Amore Elderly Care Limited

Amberley House Care Home - Stoke-on-Trent

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 26 January 2016 and was unannounced.

The service was registered to provide accommodation and nursing care for up to 74 people. At the time of our inspection 72 people were using the service. People who used the service had physical health and/or mental health needs.

The service had a registered manager. 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.

Staff were not always deployed effectively to meet people's needs and we saw that people had to wait for the support they required. People's risks were assessed though the management plans in place were not always followed to ensure people were kept safe.

Staff were aware of how to recognise the different types of abuse that may occur and how to report concerns. Systems were in place to protect people from avoidable harm and abuse and these were used when required. People's medicines were managed safely so that they received their medicines as prescribed.

People's meal time experiences were mixed and people did not always have a choice about their food. People were not always supported and encouraged to make their own decisions about their day to day care. When people were unable to make more major decisions we saw that current legislation and guidance was followed to ensure that people's legal and human rights were respected.

Staff were trained to deliver effective care to the people who used the service. People had access to healthcare professionals and were supported to monitor their health needs.

People's privacy and dignity was not always respected and confidential information was not kept securely. People told us they were treated with kindness and compassion by staff and we saw some examples of this.

People did not always receive personalised care that met their preferences. Care plans contained information about people's history and preferences but this information was not always used to provide individualised support.

People and relatives knew how to make complaints and we saw that complaints were dealt with in line the provider's procedure.

People, relatives and staff had mixed views about the whether the management were approachable and

supportive. The registered manager offered a number of ways for people to share their experiences and feedback.

The management team and provider completed quality checks and acted upon any issues identified. However, the quality checking systems had not identified some areas which required improvement.

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 consistently safe.

Staff were not always effectively deployed to meet people's needs. Risk assessment were completed but not consistently followed in order to keep people safe. There were systems in place to ensure that concerns about potential abuse were recognised, reported and investigated in line with local procedures. People got their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's mealtime experiences were mixed and people were not always offered a choice of food. People were not always asked for consent before being supported. Staff monitored people's health and were trained to provide effective support to people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not always respected and confidential information was not kept securely. People we spoke with told us that staff listened to them when they expressed their views, however, we saw some examples when this did not happen. People told us and we saw that they were often treated with kindness and compassion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care to meet their individual needs and preferences. People's care plans contained information about their history and preferences but this information was not always used to provide individualised support. People knew how to complain and complaints were dealt with in line with the provider's complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some people, relatives and staff felt that the management were not always approachable or supportive. Systems were in place to check the quality of the service though these had not identified some areas that required improvement.

Amberley House Care Home - Stoke-on-Trent

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.

This inspection took place on 26 January 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR to help us plan the inspection. We also reviewed notifications. A notification is information about important events which the provider is required to send us by law. We looked at information we had received from members of the public and the local authority.

We spoke with five people who used the service and five relatives. 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 spoke with 11 members of staff, the deputy manager and the registered manager.

We looked at five people's care records to see if they were accurate and up to date.

We also looked at records relating to the management of the service. These included quality checks, three staff recruitment files, staff rosters and other documents to help us to see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us there were not always enough staff on duty to meet people's needs. One person said, "You do have to wait for help, I'll admit that." A relative said, "I don't think my relative is safe, particularly at night time due to the lack of staff." We observed that people had to wait for support. We saw one relative in a corridor who was agitated because they could not find any staff to help their family member. They had pressed the call bell but had no response. We found two members of staff talking in another corridor and asked if they could support the person. We observed and staff told us that medication rounds and meal times took a long time because staff had a lot of people to support. A staff member told us, "There's a lot to do at meal times, there isn't enough of us. Between meal times, there's enough staff but not at lunch time. We've told the management but they say there is enough staff."

We spoke to the registered manager who told us they felt there were enough staff to meet people's needs. They showed us a tool they used to help determine staffing levels which took each individual person's dependency level into consideration. Staff rosters confirmed that the level of staff determined by the tool were on duty. This suggested an issue with staff deployment, rather than numbers of staff. The registered manager told us they had sought feedback from staff and were planning to introduce a 'twilight shift' as they had identified that staff were struggling to safely meet the needs of people who used the service during the late evening period. Staff told us and we saw that safe recruitment practices were followed. This included references and Disclosure and Barring Service (DBS) checks to make sure that staff were safe and suitable to work at the home. The DBS is a national agency that keeps records of criminal convictions.

