

Tamby Seeneevassen Amber House

Inspection report

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Date of inspection visit: 18 December 2015
Date of publication: 15/02/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



Overall summary

This inspection took place on 18 December 2015 and was unannounced. We previously visited the service on 4 June and 8 July 2015 and we identified that there were insufficient numbers of staff employed to meet the needs of people who lived at the home, that the premises were unsafe, that some care workers did not have the skills to communicate effectively with people who lived at the home, there was a lack of evidence staff had completed induction and on-going training that equipped them to carry out their role, that some people received inadequate support when they displayed behaviour that might challenge others, there was a lack of opportunity for people to comment on the care and support they

received and that action had not been taken when the need for improvement had been identified. The concerns we had meant that we placed the service in 'Special Measures.' Services in Special Measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

At the inspection on 18 December 2015 we checked that the registered provider had made the required

Summary of findings

improvements to ensure that people received a safe and effective service. We found that significant improvements had been made which meant that the service was no longer placed in 'Special Measures.'

The home is registered to provide accommodation for up to 41 older people who require assistance with personal care, some of whom may be living with dementia. On the day of the inspection there were 20 people living at the home. The home is situated in Bridlington, a seaside town in the East Riding of Yorkshire. It is close to town centre facilities and the sea front.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted an application for registration. 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs during the day but that staffing levels during the night were sometimes reduced. Night time staffing levels were increased from the day following our inspection. We made a recommendation in respect of this shortfall as we needed to see that the improved staffing levels would be maintained in the long term.

People told us that they felt safe whilst they were living at Amber House. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff had completed training in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records evidenced that staff had completed training that equipped them to carry out their roles effectively. Staff who administered medication had received appropriate training although it was acknowledged that more staff who worked during the night required this training; this was addressed on the day following our inspection.

New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people had been employed.

People told us that they received the support they required from staff and that their care plans were reviewed and updated as required. People told us that staff were caring and that their privacy and dignity was respected.

People's nutritional needs had been assessed and people told us they were happy with the meals and refreshments provided. We saw that people were encouraged to drink throughout the day to promote hydration.

There was a complaints policy and procedure in place and people told us they were confident that any complaints or concerns they raised would be listened to.

There were systems in place to seek feedback from people who received a service, and this feedback was used to identify improvements that needed to be made. Activities at the home had increased as a result of feedback received in surveys, although people told us they would appreciate more activities. We made a recommendation in respect of this shortfall in the inspection report.

The quality audits undertaken by the manager were designed to identify any areas that needed to improve in respect of people's care and welfare.

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 not always safe.

Staffing levels sometimes fell below those that were required. Although these have now improved, we need to see that this is consistently maintained.

There was a safe recruitment process in place to ensure only people considered suitable to work with vulnerable people had been employed.

People's needs were assessed and risk assessments put in place to reduce the risk of harm.

There were systems in place to safely manage and administer medication to people using the service.

Requires improvement



Is the service effective?

The service was effective.

There were effective recruitment, induction and training processes that equipped staff with the skills and experience they needed to carry out their roles effectively.

People were supported to make decisions and their human rights were protected in line with relevant legislation and guidance.

People were supported to have their nutritional needs met and to have access to healthcare professionals when needed.

Good



Is the service caring?

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

People were encouraged to be as independent as possible.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Good



Is the service responsive?

The service was not always responsive to people's needs.

Although visitors were made welcome at the home, people told us there were not enough activities to take part in.

People's care plans recorded information about their preferences and wishes for care, and these were being followed by staff.

There was a complaints procedure in place and people told us they would be happy to speak to the manager if they had any concerns.

Requires improvement



Summary of findings

Is the service well-led?

The service was well-led.

The manager was not registered with CQC but they had commenced the registration process.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Good



Amber House

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 18 December 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had

received from the local authority who commissioned a service from the home. The provider was not asked to submit a provider information return (PIR) prior to the inspection. 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.

On the day of the inspection we spoke with four people who lived at the home in depth and chatted to others. We also spoke with two visitors and four members of staff.

We spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the service, including staff training, health and safety and quality monitoring records.

Is the service safe?

Our findings

At the last inspection of the service on 4 June and 8 July 2015 we identified that there were insufficient numbers of staff employed to meet the needs of people who lived at the home and that the premises were unsafe. We told the registered provider they needed to take action to address this.

