Albemarle Rest Home Ltd

Albemarle Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Albemarle is a residential care home providing personal and nursing care to 18 people aged 65 and over at the time of the inspection including people living with dementia. The service can support up to 24 people. People had access to a shared lounge, dining room and conservatory and gardens at the back of the home.

People's experience of using this service and what we found
Records relating to risk assessment, care plans and accidents and incidents required improvement. Some known risks for specific health conditions did not have required risk assessments or care plans. Accidents and incidents were recorded but not analysed to learn from them. There were occasions when staff did not wear their face masks according to government guidance and improvements were identified in the administration of covert medicines.

Quality assurance and governance systems required improvement. They did not identify some of the risks found on inspection or gaps in people's care records. Audits needed to be implemented to ensure effective oversight and monitoring of all accidents and incidents to mitigate risks.

Improvements to the design and décor were underway. People's bedrooms were being redecorated and furniture replaced throughout the home.
Staff felt well supported by management and spoke positively about working at the home. Relatives felt the home was well organised and that the atmosphere was friendly, homely and caring. They were kept informed and staff felt communication in the home was good.

Relatives felt their loved ones were safe and received care from a consistent staff team who knew them well. Staff understood the risks to people's health and how to manage them. There were enough staff to support people safely and respond to their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at the last inspection
The last rating for this service was Good (published 28 April 2018)

Why we inspected
This inspection was prompted in part due to concerns received about visiting and management of risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home

inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Ratings from the previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the relevant key questions safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Albemarle Rest Home on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 17 Good Governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Albemarle Rest Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 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.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of

this information to plan our inspection.

During the inspection
We spoke with two people who used the service and 12 relatives about their experience of the care provided and one professional. We spoke with five staff including the registered manager, nominated individual and senior care workers. We reviewed a range of records. This included four people's care records, daily logs, accidents, incidents and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at risk assessments, care plans and policies relating to COVID-19.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

● Risk assessments were not always in place. Some risks to people's health and safety had not been included in their care records. For example, one person at risk of falls had no falls risk assessment or care plan. Another person's diabetes risk assessment did not include guidance from the district nurses on monitoring the person's blood sugars, or risks to the person if their diabetes was not managed properly.
● Staff understood the risks to those people's safety and measures in place to minimise the risk of falls. The registered managed confirmed that staff followed written directions provided by district nurses which included information on safe blood sugar ranges. Records relating to the management of diabetes were updated and a falls risk assessment and care plan was implemented soon after our inspection, but the detail contained within those records still required improvement.
● Potential risks posed by an uncovered radiator had not been identified. One person's bed was next to a radiator without a cover. This did not follow Health and Safety Executive guidance on managing the risks posed by hot surfaces in care homes. We raised this immediately during our inspection and action was taken to minimise the risk of contact with radiators whilst the provider arranged for radiator covers to be fitted.
● Accidents and incidents were reported and recorded. However, there was no analysis to identify trends or patterns to reduce the risk of them happening again. We raised this with the registered manager who assured us that regular audits would be re-introduced immediately.
● Relatives told us they were contacted if their loved one had an accident or change in health. One relative said, "They always let me know if [person] falls", another relative said, "[Person] has not had any falls but [person] had a funny turn. They got a doctor and phoned me up."
● Relatives told us they felt their loved ones were safe and were happy with the care they received at the Albemarle. One relative said, "I feel confident [person] is safe twenty-four seven". Another relative said, "[Person] is well looked after, happy and safe."

Systems and processes to safeguard people from the risk of abuse

● Staff were trained in safeguarding and were confident identifying and reporting potential safeguarding incidents.
● Improvements were needed to the level of detail in recording of actions taken in response to potential safeguarding concerns. Following our inspection, the registered manager implemented a new system specifically for the recording and reporting of all safeguarding concerns.

Staffing and recruitment

● There were enough staff to support people safely. Feedback received from staff and relatives confirmed this.

● Staff were recruited safely. Recruitment processes included reference and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions when employing those who work with vulnerable people.
● Staff turnover was low, so people received consistency in care from a staff team who knew them well. Due to the stability of the staff team, agency care staff were not used. One relative said, "We are really pleased with the care and the way [person] is looked after and the consistency of the same staff as they knew [person] before they deteriorated."

