Amberwood Care Home Limited

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Inspection report

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

Summary of findings

Overall summary

Amberwood Care Home Limited is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 44 people in one adapted building. On the day of our visit, there were 44 people using the service.

The service had three registered managers. 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 and associated Regulations about how the service is run.

This inspection took place on 1 and 2 February 2018 and was unannounced.

This was the second comprehensive inspection carried out at Amberwood Care Home Limited. The last inspection was carried out in November 2015 and the service was rated as Good. At this inspection we found areas that required improvement.

The provider did not have sufficient systems in place to assess, monitor and evaluate the quality and safety of people using the service. This had impacted on the levels of staff, response to people's feedback, health and safety and medicines management.

The provider had not ensured that people were always protected from health and safety risks associated with accessing areas such as the kitchen and laundry.

The provider had not always deployed enough staff to meet people's needs. Staff did not always follow systems to manage medicines in a safe way.

Staff understood their roles and responsibilities to safeguard people from the risk of harm. Risk assessments were in place but these were not always reviewed regularly; people received their care as planned to mitigate their assessed risks.

Safe recruitment processes were in place. People received care from staff that had received training and support to carry out their roles. People were supported to have enough to eat and drink to maintain their health and well-being.

People were supported to access relevant health and social care professionals.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA). Staff gained people's consent before providing personal care. People were involved in the planning of their care which was person

centred and updated regularly.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted. People had developed positive relationships with staff. Staff had a good understanding of people's needs and preferences.

We made recommendations that the provider implemented a system to record all complaints and systems to capture people's wishes and preferences they want at end of life.

At this inspection we found that Amberwood Care Home Limited were in breach of three regulations relating to the health and safety, staffing and governance, as the provider did not have sufficient systems and processes in place to ensure the quality and safety of the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments relating to basic health and safety measures were not in place.

People's risks assessments were not always reviewed as their needs changed.

There were not always enough staff deployed to meet people's needs.

People could not always be assured that staff followed safe medicines management procedures.

People received care from staff that knew how to safeguard people from abuse. And they were recruited appropriately.

People were protected by staff that followed procedures to help prevent and control infections.

Is the service effective?

Good

The service was effective.

People received care that was delivered in line with current legislation, standards and evidence based guidance.

People were cared for by staff that received the training and support they required to carry out their roles.

People were supported to eat and drink enough to maintain a balanced diet.

People's needs were met by the adaptation design and decoration of the premises.

The provider was seeking further understanding of their responsibilities in relation to the Mental Capacity Act 2005 and DoLS.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

People were supported to be involved in planning their care.

People's privacy and dignity were maintained and respected.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs.

People had information on how to make complaints and the provider had procedures they followed to manage complaints.

People received care that met their needs at their end of life.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have sufficient systems in place to monitor the compliance and quality of the service to take action to improve where necessary.

There was a registered manager who understood their roles and responsibilities in reporting incidents to the relevant authorities.

People were asked for their feedback regularly.

Amberwood Care Home Limited

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 checked 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.

This unannounced comprehensive inspection took place on 1 and 2 February 2018 by one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about the service including statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During this inspection, we spoke with 16 people using the service and eight relatives. Four people were not able to speak due to their dementia or poor health, we spent time observing their care and how staff interacted with them. We also spoke with 13 members of staff including both of the registered managers, the care standards coordinator, four care staff, the activities co-ordinator, the kitchen staff, administration staff, maintenance staff and two students on a work placement undertaking a Health and Safety qualification. After the inspection we also spoke with the deputy manager as they were not available at the time of inspection.

We looked at the care records for three people who used the service and 21 medicines administration records. We also examined other records relating to the management and running of the service. These included four staff recruitment files, training records, supervisions and appraisals. We looked at the staff

rotas, complaints, incidents and accident reports and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

The provider did not always protect people from the risks associated with very hot water, equipment or substances that may be hazardous to health. People living with dementia, or people who were experiencing confusion from ill health had access to areas such as the main kitchen and laundry. The hot water supply to these areas were over 40 degrees centigrade and were likely to scald an older person if used by them. In addition to the iron, washing machine and tumble dryers in the laundry and hot appliances in the kitchen, people had access to washing liquids and other substances that could be hazardous to health.

