Tamaris (England) Limited

Amelia House Care Home

Inspection report

Coningham Avenue
Manor Lane, Rawcliffe
York
North Yorkshire
YO30 5NH

Tel: 01904692265
Website: www.fshc.co.uk

Date of inspection visit:
06 July 2018
10 July 2018
24 July 2018

Date of publication:
09 August 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 6,10 and 24 July 2018. All days were unannounced.

Amelia House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and care for up to 81 older people, some of whom are living with dementia. At the time of our inspection there were 48 people living at the home. The home is divided into three areas: Appleton (general nursing), Bancroft (dementia residential) and Carlton (dementia nursing). The accommodation was on three floors with a passenger lift to connect all areas of the home.

At the last inspection, published February 2018, we found that there were breaches of five of the fundamental standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, safeguarding, staffing, recruitment and the overall oversight and governance of the service. The overall rating for this service was 'Inadequate' and the service was in 'Special measures'.

After that inspection we received concerns in relation to the levels of staffing and the regular use of agency staff and that this was impacting on people's safety. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Amelia House Care Home on our website at www.cqc.org.uk

At this inspection we found that there were five breaches of the fundamental standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, safeguarding, staffing, nutrition and hydration and the overall oversight and governance of the service.

The service is required to have a registered manager in post. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a new manager in post, who received confirmation of being registered with CQC during the inspection.

Despite the service being rated as inadequate at the last comprehensive inspection and additional support being provided, the provider has failed to deliver the required improvements to ensure people receive safe care and treatment in line with the fundamental standards. The more serious concerns raised within this report refer to people living on the dementia nursing unit, known as the Carlton Unit.

People whose dementia meant they posed a risk of harm to themselves or others or experienced periods of distress were not provided with the support they required to reduce these risks. This was because risks were

not adequately assessed and staff were not provided with the guidance they required to support people.

Medicines were not safely managed and incidents of harm or potential harm were not consistently reported which meant action required to reduce these incidents recurring was not taken.

Staff consistently told us that there were insufficient numbers of staff to meet people's needs. There was a high number of vacancies and the service relied heavily on agency staff, which resulted in a lack of consistent and stable staff on the dementia nursing unit. Insufficient numbers of staff had a direct impact on the support that people received to eat and drink during meal times.

The systems which the provider had in place to assess the experience of people receiving care had not identified the extent of concerns we observed during our inspection. There had been a failure to rectify the failings identified during our last inspection and this meant people continued to receive inadequate care.

The overall rating for this service remains 'Inadequate' and the service is therefore still in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate enforcement action, 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.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Risks to people were not adequately assessed which meant plans to mitigate risks were not effective. Accidents and incidents were not consistently reported in line with the provider's policies which meant that action could not be taken to reduce the risks of incidents recurring.

There was insufficient staff to keep people safe. There was a lack of consistent and stable staff on the dementia nursing unit and measures to mitigate the risks associated with this were not consistently effective.

Is the service well-led?

Inadequate

The service was not well-led.

Audits and management systems had failed to identify the extent of concerns we found during our inspection. They were ineffective at driving forward improvements. There was ineffective provider oversight.

Not all staff felt supported by senior management and staff described a culture which was not open or transparent.

The provider failed to act feedback from staff and visiting professionals about safe levels of staffing.

Amelia House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 6 and 10 July 2018 in response to concerns we had received about the service. Following further information of concern, we attended for a third day of inspection on 24 July 2018. All days were unannounced.

We carried out a comprehensive inspection of this service in February 2018. After that inspection we received concerns in relation to the levels of staffing and the regular use of agency staff. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Amelia House Care Home on our website at www.cqc.org.uk

Day one of the inspection was carried out by three inspectors, day two and day three was carried out by two inspectors.

Before this inspection we reviewed the information, we held about the service, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We also considered the action plans submitted by the provider following our last inspection.

During the inspection we spoke with four people who lived at the home, 10 members of staff, five family members/visitors, the deputy manager, the registered manager and the regional manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and some bedrooms, with people's permission. We also

spent time looking at records, which included the full care records for six people, who lived at the home and parts of care records for a further six people, the recruitment and induction records for one newly recruited member of staff and other records relating to the management of the home, such as quality assurance and medication.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection, we rated the service as Inadequate in this safe domain. This was because measures to reduce the risk of harm to people were not in place, staff recruitment was not safe, staff failed to act to safeguard people and there was a lack of consistent staff supporting people living on the dementia nursing care unit. During this focused inspection we found that safe continued to be Inadequate. We identified continued breaches of regulation 12 (safe care and treatment), regulation 13 (safeguarding service users from abuse) and regulation 18 (staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014, with a new breach of regulation 14 (meeting nutritional and hydration needs).

Between the second and third day of inspection there had been a serious incident whereby a member of care staff locked three people in their bedrooms in what would appear to be an attempt to keep them safe because of the distress of another person. Since this incident staffing levels have been increased on the Carlton Unit however, the regional manager advised this had only been approved for two weeks and was subject to senior management review.

