission (CQC) to be a registered manager for the service.

A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the time of our inspection staff levels were adequate to provide safe care to people, however, we were concerned about the lack of contingency plans the provider had in place to cover nurse and care staff absence when they were on leave or sick, so people were at risk of poor quality of care.

Summary of findings

People were given their medicines by registered nurses. However, we found areas of concern with regard to how people's medicine was being ordered and managed. For example, some people did not get their medicine on time and some people's records were not complete.

The provider was aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, some people's mental capacity assessments were not fully completed or details were not clear. When a person was found to lack capacity the reasons for making decisions on people's behalf were not clearly recorded.

People told us they felt safe living at Albany Lodge. They said staff were kind, caring and respected their privacy and dignity. They thought that the care they received was good and that staffing levels had improved, although people commented that sometimes there were still staff shortages and staff did not have the time they needed. We observed some staff were very task focused spending little time speaking or engaging with people in a meaningful way. The recruitment procedures were appropriate at the time of our inspection.

People were mainly positive about the meals served at the service and we observed how people were given a choice of something different if they asked for it. People's specific dietary needs were catered for.

People's rooms contained personal belongings and items that were special or of personal value to them, however, more could be done to improve the environment for those people living with dementia.

There was an activities programme at Albany Lodge. The activities staff tried hard to ensure people had the opportunity to be involved in meaningful pastimes to help stop them from feeling lonely or isolated but we found people living with dementia may have benefited from more engagement and stimulation in the lounge environments.

People's care records were reviewed regularly and focused on their healthcare needs and the risks associated with them. There was very little information on people's individual needs, history, their likes, dislikes and preferences. This meant that sometimes staff did not know people well which impacted on how staff were able to manage and support people when they became upset.

We have recommended that the service refers to current best practice guidance around activities and the environment for people living with dementia.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, the management of medicines, person centred care, governance and safeguarding people from abuse and protecting their rights. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe. People's medicines were not always being ordered and managed safely.

Staffing numbers were adequate and satisfactory recruitment procedures were in place. But following previous staff shortages there was little contingency in place to cover staff sickness and other absences.

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

Requires improvement



Is the service effective?

Some aspects of the service were not effective. The provider knew the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, some MCA assessments were not complete and did not contain enough information about why decisions had been made in people's best interest.

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

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

Areas of the environment did not fully consider the needs of people living with dementia.

Requires improvement



Is the service caring?

Some aspects of the service were not caring. People were positive about the care they received and felt respected. However, this was not supported by some of our observations because care was task orientated at times.

Staff were kind and attentive when supporting people. Staff knew the importance of treating people as individuals and maintaining their dignity when giving personal care.

Requires improvement



Is the service responsive?

Some aspects of the service were not always responsive. People's care plans and the care they received did not take into account their individual interests and social histories. These shortfalls put people at risk of inappropriate care.

Activities were available so people could be supported to follow their interests and prevent people from feeling isolated or lonely but people living with dementia may have benefited from more engagement and stimulation.

Requires improvement



Summary of findings

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

Is the service well-led?

Some aspects of the service were not always well-led. Some systems were in place to regularly monitor the safety and quality of the service people received and results were used to improve the service but some internal reporting mechanisms were weak and errors and risk were not highlighted or acted upon.

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

Requires improvement



Albany Lodge Nursing Home

Detailed findings

Background to this inspection

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

Prior to our inspection we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, previous inspection reports and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

Our inspection took place on 24 and 25 November 2015 and was unannounced. At the end of the first day we told the provider we would be returning the next day to continue with our inspection.

The inspection team consisted of three inspectors, a specialist advisor with expertise in people's medicines and

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

We also spoke with the manager, the operational support manager and 13 members of staff. We observed care and support in communal areas, spoke with people in private and looked at the care records for 14 people. We reviewed how medicines were managed and the records relating to this. We checked four staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

After our inspection visit the provider sent us additional information including policies and procedures and details of meetings undertaken at the service.

Is the service safe?