People were also at risk of infection from accessing dirty clothing and bedding in the laundry. There was a large cupboard with equipment and supplies required for the maintenance of the building that was not always kept closed or locked. No risk assessment had been made to assess whether people could be at risk of harm when accessing these areas. We brought this to the attention of the registered manager who told us, "our client group would know not to access these areas." The registered manager said they would consult managers of other care homes to see if preventing older people from accessing the main kitchens and laundry was normal practice.

Risk assessments were not in place for open staircases or staircases that led to the attic. The registered manager had not risk assessed people for age-related physiological changes which can increase the risk of falls. For example, deteriorating vision, impaired judgement and memory, altered mobility and increased frailty and dependence. Certain medical conditions may increase the risk of falls, such as dementia, low blood pressure, and urinary infections; and certain medicines for the treatment of blood pressure or pain relief can cause particular problems with balance. The registered manager told us that no one had ever fallen down the stairs. However, they had not identified people who were at particular risk of accessing the staircases or put adequate control measures in place.

People were are at risk of harm as the provider failed to have risk assessments in place to mitigate risks relating to basic health and safety measures. This constitutes a breach of regulation 12 (2a and b) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Safe care and treatment.

There were not always enough staff deployed to meet people's needs in a timely way. People told us there was not always enough staff to meet their needs. There were seven people who required two care staff to provide their personal care and nine people who required two care staff to mobilise and five who needed help with eating and drinking. Of these, seven people who were living with dementia and seven people were cared for in bed. Some people waited for long periods for personal care which put them at risk of poor skin integrity from soiled clothing. Six people had been identified as at high risk of falls; sensor mats were placed near people to alert staff to them mobilising, so that staff could support them to walk without falling. However, when the sensor mats triggered the call bell system, staff were not always available to respond, putting people at continued risk of falls.

One person told us, "I don't need much equipment; it's just getting someone to come when you ring. It might be more than 5 minutes [to wait for care]." One relative told us, "There is not enough staff, when

[Name] presses the buzzer it takes them [staff] ages to come. It can be anything from 5, 15 to 20 minutes." Another relative told us, "There is not always enough staff to help [name] have their meals."

On the day of inspection there was a residents' meeting where two people told staff they were concerned there were not enough staff. During the meeting people said, "In the mornings I find it a bit busy, when I need support there is not enough help. It is not organised." "In the mornings I am left in the toilet for a very long time before staff help me. It [the home] seems to be short of staff." Staff told us "Our handovers are always interrupted as there are not enough staff to cover at these times." "People living at the home have more needs than they used to, there is not enough staff to get to everyone when they need us." Senior staff told us that part-time staff were covering vacancies which were in the process of being filled.

The call bell system recorded the times that people called for assistance and when staff attended. The registered manager told us it would be unreasonable for a person to wait for over five minutes to have their call bells answered, but on occasions this would happen if staff were attending to someone else. We observed that senior staff could monitor the length of time call bells took to be answered in real time; they noticed that two people used their call bells frequently. The registered manager told us this impacted on staff being available to answer all call bells. The registered manager had not routinely analysed the call bell data to establish if people's calls were being responded to in a timely manner. They told us the information on the call bell system was not readily accessible and could not be pulled off into a report; they could not provide detailed information of the call bell data during the inspection. The information was available on a screen; we gathered the information from the screen for different times periods over three different days including the days of inspection and the previous weekend. The data from the call bell system demonstrated that out of 62 calls, people waited for over five minutes on 26 occasions. Of these 10 people waited over 10 minutes and 2 waited over 20 minutes. Although two people would use their call bells frequently, this did not account for the people who had to wait for over 10 minutes for their care. The registered manager told us that they would contact the provider of their call system to ask for assistance to get the data from the system, and if need be they would replace the call bell system.

The staffing levels had remained the same for at least the last nine months, with no changes made to allow for the increasing and changing dependency of people. The registered manager told us they believed they had enough staff but they needed to be more organised. We were also told that the staffing levels did not change when the occupancy levels decreased.

People were not receiving their care in a timely way as staff had not been sufficiently deployed to provide their care. This constitutes a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Staffing.