On 18 December 2015 we saw that the staff recorded on the staff rota were actually on duty. This included the manager, the deputy manager, five care workers, the cook and a domestic assistant. We checked the staff rotas for a two week period and noted that staffing levels had been maintained during the day. However, the standard staffing levels during the night were three staff, either a senior care worker and two care workers, or three care workers. The staff rota evidenced that on numerous occasions there had only been two staff on duty. The people who we spoke with mentioned this as a concern and said this made them feel less safe during the night. One person said that they had to wait a long time for attention during the night; they said this could be up to 20 minutes. Staff told us that some people needed two staff to assist them during the night, and this meant that other people had to wait for attention when there were only two staff on duty.

One person also told us that they received their eye drops at different times in the evening due to the fact that, on some nights, there was no-one on duty who had completed medication training. This meant that the senior care worker on days had to administer the eye drops before they went off duty. We discussed this with the manager, who told us that the senior care worker on days stayed at work into the night shift, so people actually received their medication at the right time. However, the lack of medication training for night staff meant that people could not be administered pain relief medication during the night. The contingency was that staff would telephone a nearby home that belonged to the same organisation and the senior person on duty would travel to Amber House to administer the medication. It was acknowledged that this was an unsatisfactory arrangement.

Visitors to the home told us there were enough members of staff on duty. One visitor said, “Yes, no complaints, they

look after [my relative] very well” and another said, “Yes, always someone around.” Another visitor told us that there was one day when a care worker went off sick and no cover could be found. They said, “But staff still coped very well.”

We discussed our concerns with the manager and they told us they would attempt to redeploy staff so that there was a senior care worker on every day and night shift, and that there were always three members of staff on duty throughout the night. The day after the inspection the manager forwarded copies of amended night staff rotas to us. These evidenced that three staff were on duty every night, and one of those members of staff was a senior care worker who had been trained to administer medication.

We recommend that the registered provider makes sure the required staffing levels are consistently maintained.

On 18 December 2015 we checked maintenance records and saw that in the fire safety inspection records dated 12 August 2015 the contractor recommended that a new system needed to be installed. We saw that a new system had been installed in October 2015 and that this included the provision of a new call bell system. There were maintenance certificates in place for fire extinguishers, gas appliances, portable appliances, the electrical installation, mobility hoists and the passenger lift. In-house checks were undertaken by one of the organisation’s handypersons. These included weekly fire alarm tests, monthly fire door tests and checks of water temperatures, window opening restrictors and bed rails. This meant that the premises were being maintained in a safe condition.

There were bedroom risk assessments in people’s care plans. These assessed areas such as trailing wires, portable appliance testing and that exits were free from obstruction. This showed us that safety in people’s bedrooms was being monitored.

Records we saw showed that staff had completed training on safeguarding adults from abuse. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns to the manager or senior care worker. One member of staff said, “I would write the details down and then time it, date it and sign it.” They said they were confident that the manager would take appropriate action and ensure issues were dealt with in line with the home’s policies and procedures. We saw that any safeguarding

Is the service safe?

alerts were stored in a folder along with CQC notifications. The folder included a safeguarding monitoring log that recorded the action taken by the manager when they became aware of safeguarding incidents, including a record of when the safeguarding team had been contacted to discuss issues and this had not resulted in an alert being submitted.

We contacted the local safeguarding adult's team prior to the inspection. They told us that they had received information about nine incidents at the home between June and December 2015. None of these had progressed to investigation. The CQC had received notifications from the manager in respect of these incidents and we noted that the manager had taken appropriate action. This showed the manager recognised the importance of ensuring these incidents were reported to the relevant authorities.

There was a policy and procedure in place on safeguarding vulnerable adults from abuse. However, we noted that this had not been updated to reflect that the name of the home had changed several years ago. The manager told us they would amend this immediately.

Staff told us that they would not hesitate to use the home's whistle blowing policy if needed, and that they were certain their confidentiality would be respected. One member of staff said, "I would trust (the manager) completely to keep information confidential."