Our findings

Albany Lodge had suffered some severe staff shortages during August 2015 because of staff sickness and leave. The manager contacted the CQC at the time to tell us what had happened and what the service was doing to keep people safe. During our inspection people and their relatives told us of their experiences at that time but most felt the numbers of staff had improved although the service was still short staffed at times. Comments included, “Staff numbers are better but they could improve on that”, “Residents are entitled to good care, but at times there are staff shortages”, “In the afternoon there are staff shortages” and “When they are short staffed they leave residents in their beds.”

During our inspection we observed staff were visible and on hand to assist people when they were needed and that there was enough staff on duty to meet people’s basic needs and keep people safe. Staff told us they thought staffing numbers had improved recently but some told us they found it hard to provide cover for staff sickness. Their comments included, “Staffing levels are fine now”, “The staffing has definitely improved more recently” and “Now we have enough staff, we can cope if there is staff sickness...sometimes we can get cover, sometimes not.” We looked at the staff allocations book on one floor and found two examples in November 2015 where staff were absent or sick and additional cover had not been provided. One night two staff were absent leaving only one member of care staff and one nurse to cover two floors and care for 15 people who had nursing and palliative care needs.

We spoke with the manager and the regional operations manager about the contingency plans the provider had in place to cover nurse and care staff absence. We were told a small internal bank system was used to cover annual leave and sickness for care staff and the provider was looking to increase numbers to make this more sustainable. During our inspection we were unable to confirm how adequate cover was provided when nursing staff were sick or absent as the service did not use agency staff. Although staffing levels were safe at the time of our inspection previous shortages at the service and evidence of recent staff shortages in November 2015 showed the provider did not

have robust procedures in place to deploy sufficient numbers of suitably qualified, competent and skilled staff at all times and to cover emergency’s and routine work at the service.

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

People using the service did not raise any issues about their medicines and comments included “What medication I need I get”, “I get my medication on time” and “I get my medication about three or four times a day. They never forget.” However, we identified concerns with the way medicines were managed on three of the four floors we looked at.

Three of the four medicine rooms we looked at were found to be clean and tidy with appropriate measures taken to secure and immobilise the drug trolley. However, the fourth was untidy and the drug trolley not secured within the room. Relevant temperatures were monitored and recorded daily to make sure that medicines were stored at the correct temperature.

Staff told us all nurses were involved in the ordering and booking in of peoples medicines with no one person having an operational overview. We found four people had not received their medicines as prescribed because staff were waiting on stock to be delivered to the service. One person’s medicine did not reconcile and they had more medicine left than they should have had. One person was prescribed a medicine that was very similar to another medicine they were taking. We asked the nurse about the medicines and if the second medicine prescribed was in addition to or instead of the first, they were unable to tell us. This was important because the person may have been taking medicine they did not need or were receiving too much of one type of medicine that may have caused them harm. The prescribed medicines should have been clarified by the nurse when the new medicine was prescribed but we could find no evidence this had happened.

Another person did not have a picture on their medicine records so staff not familiar with them may not have been able to easily identify the person who the medicine was prescribed for.

We found one person was prescribed anticoagulant’s and had missed a scheduled blood test to tell how much medicine they should be take and when. We looked at the

Is the service safe?

persons care records and could find no evidence of action taken or advice given in relation to this matter. We spoke with the manager who assured us they would look into this immediately.

We saw examples where people had prescribed creams in their bathroom which were freely accessible to any other person who entered the room. Staff told us they did not think this risk had been identified.

Some people using the service received covert medicines. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving them.) Most residents who received their medicine covertly had paperwork in place showing why this decision had been made, some decisions had been signed by the GP and the pharmacist. However, we could not always see a mental capacity assessment and discussions supporting the decision making process in peoples' best interests. It was not always clear what advice the pharmacist had given on how peoples medicine should be prepared and the medicines administration records (MAR) did not always record which medicine was to be given covertly. One person was receiving their anticoagulant medicine covertly and did not have a mental capacity assessment or best interest paperwork in place and in addition no advice from the pharmacist had been sought. It is important to record the advice of a pharmacist because adding certain medicines to food or liquids or breaking and crushing medicines to hide them can alter the way they work.

These incidents amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the service was a safe place to be. Comments included, "I have been completely safe. I've never had any troubles", "I feel safe, I trust the staff that help me" and "Oh, I'm absolutely safe in this place."