People's risks were assessed though we saw that risk management plans were not always followed. Individual risk assessments were completed for each person dependent on their specific needs and each identified risk had a specific management plan. However, some staff told us that they did not always have time to read people's plans and some relatives felt that staff did not always know what was written in the plans. For example, we saw that one person's plan for a safe environment stated that staff should 'keep in eye contact to maintain safety' and that they needed the support of two staff to mobilise safely. We observed that the person was not always supervised when they spent time in the lounge area. We also observed that the particular unit was staffed by two care assistants. Though there was a nurse allocated to the unit, we saw that most of their time was spent in another unit within the home. A number of people who resided on that unit needed the support of two staff for mobilising or personal care. When care staff were providing support to people, other people were left unsupervised, though their risk assessments stated they needed supervision to keep safe. This meant that risk assessments were not always followed to keep people safe from harm.

There were systems in place to protect people from avoidable harm and abuse. Staff had an understanding of safeguarding adults procedures and were able to demonstrate that they understood the types of abuse that could occur and how to recognise and report these. We saw that local safeguarding procedures had been followed when required and that suspected abuse was reported to the local authority and investigated when needed. The registered manager kept a record of any referrals and investigations and we saw that any lessons learned following investigations were shared with staff to help prevent further occurrences.

Medicines were managed safely so that people received them when they needed them. One person said, "I get my medication when I need it, they bring it morning, afternoon and evening for me." We observed that people were given the time and explanations they needed to take their medicines. We found that where medicines needed to be crushed to be disguised in food there had been contact made with the pharmacy to make sure that by administering the medicines this way, it did not change the effectiveness of the individual medicines. Contact had also been made people's GPs to ensure that this was the safest way to give the medicines and that it was in their best interests. Systems were in place to ensure that medication was stored, administered and disposed of safely and we saw that these were effective.

Requires Improvement

Is the service effective?

Our findings

People's experience at meal times was mixed. We spoke with people who used the service about the quality and choice of food and comments included, "I don't want chips every day, I'm sick of them" and "The food is alright, it's edible. It depends really, some days it's good. Last night for tea we had gammon and pineapple, it was beautiful." Another person said, "The food is always on time and it's brilliant." We observed that the food was late arriving to the dining rooms and some people had been sat at tables waiting for their lunch for half an hour. One person said, "The timing of meals can vary." Some people had fallen asleep and one person was becoming frustrated, stating, "I'll be waiting until next Christmas." This meant that people did not have the best start to their mealtime experience.

People told us they were offered a choice of food. One person said, "They come and ask you what you want." We observed a person sat at the dining table ask a member of staff what was for lunch. The staff member did not know and telephoned the kitchen to find out. We saw that some people were not offered choice. There were no menus available for people to see what was on offer and some chose from three options offered to them by staff. We observed one staff member supporting a person to eat, they were chatting to them and not rushing them. However, when we asked what the person was eating, the staff member told us the food was soup but did not know what kind of soup and had not asked the person whether they liked it or wanted to eat it. This meant that some people were not offered a choice of meals and staff could not always tell people what was on offer.

People's nutritional needs were assessed and support was provided when needed. We saw that one person was assessed as needing 'thick custard consistency' food to ensure they could swallow it safely. We observed that they got this, given on a spoon, which was in line with their care plan. Some people were prescribed supplements and we saw that these were given to people when required.

We saw that people were not always encouraged to make their own decisions and that staff did not consistently seek consent before providing support to people. For example, we saw that some people who used wheelchairs were not asked or informed before staff moved their wheelchairs and we observed that some people were startled by this. Some people were not given choices of food before it was served to them.

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. We spoke with staff about the MCA and some of them understood their responsibilities under the Act, though some of them had little awareness or understanding. When people 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 people's mental capacity was formally assessed for major decisions and these assessments followed the principles of the MCA. Records showed that the process for making decisions in people's best interests was followed correctly in line with the legislation to ensure that people's legal and human rights were upheld.

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. We found that referrals for DoLS authorisations had been made when required to ensure that any restrictions upon people were legally authorised.