We asked people if they felt safe living at the home and they confirmed that they did. This view was supported by the relatives who we spoke with. One relative said, "Yes, I am happy that [Name] is safe" and another relative told us they attended annual care plan reviews and the aspect of safety was always discussed. We asked staff how they kept people safe and comments included, "We have to remain aware of the surroundings all the time, keeping our eyes open" and "Safe transfers and wheelchair use."

Care plans recorded assessments and risk assessments in respect of moving and handling and the risk of falls. Risk assessments were scored to identify the level of risk involved and recorded the details of any equipment the person required to assist them to mobilise. For example, "[Name] uses the stand aid to aid mobility with the assistance of two members of staff." We saw safe moving and handling techniques being used by staff on the day of the inspection.

There were other assessments in place to assess the risks associated with bathing / showering, use of a wheelchair and hoist, tissue viability, scalding, use of bed rails and bumpers, diabetic medication, risks associated with mental capacity and the use of call bells. All risk assessments were recorded under the headings "Risk, triggers, how do we reduce the risk? Can the risk be eliminated?" This showed that any identified risks had been considered and that measures had been put in place to attempt to manage them.

We checked the accident book and noted that accidents and incidents had been recorded appropriately and were analysed monthly by the manager. This analysis included details of where the fall occurred, any injuries incurred and whether hospital admission was required. The audit form also recorded whether risk assessments had been updated following accidents and if the accident had been reported under the Reporting of injuries, diseases and dangerous occurrences regulations [RIDDOR]. This showed us that the manager was effectively monitoring accidents and incidents within the home.

All medicines were stored in one of the two medication trolleys and the trolleys were stored in the medication room. The medication room door was kept locked at all times and only the manager deputy manager and senior care workers had a key to the door. The trolleys were not taken from the room, as medication was administered from the medication room. The temperature of the medication fridge and medication room were monitored regularly and recorded; this evidenced that medicines were stored securely and at the correct temperature.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to indicate the time of day the medicines needed to be administered. The medication administration record [MAR] charts were not colour coded to correspond with the blister packs; this might have helped to reduce the risk of errors occurring.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs [CDs] and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage of CDs and noted they were stored securely. We checked a sample of medicines held against CD records and saw that the stock of medicines held

Is the service safe?

matched the records in the CD book. Two staff had signed the CD book to record when medication had been administered. A medication audit was being carried out by a manager from another service and the general manager on the day of our inspection. They identified that there was a missing CD; this was investigated immediately and it was found that a health care professional had neglected to sign the CD book when they had administered the medication. This was corrected on the day of the inspection.

There was an audit trail to evidence that medication that had been prescribed by the GP was the same as the medication delivered by the pharmacy. There were satisfactory arrangements in place for the disposal of unwanted or unused medication.

We checked a sample of MAR charts and saw that they included a photograph of the person concerned to aid recognition for new staff. When a medicine had been stopped, there was a record on the MAR chart of who had issued this instruction. We noted that the reverse of the MAR chart included information about how the person liked to take their medicines, and that codes were being used appropriately to record when people had refused their medication. We saw there were no gaps in recording. Body maps were being used to record where on the body pain relief patches needed to be adhered to ensure that staff did not always place them in the same area.

We saw that creams were kept in people's bedrooms. Staff told us that they did not receive topical charts from the pharmacy to identify where creams needed to be applied but that they would now request them. We discussed that creams needed to be stored safely to ensure they could not be accidentally ingested by people who lived at the home, and staff assured us that this would be addressed.

All staff who had responsibility for the administration of medication had completed training, and more staff were undergoing this training so that there was always a member of staff on duty who could carry out this task.

There was a recruitment policy and procedure in place. We checked the recruitment records for two new members of staff. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service [DBS]. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that this information had been received prior to the new employees starting work at the home, and staff who we spoke with told us that they had to wait until the home had received their DBS checks before they could start work. This meant that only people considered suitable to work with vulnerable people had been employed. We saw that a record of interview questions and responses had been retained for future reference. Staff were provided with job descriptions; this ensured staff were aware of what was expected of them.

We saw the registered provider's business contingency plan. The plan advised staff on the action to take in the event of flood, power failures, adverse weather conditions and other emergency situations. The plan also included the telephone numbers for staff, GP surgeries and other people who might need to be contacted in an emergency, as well as the fire safety procedure and the home's evacuation plan. We saw that people had personal emergency evacuation plans [PEEPs] in place. PEEPs record the assistance a person would need to evacuate the premises in an emergency, including support from staff and any equipment they would need to use.