The service had a safeguarding policy and a copy of Pan-London's "Multi Agencies Procedures on Safeguarding Adults from Abuse" was available in the office. Staff knew what to do if safeguarding concerns were raised. This included reporting their concerns to managers within their

organisation, the local authority's safeguarding team and the CQC. One staff member told us, "We have had safeguarding training and lots of emails and leaflets about safeguarding too." Another told us, "If I see something...I would report to the manager." Managers and staff we spoke with knew about the provider's whistle-blowing procedures and we saw they had access to contact details for the local authority's safeguarding adults' team. We looked at records which confirmed staff and managers had received safeguarding training.

The service had systems to manage and report whistleblowing, safeguarding, accidents and incidents. The whistleblowing policy gave clear instructions to staff on what to do if they had concerns and who to report their concerns to. Details of incidents were recorded together with action taken at the time, who was notified, for example relatives or healthcare professionals and what action had been taken to avoid any future incidents.

Risk assessments were in place for people covering aspects such as falls, manual handling, infection control and pressure ulcers together with guidance for staff on how to reduce the risk and these were updated regularly. There were some risk assessments in place when people's behaviour may challenge but from the samples we looked at the information provided and guidance for staff to reduce risk was minimal. For example, one person's risk assessment regarding their behaviour stated they had "a tendency to lash out and push and throw things away" However, there was little guidance to help staff manage the situation in a positive way and the care plan identified that there were no potential triggers to that person's behaviour. We spoke to the manager about the information available and our concerns that the lack of detail available did not give staff the knowledge they needed to identify possible triggers or to react to people's behaviour in a positive way.

Recruitment checks were carried out before people could work in the home. Each staff file had a checklist to show that the necessary identity and recruitment checks had been completed. These included proof of identification, references, qualifications, employment history and criminal records checks.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were told that applications for DoLS had been made to the local authority, however, when we looked at people's care records the process of assessing people's capacity, the decision to act in a person's best interest and details of any applications for DoLS were not always clear or were sometimes missing. Six of the care records we looked had either did not have a MCA assessment in place or the assessment was incomplete.

One person was resistant to personal care, staff told us and records confirmed that physical and medical restraint was used when the person was non-compliant. However, we could find no evidence of a MCA assessment or a best interest decision had taken place and it was not clear what less restrictive options had been considered before restraint was used. We did not see an application for a DoLS authorisation at the time in relation to the restraint of this person. This meant staff had no legal authority to use restraint and each time they did they were open to allegations of assault. There was very little information in the person's care plan regarding their personal preferences, history, likes and dislikes or information that could help staff understand this behaviour to identify possible triggers and less restrictive ways of dealing with the situation.

We spoke to the manager about our concerns, they assured us they would conduct an immediate investigation and consult with the local authority safeguarding team. We

later received confirmation that this had occurred and that a DoLS application had been made although authorisation had not been received. To use any forms of restraint on a person who lacks capacity without the proper processes in place is a breach under Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. Most staff told us about recent MCA and DoLS training they had undertaken. However, it was evident not all staff understood the best interest process to follow in accordance with the MCA and DoLS where appropriate and were not fully aware of which people using the service were subject to DoLS.

Staff told us they had received enough training to care for people and meet their needs. One staff member told us, "The training is OK...I have manual handling training later this week and more training booked over the next two weeks." Another staff member said, "We have lots of training coming up."

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

An electronic training and development plan was used to monitor training provision for the staff team and identify any gaps. There were areas where gaps in training had been identified. Training had been booked for staff to address these gaps, for example, health and safety and infection control training were booked for December 2015 and January 2016. The service worked closely with the local authority care home support team. We noted they were booked to provide training including equality, diversity and dignity, diabetes awareness, working with complex behaviour considered challenging and effective communication. We will look at staff training during our next inspection to ensure all mandatory training has been completed in line with the service training plan.

Is the service effective?

Staff confirmed they were supported by their line managers through regular staff meetings, one to one supervision meetings and annual appraisals. We saw records to support this.