Although people received their medicines as planned. One person told us "I get my medication in the morning, during the day and at night. They always stand and watch me take it." Improvements were required for the management of medicines. Where people had medicines that were only administered as required (PRN medicines), not all people had a protocol for staff to follow. The PRN protocols are required to ensure that people received their medicines safely, at safe intervals and their effects recorded. Where staff had administered PRN medicines they had not recorded the times. People could not be assured they received their Paracetamol four hours apart or their oral morphine medicines at the times prescribed, as staff did not record the times they had been administered. We brought this to the attention of the registered manager who implemented the missing PRN protocols. The registered manager told us they had contacted their pharmacist to arrange for a system to record the times PRN medicines were administered as there was not enough room on the Medicines Administration Records (MAR) charts to record the times.

One person required their medicines covertly; where staff administered their medicines to them without them knowing, usually disguised in food. The person had undergone an assessment by their GP who deemed giving covert medicines was in the person's best interests; the arrangements had been made in accordance with the Mental Capacity Act 2005. The record of the decision and the reasoning for the decision (in the person's best interest) had not been documented. Staff also needed to contact the pharmacist to check that they had clear guidance on how to administer covert medicines safely in food. We brought this to the attention of the registered manager who arranged for the correct documentation and guidance to be put in place.

Senior staff had identified that one member of staff had not signed the MAR charts from the previous day to confirm they had administered medicines for 16 people. There was evidence that people had received their medicines, the tablets were no longer in the blister packs. The registered manager told us the staff involved would undergo further training and supervision.

Not all processes were in place to ensure that people received their medicines safely. Staff referred to information sheets stored with people's MAR charts to ensure they administered medicines to the right person. The information sheets had a recent photograph of the person, their allergies and special notes such as medical conditions. Five of the 21 MAR charts we looked at did not have these information sheets. Senior staff told us that they had not created these information sheets yet as people had recently been admitted to the home. The information sheets were of more importance to people new to the home as staff had not got to know people and may not be familiar with what they looked like or the medicines they took. This put people at risk of not receiving their medicines safely. We brought this to the attention of the registered manager who arranged for all the missing information sheets to be created and placed with people's MAR charts.

People's risks had been assessed, and most risk assessments reflected people's current needs. However, there was not a reliable system to ensure risk assessments were always updated as people's needs changed. For example, one person had been assessed as fully mobile and their care plan stated they could walk and transfer with one staff. Between November 2017 and January 2018 this person had fallen five times, their risk assessment for mobilising and falls had not been reassessed since the first fall in November 2017. Staff relied on the information given during the handover from staff from the previous shift as the care plans were not always updated in a timely way.

People told us they felt safe living at the service. One person said, "I am safe, they're a good crowd the carers are, they look after you well." Another person told us, "I feel very safe here. I have this lovely room where I can watch the world go by." Staff demonstrated they knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. Staff told us they would report any concerns to their line manager. One member of staff told us, "I would raise any safeguarding concerns with the senior manager." The registered manager had raised safeguarding alerts appropriately and had systems in place to investigate any concerns if required to do so by the local safeguarding authority.

There were fire risk assessments and fire safety procedures in place to check that all fire safety equipment was serviced and readily available. Staff had received training in fire procedures. Each person had been assessed for their mobility in the event of an evacuation. Staff told us and records showed they had practiced the fire procedures. The provider carried out regular environmental checks and maintenance of equipment such as hoists, radiators and window restraints. They completed regular checks on the temperature and cleanliness of the water supplies.

The registered manager followed safe recruitment and selection processes. Staff recruitment files contained

all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

People were protected from the risks of infection as the provider had infection control procedures that staff followed. There were procedures in place for cleaning schedules and these were monitored for effectiveness. People told us the home was clean, one person told us, "They keep a clean home." A relative told us, "There is always cleaning going on and never any nasty smells." Staff followed procedures to help prevent infections such as washing their hands and using gloves and aprons.

People told us and we observed that staff used personal protective equipment (PPE) such as gloves and aprons when providing personal care or changing bed linen. Staff had received training in infection control and food hygiene; the service had a five star food hygiene rating from the local authority. Five is the highest rating awarded by the Food Standards Agency (FSA). This showed that the service demonstrated very good food hygiene standards.

The registered manager held regular meetings with staff to discuss areas for improvement. However, there were not enough effective systems in place to capture and recognise when people had raised concerns about the staffing levels and the impact this had had on their daily care.

Good

Is the service effective?

Our findings

People's care was assessed to identify the support they required. Each person received a pre-assessment of their needs before moving in, to enable the service to support them effectively. People's risk assessments were based on best practice and evidence based care. For example, moving and handling risk assessments.