Incidents were not consistently reported by staff to the management team. They were not reported in line with the provider's reporting policy. A staff member told us incidents of staff being assaulted happened on a regular basis but were not recorded or reported via the provider's own reporting systems. This meant that people who posed a risk of harm to themselves or others, as a result of their ill health, were not adequately supported as there was no oversight of their distress.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who posed a risk of harm to themselves or others due to distress they experienced as a result of their health needs were not safely supported. One person who displayed regular distressed behaviour had no associated care plans that referenced the potential harm posed to themselves or others as a result of this. There was limited guidance for staff about how to reduce the distress. The registered and regional manager were unable to provide any distressed behaviour forms which correlated to the incidents recorded in daily notes. Another person was displaying behaviours which could have indicated distress. There was limited information in their care plan regarding behaviours, what they looked like or guidance for staff about how to respond. There was no consideration in care records as to what people's behaviours could be communicating.

We reviewed the daily notes for one person and saw staff had made repeated reference to this person becoming distressed and placing themselves and others at risk of harm as a result of this. The service had requested support from the community mental health team to try and reduce this person's distress. A specific plan of care had been devised and was detailed within their care records. We asked to see records to show how the advice had been implemented. However, we were told by the registered and regional manager that some of the measures requested by the community mental health team had not been implemented. There was no rationale for this and the person had continued to be distressed and posed a

risk of harm to themselves and others.

Accidents and incidents were not always reflected upon to reduce the likelihood of reoccurrence. One person had recently had a fall from a chair. The provider had failed to consider whether any factors had contributed to the fall such as distress or lack of stimulation for this person. This meant the person continued to be at risk of ongoing harm. Following the inspection, we contacted the funding authority to express our concerns about this person. The person has since moved to a new home.

People's medicines were not managed safely. The service had failed to identify when people required medicine to manage their pain. We identified two people who were prescribed 'as and when required' medicines for pain. Protocols in place to describe when medicine was required were ineffective and this resulted in people not receiving their medicines. We identified people didn't have protocols in place where required, people's creams were not being consistently applied, inaccurate stock checks of medicine had not been identified and a medicine administration record stated an incorrect dosage of medicine to be added to drinks. Although the staff on shift knew that this was incorrect, new staff may not have been aware of this and this could have exposed the person to the risk of avoidable harm.

Plans in place to reduce the risk to people's skin integrity failed to be consistently implemented. One person's specialist mattress was not set at the correct weight, this meant that it would not be effective in reducing the risk of pressure damage. People were not being consistently repositioned when required. For example, one person's daily notes recorded, 'Pressure relief given after five hours because we were busy with other duties.' This meant people were exposed to the risk of harm as the care they required to maintain their skin integrity was not being consistently delivered.

People whose dementia meant they posed a risk of harm to themselves or others or experienced periods of distress were not provided with the support they required to reduce these risks. This was because risks were not adequately assessed and staff were not provided with the guidance they required to support people. Medicines were not safely managed and incidents of harm or potential harm were not consistently reported which meant action required to reduce these incidents recurring was not taken.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection we raised concerns regarding staff deployment and the high use of agency staff which meant people were not always provided with support from a consistent team of care staff. During this inspection staff, across all levels within the home, consistently told us that there were insufficient staff to meet people's needs. Staff working on the Carlton Unit told us this impacted on people as they were not provided with pressure area care in line with their assessed needs and they were concerned about keeping people safe when they or those around them became distressed.

The regional manager showed us a copy of the organisation's dependency tool which showed that they were overstaffed. However, our observations showed that people did not receive the care they required to keep them safe and well.

There continued to be a lack of consistent staff on the Carlton unit which provides nursing care and support to people with complex needs associated with dementia and other mental health conditions. Staff vacancies remained high with 77 vacant nursing hours on the Carlton Unit and 235 vacant care hours across the service. The provider reassured us that they used regular agency staff who knew the service and the people they were supporting. They also told us that the deputy manager was covering the unit for three days

a week. We looked at the rota for the period of eight weeks leading up to the inspection for the Carlton unit. We identified 33 different agency workers who completed day shifts and 19 different agency staff who worked on the night. This demonstrated people were not provided with consistent care staff who knew them well.

One relative told us, "The biggest problem I have here is that there are so many agency staff. If you ask an agency worker about my partner, they don't know anything about them. The main issue is there is no permanent nurse lead. That means there is no consistency for me or my partner."

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

Insufficient numbers of staff impacted on the support available to people who required assistance to eat and drink. We saw people did not receive adequate support in line with their assessed need. The meal time experience was disorganised and not coordinated. We concluded there was a real risk that people would not receive something to eat and drink. We observed several members of staff who were uncertain whether people had eaten their meal or not. Measures put in place to reduce the risk of choking were not always adhered to and people were offered foods against professional advice. Despite our inspection team giving feedback about this to the management team on the first day of inspection, the meal time experience failed to improve on the second and third day of inspection. This demonstrated a lack of effective leadership within the service.

For people who had been identified as at risk of losing weight, action taken to address concerns was not timely and ongoing monitoring was not always robust. People who had been identified as requiring weekly weight checks did not have this completed consistently and contact with GP's regarding ongoing weight loss was not always maintained.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection, we rated the service as inadequate in this well-led domain. There was a lack of effective leadership and management oversight, audits were not robust and did not identify concerns or drive improvements forward. We found a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this focused inspection we found a continued breach of regulation 17.