People using the service told us they enjoyed the food provided to them and were supported to have sufficient amounts to eat and drink. One person told us, "I like the food. It's basic but good...I get enough to eat." Another person said, "I usually get what I want...the portions are big enough."

We observed staff offering people drinks throughout the day. Written and pictorial menus were on display and people told us they were given a choice of meals. There was a choice of two cooked meals. One person told us, "You get two choices and you can have another choice if you don't like what's on the menu." Pureed meals were served to some people using the service with each food item served individually on the plate.

People's mealtime experiences varied from floor to floor. On the ground floor lunchtime was observed to be unhurried with support provided by staff when required. However during lunch, on a dementia unit, staff were trying hard to get people's meals out to them quickly so they would be hot. They did not have enough time to have more than a very brief conversation with people, support them and the process was hurried on to the next person. There was little conversation or stimulation.

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

People were supported to keep well and had access to the health care services they needed. Relatives told us about the healthcare services available. People told us "When I

don't feel good, they get the doctor in quickly. They are good at that", "The tissue viability service come and check on me." One relative said, "[My relative] gets to see the medical professionals when she needs to."

During our inspection we looked at how signs, environment and decoration helped to meet the needs of people living at the service. We found the dementia units were uniformly laid out in the same format as the other floors, with long corridors, doors to bedrooms and bathrooms being the same colour and little signage that people with dementia could use to help with way finding. There was some personalisation of people's bedroom doors, but this was negligible regarding recognition by people with dementia, due to its size and nature. Photographs of people when they were older were displayed but people with dementia may not recognise these as themselves, because they sometimes identify with themselves when they were younger.

There were no supportive elements in the décor to help individuals find their way to places they wanted to go to such as the toilet or dining areas. There was very little interactive material in corridors to capture interest for resident / staff interaction. There were two sitting room areas on each floor. The sitting area located in the dining room had arm chairs arranged in a semi-circular way. This enabled people to identify that there were other people present but did not take into account the likely deterioration in lateral and peripheral vision common to people living with dementia. This meant they might be aware of people sitting beside them, but not others and was of importance as contact with staff tended to be at a distance rather than close up. This did little to stimulate interaction or communication for people or provide reassurance. The other lounge had chairs arranged in front of a television like cinema seating, although this was changed when activities took place.

We recommend that the service refers to current best practice guidance around making the environment more friendly for those people living with dementia such as the work produced by the Kings Fund on developing supportive design for people with dementia.

Is the service caring?

Our findings

People told us, “The staff are nice people. They always ask how I am”, “The staff are kind and respectful” and “I get to know and like some of the staff, but they move on.” Relatives told us, “The staff on this floor are first class”, “The staff are generally good to residents...staff don’t have much time”, “[The staff] overall are very good to [my relative] ...they do move staff about with unsettles [my relative].”

We observed staff over all floors of the service and found in most cases the staff approach to people was friendly and caring, although often time restricted. We observed staff respected people’s cultural and diverse needs. Some staff were able to speak to people in their first language when this was not English, food catered for people’s religious beliefs and people were supported to attend in house religious services if they wanted to. On one floor we saw some good examples of staff using touch to reassure people such as holding their hands when they were upset. One person was in a wheelchair, had finished lunch and was ready to leave the dining area. A member of staff patiently explained that the person had to put their feet on the supports and when ready that they were going to move.

However, on the dementia floors we observed some care delivered by staff indicated a culture of hurried, task driven care. The level of contact with people from staff was often minimal and those people who shouted or staff felt were at risk of falling received more attention than those who sat quietly. There were many people who sat gazing into middle space with little or no interaction after staff had

completed the task that involved the person. Apart from when staff were supporting people to eat, we saw staff tended to stand over people when addressing them, rather than coming down to eye contact level. Most contact was verbal and carried out at a distance, whilst tasks were being performed that were not directly involving people being spoken to. There was little reassuring physical contact from staff, although senior staff had more knowledge of how to reassure people and put it into operation when time permitted. During lunch, we sat next to one person who grasped our hand and held on to it for five minutes. This was whilst waiting 30 minutes to get their meal. This was the only direct physical or verbal contact they made during this period despite the room being full with staff and people using the service. Staff told us they had received dementia care training, although there was little evidence that it was followed.