We noted that the premises were clean throughout and that there were no unpleasant odours in either communal or private areas of the home.

Is the service effective?

Our findings

At the last inspection of the service on 4 June and 8 July 2015 we identified concerns about some care workers not having the skills to communicate effectively with people who lived at the home and the lack of evidence that staff had completed induction and on-going training that equipped them to carry out their role. We told the registered provider they needed to take action to address this.

At the inspection on 18 December 2015 we saw that staff had good communication skills and were able to effectively interact with people who lived at the home. No-one raised an issue about the communication skills of staff.

We asked staff what training they had undertaken during the previous year and they mentioned training on safeguarding adults from abuse, infection control and end of life care. Staff told us they were currently undertaking on-line training, including safe handling of medicines. One member of staff told us they would be undertaking training on dementia during 2016.

We saw that a new staff induction checklist had been developed. The checklist recorded what topics would be covered during day one and week one of the training programme. Day one consisted of orientation to the home and covered topics such as fire safety and job roles. Staff also received an induction pack that included a copy of the staff handbook, a job description and a policy on safeguarding adults from abuse, missing persons, whistle blowing and fire safety. During week one staff covered the topics of accident prevention and reporting, the key worker system, infection control, health and safety, food hygiene, care plans, access to records, supervision and appraisal, and effective communication. Staff were expected to sign the document to evidence all of these topics had been discussed with them. We checked the training records for two new members of staff and the information we saw showed they had completed this induction training.

The manager told us that they and two members of staff had started a distance learning course on dementia awareness in December 2015, and that the remaining staff [including kitchen staff] would be starting this training in January 2016. In addition to this, three people would be

starting a distance learning course on mental health in January 2016. The manager told us that all staff had recently completed training on health and safety, moving and handling and fire safety.

We checked the training record and this showed that all staff [apart from one person] had attended training on moving and handling and fire safety. All staff [apart from two people] had completed training on health and safety, safeguarding adults from abuse and infection control. In addition to this, staff who were responsible for the administration of medication had completed appropriate training, and some staff had undertaken training on first aid, dementia awareness and MCA and DoLS. Most staff had either achieved a National Vocational Award (NVQ) at Level 2 or 3, or were working towards this award; the manager and deputy manager had achieved this award at Level 4.

We saw the records of staff supervision meetings. These evidenced that staff were able to discuss their training needs and any concerns they had about their role. Staff signed these records to show they agreed to the content. All of the staff we spoke with told us that Amber House was a caring environment to work in and that they were well supported by their manager.

We saw that any contact with health care professionals was recorded; this included the reason for the contact and the outcome. People told us that they could see their GP when they needed to. A relative told us that they were always informed about any health care concerns and contact with the GP in respect of their family member. Records evidenced that health care professionals such as speech and language therapy (SALT) services were involved appropriately in people's care.

One relative told us they felt communication between themselves and staff at the home was good. They told us, "If there are any problems, I know the staff will ring me or my husband to discuss them with us."

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that patient passports included up to date information.

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

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themselves. The MCA 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. We saw that care plans recorded the decisions people were able to make and the types of areas that might require a best interest decision.

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 authorisations to deprive a person of their liberty were in good order. We saw that documentation had been completed appropriately by the manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

We saw in care records the staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. There was an individual care plan and assessment about mental capacity, and in addition to this each care plan area included a reference to a person's capacity to make decisions in respect of that topic.

We saw that care plans included information about Power of Attorney (POA) or Enduring Power of Attorney (EPOA) when relatives had taken on this role. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. The records we saw included information about what authorisations the POA had been granted.

People told us that they were consulted about their care and that staff asked for consent before assisting them. In care plans we saw that some people had completed forms to record their consent to records about them being held, assistance with the administration of medication and taking photographs.

A member of staff told us that the premises were spacious and there were sufficient ramps and mobility equipment for people who needed them. There was a passenger lift to enable people to access the first and second floors. Some signage was available within the home for areas such as

shower rooms, toilets and the dining room although the manager acknowledged that this needed to be expanded to ensure people could easily locate their bedroom and other areas of the home.