People were supported to maintain good health and had access to healthcare professionals when they needed them. People told us and records showed that GPs visited the home regularly. We saw that people had specialist input from professionals when required. For example, we saw that one person had been referred to their GP because staff had concerns about their low weight. We saw that the GP prescribed nutritional supplements and that staff followed the advice given by professionals and the person was given their supplements as prescribed.

Staff told us and records showed they had training and supervision to help them support people effectively. One staff member said, "I've just had behaviour management training and I've done manual handling recently." We saw that some training was being delivered on the day of the inspection by the newly appointed Learning Administrator. This was a new full time role created by the registered manager to ensure that staff were supported with regular supervisions and appraisals as well as induction training, Care Certificate and National Vocational Qualifications. We saw that staff effectively supported people using their learning from recent training. For example, we observed two staff supporting a person to move using a hoist. They used the correct procedure to support the person safely and provided reassurance to the person by explaining what was happening and asking if they were comfortable.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity were not consistently respected and promoted. We saw that confidential care records were kept in corridors outside people's rooms. This meant that anyone visiting the home could access personal information about people who lived there. We observed that a number of people's bedroom doors were propped open and people could be seen walking around wearing their night clothes. Some people were walking around with bare feet and we saw one person wearing one slipper. We saw another person was sat in their room and looked uncomfortable. We asked how they were and they told us, "I'm waiting to go to the toilet, I've pressed my buzzer and I've been waiting long enough." We saw that their call alarm had been turned off and the person told us that staff had promised to return when they could. These issues meant that people's privacy and dignity were not always promoted.

People told us that staff listened to them when they expressed their views. One person said, "Staff listen to me." We saw that some people were given the explanations and time they needed to make choices. A staff member told us, "I always ask people what they want and what they like." We saw that some staff did this and spent time with people to try and understand what they wanted. However, we saw some examples when this did not happen. We saw one person was given porridge for their breakfast without being asked what they would like. Staff said, "Families tell us what people like and how they have lived" when people were unable to say for themselves. We saw records that showed that families had been involved in developing people's care plans. However, some relatives told us that they felt staff did not always read people's care plans. This meant that people were not consistently supported to be involved in choices and decisions about their care.

People told us and we saw that staff treated them with kindness and compassion. One person said, "All the staff are lovely. It isn't a bad place at all." Another person said, "Being here is a comfort to me, we always have a laugh." Relatives told us that most staff knew their family members well. One relative said, "It's the same carers that work in the daytime, they know [Person who used the service] really well." We observed some caring interactions between people and staff and we saw that staff took action when people were upset. For example, we saw that a staff member noticed a person looked unhappy. They knelt down beside the person and asked them what the matter was. The person, who had dementia, struggled to tell the staff member what was wrong. The staff member spent time talking with the person and offered them things they may like. The person decided they would like to go and sit in the lounge and the staff member supported them to do this whilst chatting with them which made the person smile. We heard another staff member say, "You look beautiful with your hair done" which made the person smile. A staff member told us, "We try to make people feel like we're family and friends."

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was personalised to meet their needs. We saw care records that contained information about people's care preferences and life histories which meant staff had access to the information they needed to provide personalised care and meet individual needs. However, this level of personalised care was not always delivered. Some staff told us they did not have time to read people's care plans and some staff said they were aware of people's preferences but did not have time to spend with people. One staff member said, "There is no chance for us to take people out, though we would want to." Another staff member said, "We provide personal care to meet people's basic needs but we don't make a difference."

We saw a family member had been involved in one person's care plan which stated they suffered with back ache and preferred to lie on their bed at this time. We saw this person told staff their back was hurting a number of times and no staff members offered to support them to lie on their bed. One staff member replied, "The nurse gives you medication for that and you've probably already had your medication." This meant that people's care was not always personalised to meet their preferences and staff were not always responsive to their needs. Some people told us that staff knew what they liked and provided this for them. One person said, "They've even bought me some beef dripping in because they know I love it." Another person liked to have some brandy and we saw that they got this.