Following the last inspection, the provider arranged for additional support to be provided to make the required improvements at the service. The focus of this support was on the Carlton unit in response to the risks we identified. Additional clinical oversight and 'Resident Experience Managers' provided support. This had been withdrawn at around the time of the new manager starting at the service in mid May. CQC have been provided with a weekly action plan since the last comprehensive inspection which showed the changes which had been made. Despite this, there remained a lack of effective leadership and provider oversight at the service which has resulted in significant concerns being identified during this inspection.

At this inspection the service had a new manager, who had been in post for around ten weeks. During our inspection they received confirmation of being registered with CQC. The regional manager was providing support to the new registered manager. The regional manager had been providing weekly support visits and the registered manager had a mentor, in the form of an experienced registered manager from within the provider organisation.

Although the new registered manager and the regional manager undertook audits at the service, they had failed to identify the risks we saw during this inspection. The registered manager had completed monthly audits which looked at various aspects of care throughout the service. However, when improvements were identified as being required there was a lack of clarity about who would be responsible for these. For example, the last three medication audits highlighted the same improvements were needed for the application of prescribed creams. This continued to be an area of concern observed during our inspection. The audits also failed to recognise the shortfalls in medicines that we identified as part of this inspection. When we spoke to the regional manager about this, they recognised there was a lack of clarity in people's management roles. They told us they had identified the need to be clear about roles and responsibilities within the management team and the registered manager completed this area of work whilst we were in the service.

Audits completed on bed rails and pressure-reliving mattresses had failed to identify when such mattresses were not set correctly. The correct setting information was not recorded to enable effective checks to be completed. We raised this with the regional manager who advised us that this information would be contained within people's care files moving forward.

Care plan audits had failed to recognise when people's needs had changed. For example, one person's care plan stated that they could eat independently, this was not accurate and was updated immediately when the provider was made aware of this. Another care plan stated that a person was immobile and required the

use of sensory mat. We observed this person to be mobile and not using the equipment. The nurse informed us the sensory mat was no longer necessary and a best interest meeting had been held to agree this. Records of this meeting could not be located. Records were inconsistent when detailing the frequency of repositioning required for people and this has failed to be highlighted in ongoing audits. This resulted in people being repositioned less frequently then required.

Systems that had been introduced to try and mitigate risks associated with a high usage of non-permanent staff were not effective. The service had introduced their own document called an 'at a glance sheet' to assist staff and agency staff with a summary of the main needs of people living there. We identified errors on this document which could have put people at risk of avoidable harm. The errors related to information about people's recommended fluid and food intake. This document also failed to highlight those people whose behaviour posed a risk to themselves, others or staff.

Senior management advised us there were clearer systems in place for oversight on the units. Unit leads completed daily checks on charts and records and signed to confirm that they had been completed accurately. However, we identified numerous gaps in these charts which had failed to be addressed through this quality monitoring system or escalated to management. This system was therefore ineffective.

We observed a daily staff meeting, '10 at10' which involved key staff from the home and was led by the registered manager. This forum was introduced to enable staff to share information across the home. However, many incidents identified during the inspection had failed to be shared with the management through this forum which meant it was not an effective tool for management oversight.

The provider failed to listen to feedback from the staff and home management team regarding suitable staffing levels within the service. Staff from all levels within the service consistently told us that there was insufficient staff and that they raised these concerns with the senior manager responsible for oversight from the provider. Comments included, "We have raised our concerns with the management about staffing levels, they respond telling us that the staffing levels are based on statistics. Its ok that the computer tells them that but doing it is very different." Other staff members said, "We tell management but they just say, it's not our fault that we can't recruit" and "We tell the management that it is not safe."

Staff told us that morale was low and they didn't feel they could go to senior management for support. Comments included, "[Senior manager] makes the atmosphere very tense, I feel like going home and crying, it stresses us all out", "Morale is low at the moment and the management don't help."

A number of staff we spoke with asked not to be named or identified to the senior manager for fear of repercussions. This suggested a culture which was not open or transparent.

Feedback from visiting professionals also expressed concerns about staffing levels and the wellbeing of staff, comments included "I have concerns regarding the level of staffing in relation to the resident's needs, the care staff appear to be trying their best to support however morale was very low and staff were tearful."

There was evidence of poor collaboration with other professional services as professional advice was not adhered to or acted upon for some people.

Despite the service being rated as inadequate at the last comprehensive inspection and additional support being provided this had failed to deliver the required improvements to ensure people received safe care and treatment in line with the fundamental standards. The systems which the provider had in place to assess the experience of people receiving care had not identified the extent of concerns we observed during our

inspection. There had been a failure to rectify the failings identified during our last inspection and this meant people continued to receive inadequate care.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the availability of the new registered manager. Staff members told us, "The registered manager is not visible, they need to come out of the office and see the floor" and "I haven't had a lot to do with the [registered] manager yet but they are visible on the floor and approachable."