Using medicines safely
● Overall, medicines were ordered, stored and administered safely. However, the administration of covert medicines needed improvement. Covert medicines are hidden or disguised in food or drink so they can be given in the person's best interests. Some medicines were being crushed which was against manufacturer's guidance. The provider took immediate action to stop this practice and assured us new systems would be implemented to ensure covert medicines were administered according to guidance.
● Staff were trained and their competency to administer medicine assessed to ensure they had the knowledge and skills to do so safely .

Infection prevention and control
● We were somewhat assured the home was facilitating visiting in lines with guidelines. People were supported to have visitors inside the home but there was a time limit and restrictions on the number of visits per week. We signposted the provider to further guidance and they agreed to review their visiting policy to ensure it reflected government guidelines.

● We were somewhat assured the home was using PPE effectively and safely. This is because there were occasions when face masks were not worn according to guidance and we received some feedback that not all staff wore a face mask when visits were made to the home.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Action to continually assess, monitor and mitigate the risks relating to the health, safety and welfare of service users had not always been taken.

● Medicine audits had not identified some covert medicines were being crushed against manufacturer's guidance.

● Accidents and incidents were not analysed to learn from them or identify any actions that could reduce the risk of them happening again. For example, there was no analysis of falls to identify any trends or patterns. We were given assurance these would be implemented immediately.

● Quality assurance systems and audits did not identify risk assessments and care plans that were missing from people's care records. We were sent copies of these shortly after our inspection. However, the level of detail still required improvement to ensure all relevant risks to the person's health and how to manage them were documented. For example, one person's diabetes risk assessment and care plan did not include signs and symptoms which might indicate their diabetes was not being managed effectively.

● Risks posed by exposure to a hot surface had not been identified. One person's bed was placed right next to a radiator which surface temperature was hot to touch. This person had dementia and a risk assessment had not been completed. The provider took immediate action to minimise this risk and made arrangements for radiator covers to be fitted.

● Oversight of record keeping following accidents or incidents required improvement. Records did not always evidence whether medical advice was sought following an accident or injury. Discussions with the registered manager identified some actions taken in response to incidents had not been recorded. The registered manager assured us a new system would be implemented to clarify processes in response to accidents and incidents.

● PPE was not always worn according to government guidelines. There were occasions when face masks were not fitted correctly which meant they slipped below the nose and one person was observed with their face mask pulled below their chin. We received feedback from one relative that not all staff wore face masks during visits.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately, during and after the inspection. They confirmed interim action had been taken to address the risks posed by hot surfaces and audits of accidents and incidents within the home would commence immediately.

● Improvements to the design and decoration of the home were underway. People's bedrooms were being redecorated and all furniture in the home and bedrooms replaced. Walls were being re-painted and carpets replaced. People's views on colours were gathered to encourage their contribution to these changes.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a positive working culture where staff felt well supported and people and their relatives experienced good communication and consistency in care.
● Relatives gave positive feedback about the way the service was run, the atmosphere and caring culture. One relative said, "It is very well organised, I am impressed." Another relative said, "The best thing is the homely atmosphere there, it feels more like home."
● Staff spoke positively about working at the home and the support they received. One staff member said, "I have always liked working here, good support off everyone, we work well as a team." Another member of staff said, "It is a good place to work, I love my job, love the clients we have here, because we are a small home they recognise and reward."
● Staff felt that communication was good and that important information and updates about risks to people were discussed during handover at every shift. Monthly staff meetings were used to share key updates and changes in policies or procedures.
● Relatives sent compliments in thank you cards and messages. However, there was no formal system to encourage feedback from people, relatives, staff or professionals to help plan for and make improvements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We were notified of important events and incidents within the home. However, we identified one recent event in the home which had not been notified in accordance with the regulations. We raised this with the registered manager and a notification was submitted shortly after our inspection as required.

Working in partnership with others

● The provider worked closely with district nurses and their G.P surgery and a ward round visit was carried out every week.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others were not in place or not operating effectively.