Albemarle Rest Home Ltd

Victoria Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected this service on 7 and 12 October 2015. The inspection was unannounced.

We were not able to gather all the evidence we needed to make a judgement on the first day of our inspection because the provider and the registered manager were not available to speak with us. We went back on a second day to make sure they had the opportunity to tell us how they managed the service and about their plans for continuous improvements.

There was a registered manager 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.

The service provides accommodation, nursing and personal care for up to 23 older people who may be living with dementia, a physical disability or sensory impairment. On the day of our inspection, 17 people lived at the home.

The provider's policies and procedures to minimise risks to people's safety were shared with the staff. Staff understood their responsibilities to protect people from

Summary of findings

harm and were supported to raise any concerns. The registered manager assessed risks to people's health and welfare and people's care plans minimised the identified risks.

There were enough staff on duty to meet people's needs. The registered manager checked staff's suitability to provide care during the recruitment process.

The provider's medicines policy included training staff and checking that people received their medicines as prescribed, to ensure people's medicines were administered safely.

People received care from staff who had the skills and experience to meet their needs effectively. Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. Staff were supported and encouraged to reflect on their practice and to develop their skills and knowledge.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for a DoLS for one person to make sure they had legal authority to take the agreed actions to keep the person safe. For people with complex needs, their families and other health professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because staff knew about people's individual dietary needs. People were offered a choice of foods and were supported to eat and drink according to their needs.

Staff were attentive to people's moods and behaviours and understood how to minimise their anxiety. People were supported to spend time with other people who lived at the home. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health and when their health needs changed.

People and their relatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed.

People and relatives told us care staff were kind and respected their privacy and dignity. They were confident any concerns would be listened to and action taken to resolve any issues.

People and relatives were encouraged to share their opinions to enable the provider to make improvements in the quality of the service. Staff were guided and supported in their practice by a management team they respected.

The provider's quality monitoring system included regular reviews of people's care plans and checks on equipment, medicines management and staff's practice. The provider's visions and values were understood and shared by the managers and staff. The focus of the service was to ensure people enjoyed the best possible outcomes from the service delivery.

Plans to improve the quality of the service included improvements to the environment to better support people with dementia and including people's wishes for how they would like to be cared for and supported towards the end of their life.

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?
The service was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Good

Is the service effective?
The service was effective. People were cared for and supported by staff who had relevant training and skills. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to other healthcare services when their health needs changed.

Good

Is the service caring?
The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by encouraging them to make their own decisions.

Good

Is the service responsive?
The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff understood people's, likes and dislikes. People were supported to spend time with others, according to their abilities and preferences. People were confident any complaints would be dealt with promptly.

Good

Is the service well-led?
The service was well led. People were encouraged to share their opinions about the quality of the service to ensure improvements focused on their experiences. The management and staff team shared the provider's values to provide an effective, good quality service that delivered the best possible outcomes for people.

Good

Victoria 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.

The inspection took place on 7 and 12 October 2015 and was unannounced. The inspection was undertaken by two inspectors and a specialist nurse advisor.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with one person who lived at the home and three relatives. We spoke with the provider, the registered manager, the nurse manager, one nurse, five care staff, the cook and a housekeeper. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

None of the people living at the home were able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed four people's care plans and daily records and 17 medicines records to see how people's care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the available records of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

Relatives told us the service was good and they were confident their relations were safe at the home. One person told us they did feel safe.

Staff knew and understood their responsibilities to keep people safe and protect them from harm. A member of care staff told us if they saw a mark or bruise (on a person) they would record it and report it to the nursing manager straight away. Staff told us they had safeguarding training and the contact number for the local safeguarding team was in the office. They told us they would contact the safeguarding authority themselves if their concerns were not taken seriously.

Care staff told us they felt encouraged by the whistleblowing policy to raise any concerns. A member of care staff told us they needed to be observant and watch how people behaved around members of staff. Records showed the provider investigated issues that staff raised and took prompt disciplinary action to keep people safe from the risks of harm.

The provider's policy for managing risk included undertaking an assessment of people's individual risks. In the four care plans we looked at, the registered manager had assessed risks to people's health, physical and emotional wellbeing. Where risks were identified, people's care plans described how staff should minimise those risks. The manager checked risks to people's mobility, communication and understanding, for example, and the care plans described the equipment needed and the actions staff should take to support people safely.