People had 'catering information sheets' in their care plans that recorded their nutritional needs and their likes and dislikes. For example, "[Name] likes a small dinner. They require a sugar-free diet as they are diabetic." People had nutritional assessments in place and appropriate risk assessments had been developed around the risk of malnutrition or the risk of choking. People's weight was being monitored as part of nutritional screening, and food and fluid intake charts were being used when nutrition was an area of concern. We saw that people were referred to a dietician or the Speech and Therapy team (SALT) when there were concerns about weight loss.

On the day of the inspection we saw that the cook walked around the lounge areas and spoke with people, asking if they were happy with the meals on the menu and if they would like an alternative. One person whose weight had declined could not decide what to have; we saw the cook offered a variety of options and one was chosen by the person concerned. We saw that this was prepared for them and that they did eat their meal. One person who lived at the home told us, "[The cook] is making some smashing meals" and another said, "The kitchen staff are very good to me and I always enjoy my food." All of the people we spoke with said they were happy with the choices of meals on offer and they were offered alternatives.

Most people ate their meal in the dining room, but some people chose to eat their meal in their bedroom or in one of the lounge areas. We observed the serving of lunch in the dining room and saw that the tables were set with tablecloths and placemats and there were condiments on each table. There were sufficient numbers of staff in the dining room to ensure people were served in a timely manner so their food did not get cold. People were offered a choice of main course and dessert and a choice of drinks. People were also offered clothes protectors. None of the people in the dining room required help with eating and drinking, but there were sufficient numbers of staff on duty to take meals to people's rooms and assist people in the dining room if this were needed. There was a menu board with the choices for lunch recorded, although we noted

Is the service effective?

there were no picture menus. Picture menus can help people with a cognitive impairment to choose a meal. We heard people making complimentary comments about the meals and the cook.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Is the service caring?

Our findings

At the last inspection of the service on 4 June and 8 July 2015 we identified concerns about some care workers not having the skills to communicate effectively with people who lived at the home and how this could impact on the care people received.

At the inspection on 18 December 2015 we observed positive interactions between people who lived at the home, visitors and staff which demonstrated staff were caring and compassionate. We saw that staff communicated effectively with people who lived at the home and others.

People who lived at the home told us they felt staff cared about them. One person mentioned their key worker; they said, “[Name] is very good and gentle when bathing and helping me to the toilet.” Other people mentioned staff by name who they said they thought highly of, although one person mentioned that the people living with dementia received more attention from staff than other people. They said, “If you haven’t got dementia you are left to your own devices.” Another person mentioned that they had more confidence in the older staff but did not expand on the reasons why. On the day of the inspection we observed that staff spent time with people who lived at the home, regardless of their cognitive ability. We noted that, when staff walked through communal areas of the home, they took the time to engage with people, and they spoke with them in a respectful manner.

The relatives who we spoke with told us that their family members were well cared for. One relative told us, “The staff care about [Name] and they show this in their behaviour towards her.”

Staff told us that people were supported and encouraged to maintain contact with their family and friends. We saw that visitors were made welcome. One relative said, “I am always made to feel welcome when I visit and I can visit at any time” and another told us that staff were always positive with them and used their first name when greeting them.

We noted that the staff handbook included information for staff about the need to maintain people’s confidentiality and about sharing information appropriately. People told us that staff respected their privacy and dignity and that confidential information remained so.

We saw that care plans recorded a statement about dignity; “Zero tolerance of abuse is the first dignity challenge and the absence of dignity from the delivery of care may develop into a safeguarding matter.” Staff told us that they knew how important it was to respect people’s dignity. We saw that care plans recorded whether people wished to be assisted with personal care by a male or female carer and that both males and female care workers were employed at the home so this could be met. We observed that staff knocked on bedroom and toilet doors before entering. A relative told us that their family member’s privacy and dignity was respected by staff at all times.

On the day of the inspection we saw that people were encouraged to do things for themselves if they could. At lunchtime staff only assisted people if they indicated they would like some help or if they looked as though they were struggling. Staff told us that they always encouraged people to be as independent as possible.

There was information about advocacy services available to people who lived at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Some people’s care plans included information that had been obtained from the NHS Choices website about specific illnesses; this helped staff to understand the person’s condition and provide appropriate care, support and information to people.