People were supported to eat and drink enough to maintain a balanced diet. Staff were allocated to people who required assistance to eat and drink. People had been assessed for their risk of not eating or drinking enough to maintain their health and well-being. Where people had been assessed as at risk of losing weight or choking, they were referred to health professionals such as their GP, dietician and Speech and Language Therapist for further assessment and advice. Staff followed the health professional's advice. For example, where people were at risk of choking due to swallowing difficulties staff ensured people received thickened fluids as recommended and stayed with people as they ate and drank.

People's individual dietary needs were met. People could choose what they ate and where. One person told us, "They come round with a list and you pick out what you want. There's generally a choice of about three.", "It's really good food, I generally have them here (in their room). It's my choice." People liked the food they told us "It's varied, well presented, no trouble at all. It's appetising. One thing I like about it here you can have a bottle of beer if you wanted. You can have a sherry, that's very nice."

People received care from staff that had the skills and knowledge to meet their needs. All new staff had an induction where they received training in core areas such as health and safety, moving and handling, infection control, nutrition, end of life care, dementia awareness, understanding the mental capacity act and safeguarding of vulnerable adults. New staff received close supervision and shadowed staff that were more experienced; they were assessed for their suitability and competency during their probation.

Staff received on-going training and their competencies checked by senior staff. There were systems in place to provide on-going support to staff and they confirmed they received regular formal supervision. Staff told us they felt supported by the senior team, one member of staff said, "[Senior member of staff] is very supportive, I can always go to them with anything."

People needs were met by the adaptation, design and decoration of the premises. The first floor had a small lounge that people could use as well as the communal areas downstairs. People's rooms were spacious and the corridors were kept clear for ease of access. People had access to all areas of the home as there were no steps; all flooring was either flat or gentle slopes. People accessed the lifts themselves whenever they wanted to, to go from floor to floor.

Staff worked together within the service and with external agencies to provide effective care. District nurses visited the home regularly to provide nursing care such as dressings to wounds. One relative told us, "[Name] has a nurse daily to deal with her legs and the GP drops in regularly to check she's ok." Staff provided key information to medical staff when people were transferred into hospital so their needs could continue to be met.

People had access to healthcare services and received on-going healthcare support. One person told us, "I have had two new pairs of glasses since I have been in here, three years, and the chiropodist comes and so does the GP if I need them. I am well looked after." Staff worked closely with GPs to provide prescribed care to manage people's illnesses in the home, such as providing antibiotics. People were helped to attend health screening and specialist appointments. People or their legal representatives were asked for their consent to have flu vaccinations and these were provided in conjunction with the GP practice.

People were encouraged to make decisions about their care and their day to day routines and preferences. People told us they were always asked about consent to care and treatment. Everyone had been assumed to have the capacity to make decisions about their care; where this changed their GP was involved in assessing them under the Mental Capacity Act 2005 (MCA).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for a DoLS for two people, one was being assessed and the other had been declined as the DoLS was not required.

The registered manager and staff did not fully understand their roles in assessing people's capacity to make decisions and when to refer them for a DoLS assessment. The registered manager told us, "I recognise that we need to find out more about DoLS, so I've engaged with the local council who are providing support and training."

Good

Is the service caring?

Our findings

People received care from staff that they knew. People were happy with the care and support they received. People told us, "It's like one big happy family. I love it here.", "There is always someone stopping by my door to check I am ok.", "They [staff] are always kind to me and I have never felt uncomfortable here." One relative told us, "Staff are extremely friendly. [Name] really likes them."

We observed that staff treated people with warmth and kindness. Relatives were satisfied and pleased with how staff cared for their family members. One relative said, "I do have peace of mind when I leave here. They do their best to look after [my relative]."

Staff were knowledgeable about the people they were caring for. Staff knew people's preferred routines and the family and visitors that were important to people. One person told us, "I only have one son living locally who is a regular visitor here so they [staff] know him quite well." People's visitors were welcomed. One person told us, "My daughter works, so she comes to visit as and when she can and she always gets offered a drink and something to eat too if it happens to be a mealtime." Another relative told us, "They go above and beyond to look after residents here. We are very happy and are made welcome every time one of us visits."