The provider's policy for managing risk included risk assessments of the premises and equipment, which resulted in contracts with specialist service providers. Records included maintenance and service contracts for gas safety, disposal of medical waste and for hoist maintenance. For example, on the first day of our inspection the specialist bath had broken down, but it was repaired through a maintenance contract the following day.

Staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency. The provider showed us a fire safety check that had been undertaken by an external professional, two months before our inspection. The provider told us they were making progress with the recommended actions, apart from one, which was to prepare a personal evacuation plan for each person. The recommendation did not take into account the level of people's dependencies and would not be the safest action.

For example, only one person who lived at the home was independently mobile, which meant 16 people needed support from two staff and a hoist to mobilise and evacuate the building. As this could not be done quickly without risking the safety of people and staff, they had not completed a personal emergency evacuation plan for each person. The fire safety procedure included smoke alarms in each room, 30 minute fire resistant doors, and an alarm system that showed the safe zones in the building. The emergency risk management plan involved moving people to the safe zone and calling the fire brigade who were located minutes away. A member of care staff told us the first thing they would do in the event of a fire alarm was to check which zone was safe.

Staff kept a log of incidents and accidents, which included a record of the actions taken to reduce the impact and minimise the risks of a reoccurrence. For example for one person who had developed a sore patch on their fragile skin, the registered manager had asked care staff to confirm which sling size they had used to hoist the person and to check whether the elastic in their clothes was tight as potential causes. No incidents had resulted in serious injuries that needed to be notified to us.

People and relatives told us there were enough staff to support them or their relations. One person told us staff came when they called them and, "They didn't take long" to respond. One relative told us they visited several times a week, so they would know if their relation's needs were not met. The manager told us they had used a dependency needs because most people were completely dependent on staff for eating, drinking, mobilising and for personal care. Care staff told us there were enough staff on duty to care for people according to their needs. They told us when staff left, the registered manager responded promptly and recruited new staff.

The provider's recruitment process ensured risks to people's safety were minimised. Records showed the registered manager checked staff's suitability before they started working at the home. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any

Good

Is the service safe?

information about them. The DBS is a national agency that keeps records of criminal convictions. The nurse manager made sure nurses maintained their professional status by checking their registration (PIN) numbers were current. The nurse manager told us, "The agency that supplies our nurses, when needed, sends us the information we need, photo ID, proof of DBS check, previous experience and courses completed." They told us they gave feedback about each agency nurse that worked at the home to make sure agency nurses demonstrated the skills, behaviours and experience expected of them.

People's medicines were managed safely and only administered by qualified nurses. Medicines were kept securely in a locked room or locked cabinet, where only nurses could access them. Leaflets for each medicine were kept in a folder so nurses could check what each medicine was for and be alert to any signs of an adverse reaction.

The pharmacist provided medicines administration records (MAR) for each person, which stated the dosage, frequency and time of day they should be administered. The 17 MARs we looked at included the person's photo, any allergies and were signed and up to date. Two medicines we looked at needed to be given first thing before food. Records showed these medicines had been administered by night staff before they went off shift, to ensure they were administered before the person had breakfast.

A nurse told us one person often declined to take their medicines despite gentle encouragement. The nurse explained they would try again later, but if the person declined again they would destroy the medicines and record that on the MAR and in their care record. We asked whether anyone was given medicines covertly, that is, without their knowledge. The nurse manager told us one person had difficulty swallowing so one of their medicines had been changed by the GP to a liquid format and one to a crushable format, to make them easier to swallow. Records showed a staff had arranged for a GP to visit and review another person's medicines the week after our inspection. The nurse manager told us the GP would assess the risks of the person not taking their medicine and advise whether their medicines should be given covertly.

Good

Is the service effective?

Our findings

One person told us staff met their needs effectively and said, "They pop in and see if you are OK and if you want anything" and, "The girls are always coming around to see if my water needs changing." Relatives told us, "[Name] is very well looked after" and "[Name] is always clean, bathed, hair brushed. They give the right care, they are very tactile."

People received care from staff who had the skills and knowledge to meet their needs effectively. Even though most people were not able to communicate verbally, we saw staff understood and anticipated their needs. Records showed care staff received training in the use of moving and handling equipment, applying topical creams and bathing. A member of care staff told us that if a particular type of training was needed, they would raise this with the nursing manager who, "Usually sorts it out." The nurse manager showed us the staff training records which included moving and handling and the principles of dementia care. They told us staff had recently attended end of life training and planned training included healthcare for care staff, which would include workbooks to demonstrate and verify staff's learning.