Some people had a ‘Do Not Attempt Cardiopulmonary Resuscitation’ [DNACPR] form in their care plan folder. Those that we saw had been completed correctly. Although no-one was receiving end of life care at the time of this inspection, some staff had undertaken training on this topic so they had the skills they needed should they need to provide support to people who were at the end of their life.

Is the service responsive?

Our findings

At the last inspection of the service on 4 June and 8 July 2015 we identified concerns about the support some people received when they displayed behaviour that might challenge others and that there were not always enough staff to support these people. We told the registered provider they needed to take action to address this.

On the day of this inspection we saw a copy of a new pre-admission assessment that had been developed. This included information about medication, allergies, pain and pain management, dietary requirements, mobility, tissue viability, continence, personal hygiene, cultural and social interests, and mental capacity. Care plans were developed from this information outlining how these needs were to be met. We saw that a new document called 'My Life Story' had been introduced although staff had only just started to record in those we saw. However, care plans we looked at were written in a person centred way and identified the person's individual needs and abilities. Records evidenced that the information had been gathered from the person themselves, their family and from health care and social care professionals involved in the person's care where possible.

People who we spoke with were aware of their care plans but were not certain whether they had been involved in their development or if they were reviewed. A relative told us that they were aware there was a care plan in place for their family member and that they could request to have a look at the plan at any time. We saw that care plans were reviewed in-house every month and that more formal reviews were undertaken by the local authority when they had commissioned a service from the home.

A member of staff told us they tried to spend as much time as possible with people who lived at the home; they said they had more time to do this in the afternoons. We saw that there was a staff presence in communal areas of the home at all times. When people displayed behaviours that could put themselves or others at risk, plans had been developed to advise staff how to manage the person's behaviour to minimise any areas of risk.

There was a motivation class every Wednesday and a sing-a-long with volunteers who visited the home one a month, and the hairdresser visited the home once a week. On the day of the inspection we saw that one person was

making a Christmas card with help from a care worker. However, some people told us that there were a lack of activities and that they would like to play more bingo. This was supported by a visitor we spoke with. We discussed this with the manager and they acknowledged that more could be done to involve people who lived at the home in meaningful activities, and they assured us that this was being addressed. They told us that they had also decided that they should provide some 'rummage boxes'. These are boxes that are full of interesting items such as bits of fabric, spools of thread, lace, colorful balls and costume jewellery that provide people with something to do and something to 'tidy'. Rummage boxes are often used to alleviate anxiety.

We recommend that the service sources information about providing meaningful activities for people living in residential care settings.

We saw that some people were supported to go out. One person went into the town centre using their mobility scooter and one person told us they regularly went out to see their relative. Another person told us that care workers sometimes took them out in their wheelchair. This meant that people had contact with the local community.

Staff told us that they kept up to date with people's changing needs through reading care plans and also through the handover or 'flash' meetings that took place at the start of each shift. The manager told us that they discussed any concerns or changes to people's health, any visits from health or social care professionals and that they checked that food and fluid charts and bed rail checks were up to date. We saw some examples of handover sheets on the day of the inspection and noted that everyone who lived at the home was named on the list to help staff in recording details about every person who lived at the home.

In addition to this, there was an allocation sheet that recorded who was responsible for each task on the shift. This meant that all staff were aware of their responsibilities during the shift and helped to make sure all tasks were completed.

Staff told us they tried to give people choices and to help them make decisions. For example, they would show them two meals so they could decide which one they wanted and would show them a selection of clothing so they could decide what they wanted to wear. One member of staff

Is the service responsive?

said, “We allow people to make choices and we respect their choices.” Another member of staff said that they talked to people all of the time to establish that their choices were being met.

We saw that the complaints procedure was displayed within the home and the manager told us that it was also included in the home’s statement of purpose. They said that they had not received any formal complaints since the

last inspection. We saw that the home had received three compliments from people since the last inspection in the form of thank you cards; these were on display in the home.

People who lived at the home and relatives told us that they could raise issues and they were confident they would be dealt with. Staff told us they would listen to a person’s complaint or concerns and would then report the issue to the manager or deputy manager. They said that complaints were taken seriously.

Is the service well-led?

Our findings

At the last inspection of the service on 4 June and 8 July 2015 we identified concerns about the lack of opportunity for people to comment on the care and support they received and that action had not been taken when the need for improvement had been identified. We told the registered provider they needed to take action to address this.