People had mixed opinions about the provision of activities at the home. One person said, "There's not enough to do. We have activities but they're very basic. The movement to music is good." Another person said, "We have activities, you can do them if you want to or not. Sometimes I do them but I aren't that bothered personally. We do things like exercises and games." We saw that an activities board was displayed in the home to inform people about what activity was taking place. 'Music Time' was scheduled for the morning but we did not see this take place. 'Arts and Crafts' was scheduled for the afternoon and we saw that an external activity provider came in to do the activity in one of the three units in the home. We did not see other activities taking place but were told by the registered manager that the activities coordinator was holding residents' meetings though this was not advertised in the home.

People were supported and encouraged to maintain relationships with people that mattered to them. We saw and relatives told us they could visit when they liked, without restriction. One relative said, "We can visit often, they [staff] are always really friendly and supportive to all the family." One person who used the service told us that their relative, who had dementia, also lived at the home but was based in a different unit. They said, "She's very poorly but they [staff] bring her to see me or take me to see her."

People and relatives told us knew how to complain if they needed to. They told us they would feel able to complain if required and some relatives told us they had made complaints to the management. There was a complaints procedure in place and records showed that complaints, both verbal and written, had been recorded and dealt with in line with the procedure. We saw that investigations into complaints were on going or completed and that people received written responses to their concerns. We saw that one complaint was upheld and related to the response times to the nurse call alarm. The registered manager

identified through investigation that all alarms for all three units at the home were linked through the same system and this was making it more difficult for staff to respond. The system had since been changed so that alarms now only sound in the unit it has been activated, so that staff know where a response is required.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. People and their relatives knew the registered manager and deputy manager though not all of the people and relatives we spoke with felt the management were visible and approachable. One person said, "I can and do have a word with the management, I'm on good terms with them." A relative said, "We don't see the manager, they're always in the office and it can be hard to get in touch with them. The deputy is more available."

Staff we spoke with had mixed opinions about the support they received from the registered manager and management team. One staff member said, "I feel well supported, if I have a question, I can ask the manager" and another said, "It's a well-run home here. The manager holds a meeting with us every day." However, other staff comments included, "I don't feel appreciated by the management, we are supportive of each other" and "I sometimes feel supported but not all the time. The manager never comes to this part of the home. The deputy manager does sometimes, she's great and she listens." When we spoke with the registered manager, they had not been made aware of these issues. They told us and records showed that staff received supervisions and participated in meetings where they were given the opportunity to share any concerns. A staff survey was due to be distributed in the coming weeks and there was also a 'Your Say' forum for staff to participate in should they choose to.

The registered manager told us they encouraged involvement and feedback from people and their representatives in a number of ways including surveys, meetings and by holding a regular 'Managers Surgery' which was held during day times and evenings to ensure it was accessible to all. Relatives' meetings took place bi-monthly at the request of relatives who had felt that monthly meetings were too often. We saw records that showed that residents' meetings were held regularly and we saw a meeting planner with all residents, relatives and staff meetings planned for the next 12 months. Records of meetings showed that residents had requested to go out more. The registered manager told us they had now recruited more staff to drive the home's mini bus and increased the number of hours for the activity coordinators so that more trips out could be planned. Residents requested to go and see the Christmas lights but this was cancelled due to the weather.

Systems were in place to assess and monitor quality and these were used to drive improvement. The registered manager completed daily quality checks of the environment and we saw that a 'resident of the day' initiative had been implemented. This helped to ensure that each resident had the opportunity for an in depth review of their care and focussed on key areas such as weight, falls history and skin integrity. We saw that people's records were up to date and regularly reviewed and that referrals to specialist professionals were made when required. The provider arranged for a number of quality audits to be completed regularly including medicines and infection control and we saw that action has been taken when required. For example, we saw that a medication audit had identified that some people's protocols for when to administer 'as and when required' medication needed to be updated. We saw that the protocols in place were up to date and fit for purpose. However, the quality monitoring systems had not been effective in identifying areas which required improvement, which were identified during the inspection so the systems in place were not always effective.

The registered manager analysed accidents and incidents to identify any patterns or trends. This enabled the manager to take action if needed to minimise the risks of a re-occurrence. We saw that an analysis of incidents identified that one person was continuing to experience falls despite having a sensor mat in place. The registered manager investigated and found that the person preferred to be in a busier area of the home where they could hear people near to them. The registered manager arranged to them to move bedrooms to be closer to the nurses' office and this helped to reduce the number of falls and improve the quality of the service they received.