Staff told us that people were encouraged to maintain relationships that were important to them. One person had their own telephone, their relative told us "It helps us to keep in touch and we have had [extra television channels] put in. "One person told us "Visitors can come anytime, another resident comes to see me sometimes and has a chat, but otherwise I am happy in here." Another person said, "My [relative] is allowed to bring her dogs. They are very well behaved and it's nice to see them."
Staff had received training in equality and diversity; staff respected people's wishes in accordance with the protected characteristics of the Equality Act. For example people were helped to maintain their relationships with their partners or spouse no matter their age, race or sexuality. One person was helped to use social media to speak with relatives. One person told us "I am Church of England but I don't go at all now. There's a little service in a small room."

People were kept informed of any updates or news about the home and made choices about how they spent their time. One person told us, "There is a newsletter that comes round with all the activities on." People could choose whether they took part in activities. One person said, "Because I choose to stay in my room, there isn't much I join in with really, but they do still tell me about things in case I change my mind." Another person preferred to stay in their room, they told us "To be honest I like to spend time on my own here (in their room). It can get a bit noisy down in the dining room." One person chose to sleep in the mornings. When they were ready they were helped to wash and dress and joined others in the communal area where they received something to eat.

People were supported to make decisions and express their views about their care. They could have access to an advocate if they felt they needed support to make decisions. An advocate is someone who supports people and enables them to express their views and concerns. There was a residents' meeting in the afternoon. People had the opportunity to have their say about how the home was run; they discussed

amongst other things staffing levels and the menu. Staff encouraged each person to have their say. One person who wanted to attend could not because a health professional arrived at the same time. They told us, "I wanted to go to the [residents] meeting at 2pm but my [health professional] came. I didn't want to miss him, so they [staff] came and told me what was said in the meeting afterwards so I didn't miss anything."

People's privacy and dignity was respected. One person said, "I have cream on, but the girls [staff] are very gentle and make sure the sheet is over me when they do it. They draw the curtains too." People's rooms reflected their personalities and previous lives; they had photographs and items of meaning in their rooms to make each room individual.

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance and staff were provided with training about the importance of confidentiality. Information about people was shared on a need to know basis. We saw that people's files were kept secure in filing cabinets and computers were password protected to ensure that information about people complied with the Data Protection Act. Handovers of information took place in private and staff spoke about people in a respectful manner.

Good

Is the service responsive?

Our findings

People received individualised and person centred care that met their needs. People had comprehensive care plans that provided staff with detailed information of how to care for them. One person told us, "Someone asked me about what I needed and what I liked when I first moved in." People and their relatives were involved in setting up people's care plans and had reviews of their care as their needs changed. One person said, "They [senior staff] keep my family informed, so they don't have any surprises when they visit."

People received their personal care as planned. One person said, "I get two showers a week which I think is enough with a strip wash in between." Some people could not use their call bells to summon assistance; staff visited their rooms at regular intervals to check on their welfare.

Staff ensured that people received the support they needed to mobilise safely. Staff observed people as they mobilised and provided prompts or guidance to help them keep safe. One person told us "I don't have the [staff] so much. I'm okay as long as I've got the [walking] frame. Another person received additional support with their mobility, they told us, "They [staff] talked to me about getting the physiotherapist in to help get me stronger and I suppose it's them who organised it as they came today."

People were supported to celebrate special days of the year such national cheese day. Activities included pet therapy where people could handle gerbils, guinea pigs and dogs. The activities co-ordinator told us, "I am planning for St. Patrick's Day; we are having some children in the home showing us some Irish dancing." One person told us "I do enjoy the quizzes, but I told them [staff] today the questions were really easy. Almost what you would ask a child." The activities co-ordinator said these had come from a book for older people but would look at other resources.

People told us about the activities they enjoyed, one person new to the home said, "I have been out to the pub once for a pint since I came here, that was nice." Another person said they enjoyed, "Reading the paper and doing bingo downstairs." One person had a quiet space set up so they could do their jigsaws.

Staff complied with the Accessible Information Standard (AIS) as they had system in place to support people to access information in a specific way due to their disability or sensory loss. The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given. For example there was a computer used by a person with limited vision, the keyboard had large black letters on white keys which made the keyboard easier to use. Another person used a computer tablet to help them communicate. The person's relative told us "Some of the staff have even helped [my relative] to use her tablet when she gets stuck. She almost stopped using it at home." The registered manager recognised that this would have to develop as people's needs changed.