People told us they felt staff respected their privacy and dignity, comments included, “If the door is shut, they knock”, “I do have dignity” and “[The staff] do treat me with respect and dignity. When they are washing me they shut the door.” Staff explained how people chose what they wanted to eat or wanted to wear and if they wanted to take part in any activities, and respected the choice people made.

People were encouraged to bring items into the service to personalise their rooms. We found most bedrooms were decorated and furnished as people liked with items of personal value on display, such as photographs, memorabilia and other possessions that were important to them.

Is the service responsive?

Our findings

Although most people we spoke with were unaware of their care plans, one person told us, “[The staff] do engage with me on my care plan.” Relatives told us they felt involved in the care of their family member. One relative told us, “We are involved with [my relatives] care plan...they ring when she is not well.”

Relatives told us that some members of staff knew their family members well however with some staff this was not the case. One relative told us, “The staff who have been here a long while know [my relative]...they don’t have a lot of information on [my relative] otherwise she and others would not sit around as much.” Another relative explained, “The knowledge of people comes with the consistency of staff...some staff really connect with residents but with some staff it’s just a task for them... [my relative] needs interaction.”

When we looked at people’s care records we found they contained information regarding health and any associated risks. Most care records contained little or no information about them as individuals such as life histories, likes, dislikes and social interaction needs. They were mainly task orientated and lacked personalisation. This meant that it was hard for staff to react effectively to people’s needs, distress and any aggressive behaviour that people may display, outside of their physical needs. Staff told us information had been requested from relatives, but not returned, however, we were of an opinion that much of the information that could help support care delivery could be discovered by speaking with and observing people. For example, one person we spoke with for 30 minutes told us about the jobs they had during their working life and their experiences. None of the information they gave us was recorded within their care plan.

A culture of person centred care was not evident at this service. We noted areas of care were task driven with staff responding to people’s needs rather than taking a proactive approach to care and support. On one floor before lunch we observed people sitting in the dining/sitting area and saw that staff contact with them was brusque and minimal. This was not due to the attitude of the staff, rather their task driven priorities. One staff member was sitting in close proximity to people, but was engrossed in updating care plan information so contact was minimal with basic acknowledgement of people. This

was also the case for staff entering and leaving the room with a quick hello. In contrast, when one person was in danger of falling, three staff members appeared to make sure they were safe. One person was rude and aggressive to staff when contact was minimal, but their attitude softened and changed when staff took more time to talk to them and make them a cup of tea. Their aggressive demeanour returned when they felt staff were not listening or paying attention to them.

We spoke to managers about our observations and about how staff could make their interactions with people more meaningful and person centred and how person centred care improves people’s experiences. For example, identifying and understanding an individual’s routine can help identify the causes of behaviour that challenges or causes of incontinence. This would also help staff better support those people whose behaviour may challenge by identifying any triggers and having positive proactive responses and guidance in place to help people when they became angry or distressed.

The manager explained they were in the process of making people’s care plans more person centred and after the inspection provided some examples, however, the majority of care records we looked at had very little person centred information that reflected their personal preferences. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us about the activities at the service, comments included, “There is too much time and little to do...if there is anything happening in the home, I take part in it”, “There is not enough to do. I would like to read my books but there are no books here at all” and “I don’t get out much. I do get out into the garden if someone takes me.” One relative told us, “They do have activities, but a lot of people on this floor don’t go because they are in their beds.” Another relative said, “There could be more activity. Most takes place downstairs.”

Two activities coordinators worked over seven days to provide activities at the service, these included bingo, tombola, card games, arts and crafts. We spoke to one activities coordinator who told us about the outings that some people took part in like trips to Brighton beach or the flower shop. We were told four people were attending a local garden centre the next day and that a small bus had been hired to drive them there.

Is the service responsive?

We asked the activities coordinator what activities were available for those people who were bed bound or at the risk of social isolation. They explained they tried to see everyone to give them some “1 to 1 time,” this may be a chat, a hug or holding hands and could last from five to 15 minutes at a time, we saw these sessions were recorded in some people’s care records. During our inspection different floors were being decorated with Christmas decorations and Christmas music was playing. The activities coordinator explained activities would vary from day to day depending on what people wanted to do and they appeared to know people and what they liked to do well.