Care staff told us they had an induction programme of training and working with experienced staff when they started working at the home. Care staff told us they were observed in practice and had to be assessed as competent by senior staff, before they worked with people independently. The nurse manager told us, "All staff are observed in practice against a list of demonstrable skills, I ask them what they look for before starting (to deliver care)." The checklist of skills assessed included bed bathing, using a hoist and slide sheet safety and assisting a person to eat.

Staff told us they were supported and guided in their practice. The nurse manager continued to check staff's competence in these skills throughout their employment and scheduled regular supervision meetings to discuss staff's performance and professional development. Staff told us they had been supported to achieve nationally recognised qualifications in health and social care.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Relatives told us they were confident their relations made their own decisions whenever possible. One relative said, "Staff respect her wishes."

The guidance for staff in people's care plans included 'prompting' and 'encouraging' people, to make sure people were supported to make their own decisions about their care and support. A member of care staff explained this meant they would give a person information relevant to the decision and if the person was still unable to communicate a preference, they should do what they thought was best for the person, unless the person declined. We saw staff understood and respected the decisions of people who could only communicate through their body language and facial expression.

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The registered manager understood their responsibility to comply with the requirements of the Act. In one care plan we looked at, the registered manager had a meeting with an external health professional before making an application to the local supervisory body. This was because the plan to keep the person safe included aspects that would be classed a deprivation of the person's liberty, without their agreement. At the time of our inspection the application was still being processed by the supervisory body.

People were offered a choice of nutritionally balanced meals that met their specific dietary needs. One person told us, "If there is something I do not like, they will cook me something else that would suit (me)." At lunch time we saw the menu board offered a choice of two different hot meals and two different puddings. The cook told us the menu ensured a dietary balance of protein, carbohydrates and vitamins and they always used full fat milk. They told us there was a two week menu that was varied according to people's allergies, dietary needs, likes and dislikes. They said "There is always enough food to cook the menu and offer choice and to vary the menu according to people's suggestions."

Most people needed a soft diet and support from staff to eat. A relative told us, "I know if [Name] has eaten well." A member of care staff told us that staff, "Know people very well" and offered people meals that they knew they would like or that they, "Will manage to eat." When meals were brought into the lounge we heard staff telling people what

Good

Is the service effective?

was on their plate. One person pushed their plate away and staff slowly and carefully asked if it was one particular food on the plate that they did not like. The food item was removed from the plate and the person ate the rest of their meal.

The nurse manager told us, "We chat with relatives about people's likes, dislikes and preferences, but we don't always get a lot of information. We learn about people once they are here. [Name] has an allergy to fish, so she is offered something else on Fridays and [Name] and [Name] are diabetic." We saw this information was posted in the kitchen. Care staff told us they knew about people's dietary needs from their care plans and by getting to know them well.

Care plans included an assessment of people's nutritional risks. For one person who was assessed as at risk of poor nutrition, their care plan included monitoring their weight and their food and fluid intake. Staff kept a food and fluid chart for the person which recorded the actual amount of their intake. For people who were not identified as at risk of poor nutrition, care staff recorded whether they had eaten well and shared information about the person's appetite at handover. This ensured any changes in people's appetites were known to all staff.

Relatives told us their relations were supported to maintain their health. One relative told us, "They ring up straight away if there are any medical issues." Care plans we looked at included records of visits and advice from other health professionals, such as the community health team, GPs and opticians. Staff supported people to follow the other health professionals' advice. For example, staff recorded when one person was given fortified drinks on their MAR sheet, because they had been prescribed by the GP. A visiting health professional told us they were asked to visit appropriately. They told us, "If I say 'encourage fluids' I explain why they are important and assess the impact. Staff take my advice and I see the impact in improved patient outcomes."

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person told us, "It is just as if I am at home. I am quite content here." Relatives told us, "[Name] is very well cared for. It must be very difficult, but somehow they manage to do it so well" and "The staff are all very friendly. They are all kind, thoughtful."

People appeared relaxed in staff's company. Care staff maintained eye contact with people, spoke in a calm tone of voice and used touching and holding hands to reassure people they were being listened to. Staff explained to people what they were doing, for example, when getting them a drink or supporting them to move. A member of care staff told us, "I do my best for people as if they are my Mum or Dad."