At the inspection on 18 December 2015 we saw that satisfaction surveys had been distributed to people who lived at the home in March 2015 and to relatives in July 2015. The responses had been collated and an action plan had been developed. Most of the responses received following both surveys were positive, although people who lived at the home stated that they did not know who their key worker was, that they would like more activities and that the manager was not always available. The action plan recorded that there would be an increased availability of activities and we saw that this had occurred. However, people told us that they would like more activities and we shared this information with the manager. They had recognised this and had plans in place to increase activities further. The action plan developed as a result of the relative survey recorded, "There is a new manager in post who is planning to have resident / relative meetings every quarter to facilitate feedback and dialogue" and that this would be completed by August 2015.

The relatives we spoke with did not recall being invited to a resident / relatives meeting. However, the manager told us that a meeting had been held for people who lived at the home and relatives in September 2015. She said that ten people who lived at the home attended the meeting but no relatives attended. Another meeting for December 2015 had been advertised and the manager said that no relatives had turned up. They believed that this was because the meeting was too close to Christmas and told us they were currently considering how best to engage with relatives.

One relative told us they had recently completed a satisfaction survey but they had not seen any results or actions. We discussed with the manager how it would be helpful to display information about the outcome of surveys and the action that had been taken to address any shortfalls.

The registered provider is required to have a registered manager as a condition of their registration. There was a manager in post on the day of this inspection who was not registered with the Care Quality Commission [CQC]. However, they had submitted their application for registration and we are aware that the application is currently being processed.

Staff, people who lived at the home and visitors spoke about how Amber House had improved in recent months and how the manager had made positive changes. A relative told us that standards had improved at Amber House, especially over the past four months. They said staff were more "On the ball" and that their attitude was more helpful. Staff told us they had confidence in the manager, who had an 'open door' policy. They all felt that they were able to discuss issues with the manager and said that they would report any concerns, complaints or issues to them immediately.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken. We asked for a variety of records and documents during our inspection. We found that these were easily accessible and stored securely.

Staff who we spoke with told us that they would always consider an incident or a complaint as being as opportunity for learning. They said they would think about how the situation could have been prevented. One member of staff said, "I would ask myself if there was anything I could do or should do to prevent it from happening again." One member of staff told us that they were asked in their supervision meeting with the manager if there were any areas that required improvement. This showed that the manager and staff looked at way of improving the service for people who lived at the home.

Staff said that they attended regular staff meetings and that these meetings were a 'two way process'. Information was shared with them but they also got the opportunity to raise concerns, ask questions and make suggestions. We saw the minutes of meetings held in July and October 2015 and noted the topics discussed included the most recent

Is the service well-led?

CQC inspection report, safe recording and staffing issues. We saw that two more staff meetings had been organised; a senior meeting on 22 December 2015 and a full staff meeting on 23 December 2015.

We saw the audit matrix and noted that this was a monthly calendar of all audits that would be carried out by the manager, deputy manager or other designated staff. Planned audits included those for safeguarding, dining, medication, care plans, infection control, mattress checks, accidents, staff induction training and health and safety. The deputy manager had carried out a medication audit in November 2015 and we saw that a medication audit was been carried out by a registered manager from another home within the organisation and the general manager on the day of our inspection. In addition to this, the manager had carried out audits on accidents, safeguarding incidents, infection control, care plans and the dining experience. We saw that all audits included space for recommendations / actions to be recorded.

The atmosphere in communal lounges was calm and people told us there was a happy atmosphere at the home. One person who lived at the home said, "The atmosphere is usually good – there is usually a smile and a laugh."

There were no written values displayed at the home but we noted that the home's statement of purpose recorded their aims and objectives. The manager described the culture of the home as, "A home environment that met people's needs" and "An open door policy. A kind, effective, personalised service." Staff described the culture as, "Homely, open communication with relatives, friendly staff" and "Positive." One care worker told us that they felt valued and appreciated as a worker and that Amber House "Feels like a family."

We asked the manager if there were any incentives for staff. We were told that they were considering paying staff more if they had achieved a NVQ award but currently there were no financial incentives. They told us that the registered provider invited every employee to a night out at Christmas and that many of the staff at Amber House attended; they said this was appreciated by staff.