However, we observed that some people may have benefited from more engagement and stimulation in the lounge environments due to their dementia needs. We spoke to the activities coordinator about ways to enhance people’s surroundings for example, reminiscence style equipment such as memory boxes for people to investigate or dolls and soft toys or furnishings for them to touch and hold. They explained they did have some toys that people liked but they tended to take these back when the activity was over as otherwise they would disappear. We spoke to the manager about ways to further improve the quality of people’s lives living with dementia.

People were able to maintain relationships with people that matter to them. One person told us, “I see my relatives often. There are no restrictions to their visiting.” One relative told us, “There are no visiting restrictions for relatives.”

Most people we spoke with told us they or their relatives would complain or comment on issues they were not happy about they said, “If I’m unhappy about something, I’d say” and “On this floor there have been no complaints from me but I would say if not happy.” One relative told us, “Any problems I go straight to the manager, she sorts it out.” Another relative told us they knew how to complain but would appreciate a similar process and suggested a complaints book that relatives could write in. The service had a procedure which clearly outlined the process and timescales for dealing with complaints. Complaints were logged and monitored at provider level.

We recommend that the service refers to current best practice guidance around activities for people living with dementia such as the resource toolkit for living well through activity in care homes produced by the College of Occupational Therapists.

Is the service well-led?

Our findings

Regular audits were undertaken to assess internal standards at the service. A program of regular audits were undertaken by the manager to monitor people's health needs these included information about wound management, bruises, skin integrity, falls, hospital admissions, call bell audits, and analysis of accidents and incidents. Weekly clinical review meetings were held to discuss identified risks and trends with clearly identified actions and the person responsible for completion.

We found the above audits were in place and noted how they help drive improvement in the service, for example, monitoring people's falls and the triggers and risks that could be avoided. However, we were concerned that, the monthly medication audit undertaken by the nurse in charge of each unit did not highlight the errors we found in people's medicine records so it was hard to see how the manager could monitor progress, learn from events and improve standards. We were also concerned that the provider had not assessed the risk appropriately or introduced sufficient emergency measures to ensure the health safety and welfare of people when staff were unexpectedly absent or sick. This was a breach under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People and their relatives were mostly positive about the way the service was managed and generally felt things were improving since the staff shortages in August 2015. They said, "Since the new manager came things have improved 100%. She is always around", "The new manager is trying to improve things", "Since August the manager doesn't support the unit as much... too much pressure I think" and "[The manager] is trying to improve activities around the Home... I can say overall it's very good here."

Most staff told us they felt supported by the management at Albany Lodge. Their comments included, "Things are

getting better...she is a very good manager...it's a massive difference to how things used to be", "The manager is very supportive, she is hands on and I will sing her praises...it makes my day when I see her on the floor" and "We are very well-led by the manager. Fantastic leadership skills." Two staff members we spoke with told us they did not feel supported or appreciated and spoke about the lack of support during the staff shortages in August 2015.

Regular relatives' meetings were conducted to gain the views of people and their relatives. We saw records of these and noted where concerns that had been raised they had been addressed. For example, one person said the food they received was not what was expected on the menu, minutes noted this was investigated by the manager and actioned by the kitchen staff. Two people we spoke with felt if there was an issue the manager would address this however one relative we spoke with felt there was very little change after suggestions were made at relatives meetings.

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

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

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
People's medicines were not always being ordered, recorded and managed in line with policy, procedure, current legislation and guidance.
Regulation 12 (2)(g)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
The provider did not consider people's mental capacity and follow correct procedures by gaining lawful authority when using forms of restraint to make sure people were protected from abuse. Regulation 13 (4) (b) and (5)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
The provider did not have procedures in place to deploy sufficient numbers of suitably qualified, competent and skilled staff to cover emergency's and routine work at the service Regulation 18 (1)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
The provider failed to provide care and treatment that was appropriate, met people's needs and reflected people's preferences. Regulation 9 (1)(a)(b)(c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have systems and processes that enabled them to identify and assess risks to the health, safety and welfare of people who use the service.
Regulation 17 (2) (b)