People felt confident that they could make a complaint. There was information available to people on a notice board. One person told us, "If I was ever unhappy I would speak to the carers [staff] and they would sort it out. I don't see much of the managers, but I know who they are." People had the opportunity to raise

any concerns informally with staff or managers, or formally in writing. One relative told us "If I felt strongly enough about something, I would speak to the family [provider and registered manager] but when you are living in a large care home, you sometimes have to accept that things are as they are." Another relative told us, "I can't imagine we would ever need to complain, but they are very approachable and would sort it out, I'm sure." The provider had procedures in place to respond to people's concerns. Complaints had been responded to in a timely way. However, the registered manager did not have a system to analyse the complaints for themes to use as learning to improve the care people received.

People received care that provided relief from their symptoms towards the end of life. Staff worked closely with district nurses to provide care that met people's needs. People had not always had the opportunity to discuss with staff what it meant to be at the end of life and make their preferences known, such as remaining in the home or receiving care in a hospital. Some staff had received training in end of life care, but the registered manager had not implemented a system for capturing people's wishes in an advanced care plan. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care.

We recommend that the registered manager implements a system to capture people's wishes and preferences they want at end of life.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have sufficient systems in place to monitor the compliance and quality of the service to take action to improve where necessary. There was no system in place to monitor the dependency needs of people and relate this to the deployment of staff. People were kept waiting for care as there were not enough staff deployed to meet their needs. People had complained about the lack of staff in a resident's meeting in November 2017, but no action had been taken. Evidence of people waiting for their care had not been identified as there was no system to routinely analyse the call bell system. The registered manager told us they could not access the data easily; they had not made arrangements with the provider of the call bell system to arrange for this. We observed on the screen there was an option to transfer the data on a spread sheet, but this had not been explored.

The registered manager did not have enough oversight of the safety of the environment within the home. People who lived with dementia and people who could experience confusion due to ill health had access to areas such as the kitchen and laundry room, which put them at risk of harm from hot equipment and substances that could be hazardous to health. The registered manager had not used the health and safety executive information available specifically for care homes to ensure that people's risks had been reasonably mitigated. People were exposed to unnecessary risks by having access to the laundry, kitchen, equipment cupboards and the attic.

There were not enough systems in place to ensure that all updates to people's care, as their needs changed, were communicated to all staff or updated in people's care plans. Not all staff received the information about people's changing needs as they would be asked to answer call bells during handover due to the shortage of staff. People could be at risk of not receiving care that reflected their needs as people's care plans were not always updated to indicate people's current needs.

Systems for monitoring the management of medicines required improvement; staff had not always ensured all systems designed to keep the management of medicines safe were in place. For example, key information about people including their allergies and their 'as required' medicines were not always available to staff that administered medicines.

The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality and safety of the care provided. This constitutes a breach of Regulation 17 (2a) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Good governance.

There were three registered managers. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager understood and carried out their role of reporting incidents to CQC.
Amberwood is a family run business; two of the managers were directors and the other registered manager registered in December 2015. All of the managers and administrators were members of the family along with

other personnel such as the maintenance person.

People were aware that the home was owned and managed by one family. One person said, "I know it's a family business and it seems very organised. Clean and tidy and never any raised voices from anyone, so I guess that means people are happy."

There was a deputy manager and senior care staff who provided all of the face to face daily management of the home. All people using the home knew these staff well and felt comfortable approaching them about their needs. These staff were confident and competent in their roles and this was demonstrated in the level of care and contentment within the home. One person told us "They [deputy and senior staff] are all very friendly and quite happy to have a chat with you."

Some staff had completed satisfaction surveys in January 2018. These showed that staff were overall very happy, however, where they had raised concerns about the levels of staffing and suggested more activities for people to be able to practice their religion; these had not been acted upon.

One relative had completed a satisfaction survey which showed their complete satisfaction with the care of their relative. They said, "They [staff] treat mum with gentle kindness, dignity and respect her wishes." The registered manager told us they regularly sent satisfaction surveys, but there was no analysis of the feedback or action plan to make improvements following people's comments.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have risk assessments in place to mitigate risks relating to basic health and safety measures. Regulation 12 (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality and safety of the care provided. Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff had been sufficiently deployed to provide people's care in a timely way. Regulation 18(1)