Care staff understood people's moods and behaviours. We saw they understood people who were not able to communicate verbally and supported them with kindness and compassion. When one person appeared to be agitated, we saw care staff offered the person their hands and spoke reassuringly until the person smiled. One member of care staff told us "We are all interested in the well-being of the people here, and that, to me, is the main thing."

Most people were not able to tell us how they were involved in discussing and agreeing how they were cared. We heard care staff involving people in everyday decisions about where to sit, and what to drink. They explained the choices and offered care to people and watched their body language to gauge their consent. A member of care staff told us they were advised and guided by people's families about preferences related to food, drinks and daily routines. They told us they, "Always look out for signs, verbal and non-verbal, such as facial expressions, to judge whether a person likes something or not."

The provider told us, "Staff are trained to support people. The first rule is 'never argue' with a person who presents behaviour that challenges." Care staff told us if a person declined care they would give the person time and come back later when the person had had a chance to consider it and would try to distract the person. One member of care staff told us, "You can't be adamant that you are right and they are wrong. It's their home."

Two relatives told us the care plan discussions meant they could share information about their relation's life, which included their religion, family and significant events. We saw there was a list of people's birthdays in the kitchen so staff knew when to support people to celebrate their birthdays. Care staff knew about and respected people's diverse needs and preferences. The nurse manager explained how one person was supported to maintain their religious practices. A relative told us, "Staff respect her wishes."

Relatives told us they could visit whenever they liked and always felt welcome. One relative said, "I am always offered a cup of tea." One relative told us they visited every day. They said staff respected and supported their preference to spend time privately with their relation in their room.

Good

Is the service responsive?

Our findings

Relatives told us their relations were cared for and supported in the way they had discussed when planning care. One relative told us, "[Name] came to the house and went through everything, food and clothes." We saw people and relatives had personalised their own rooms with photos, memorabilia and personal effects from their previous lives.

Care staff told us they knew about people's previous lives, preferences and interests because they read their care plans and chatted with people and their families. One member of care staff told us, "Our knowledge of a person's likes and dislikes is built up over time. We assess the situation day by day and look out for clues, verbal and non-verbal, on how the person is reacting to the support and the way it is being provided."

Care plans included a personal profile named, "All about me." The personal profile included information about people's preferences for sleeping and how they spent their day. For example, one care plan we looked at described the number of pillows the person liked, their preference for what to wear in bed and that they liked to have a bedside light on at night. The nurse manager told us, "Some people are able to make their preferences known. For example, [Name] can point to her room, [Name] can be encouraged to get up as long as she is assured she can come back to her room after lunch and [Name] can chat about what is on the television."

The personal profiles described people's ability and level of interest to engage with their surroundings. The nurse manager told us staff tried to encourage one person to engage with activities such as listening to audio tapes and going to a lunch club, but the person declined to socialise or go out. They told us, "[Name] goes out into the garden after lunch, weather permitting."

One person who was able to communicate with us told us they could decide for themselves when they got up, where they spent time during the day and when they wanted to go to bed. One person told us, "They (staff) come along and if I don't want to go to bed, I sit and read and they say 'just tell us when you want to go to bed – that's fine."

Staff recorded information about people's moods, appetites, and behaviours and whether anything was 'unusual'. We saw a record staff kept for one person whose behaviour had recently changed. They planned to use the information to identify potential triggers for the changes and to analyse which response by staff was most effective at calming the person. One relative told us, "I know what is going on because staff tell you."

Care plans were regularly reviewed and updated when people's risks and needs changed. For example, one person whose dementia had progressed was noted to be less able to move position independently, but more unpredictable in their movements. Their care plan stated they should be supported to sit in a recliner chair, to reduce the risk of falls. The nurse manager told us another person was no longer safe in a recliner chair, "So is now nursed in bed." Relatives told us, "I don't attend for monthly reviews of care, but I could say if I wanted to change things" and "There is a review of needs planned for Friday, with the social worker."

Staff shared information about changes in people's needs during their handover meetings. An agency nurse told us the information shared between staff was detailed and gave them confidence in supporting people. They told us, "The night staff showed me around. I was told which people were particularly poorly, who should be resuscitated and who had a DNAR in place. I was shown the drugs trolley and the controlled drugs. [Name] stayed late to share information. There is also a book for agency staff, it has everything in it. It is like a bible."

The registered manager told us they had not received any complaints about the service in the previous 12 months. They had a file ready to record complaints and the actions taken to resolve them. None of the people or relatives we spoke with had any complaints about the service. One relative told us, "I would complain directly to [Name] if I needed to."

Good

Is the service well-led?

Our findings

People and relatives were happy with the quality of the service. Relatives told us they felt well informed and were confident the registered manager responded to their concerns. A relative said, "The staff are all good" and "[Name] is very well looked after."

People and their relatives were encouraged to share their views of the service through an annual survey. They were asked their opinion about the quality of care, the staff and whether they were kept informed. Only one relative had responded to the latest survey, so the nurse manager had written a follow up letter to remind people their opinions were valuable to maintaining and improving the quality of the service. One relative told us they had received a survey, but had not yet responded, because they were happy with the quality of the service.

We asked the nurse manager if they had any plans to improve the environment to support people with dementia as they moved around the home. They told us they had not wanted put people's names or photos on their bedroom doors, to protect their privacy and dignity. They said they would look at how people might better distinguish between the doors along the corridor and associate with their own rooms by using pictures or memorabilia that might trigger good memories.

The registered manager notified of us of incidents and important events, in accordance with their statutory obligations, and demonstrated the skills of good leadership. Care staff told us the managers were very receptive to their suggestions and concerns and they felt free to raise issues with them. One member of staff told us they had been in post a long time because it was a nice place to work with a friendly atmosphere and the staff and managers were good. They told us, "If I have a problem I will go and talk to [Name] because she is very approachable."

The service was delivered in an open and transparent way. Staff told us they shared the provider's values of providing 'good outcomes' for people. The provider told us, "Staff have been continuously employed for a long time. We know they know what they are doing. I take strong disciplinary action if I am not satisfied with staff's performance. It gives staff the confidence to challenge poor practice and to share their concerns with us." Several of the care staff had worked at the home for more than 10 years.

Care staff told us they were given guidance and reminders about best practice at team meetings. A member of care staff told us attended team meetings and 'mini meetings' to discuss people's needs, support plans and current issues. Minutes of the most recent recorded meeting showed they were reminded about attending supervisory meetings and discussed the results of recent audits. Records showed the nurse manager conducted annual competency assessments of nurses' medicines administration practice. The nurse manager checked the nurses' general knowledge, their knowledge of people's needs and how nurses ensured medicines were given in accordance with their prescription.

The registered manager followed a monthly audit schedule to check that people received the care they needed. We saw the results of the manager's recent audits of the audits of equipment and medicines. Action was taken when issues were identified, such as replacing worn mattresses, which demonstrated the measures in place were effective to minimise risks to people's health and welfare.

The registered manager told us they conducted informal quality audits of the home and people's care, but they did not keep a written record unless issues were identified. They told us, "I do a swoop. That includes randomly testing the call bells and seeing how long it takes for staff to answer. I tread on sensor mats and wait for staff to respond. I check the taps and record any dripping taps on the maintenance list. I pop in doors and check people are okay. I know who likes to go to bed in the afternoon, so I would ask why, if I saw someone in bed when I didn't expect it. I ask [Name] how she is." The provider told us, "Water checks are not completed as a matter of course, but rely on exception reporting, by staff to the manager. For example, the manager will take first action, for example, examine the filter to make sure it is not blocked. If this does not fix the problem, we call a plumber."

Staff told us the provider responded to any concerns they raised about the premises and equipment. Staff told us they reported them to the manager, who made sure the provider was informed and able to plan for repairs or replacements. We saw some repairs were needed to the

Good

Is the service well-led?

kitchen floor and the cook told us they were waiting for a replacement fridge door seal. The manager confirmed the cook had reported these issues and they were confident the provider had plans to repair them in a timely way.

The provider was working with other healthcare providers to ensure people received the best quality of care. For example, the provider had taken action to improve people's experience of transition between services. The home was involved in a pilot scheme to promote joined up care. The scheme included a regular 'ward round' by a doctor from a local surgery, visits by the community liaison nurse and meetings at the doctor's surgery to discuss people's on-going and future health care needs. The community nurse told us this enabled them to develop a relationship with people and their families and to talk about their future wishes in advance.

The nurse manager told us taking part in the scheme had prompted them to consider how to approach the difficult conversation with relatives about end of life care. They showed us a document produced by the local NHS Trust, entitled, "Towards Life's End". The document included recognising people's wishes, spiritual, cultural and practical needs and would ensure people received the care they wanted at the end of their life. They told us they would the document, with relatives' agreement, at the next review of care with relatives.