Dove Care Homes Limited

Amberley House Care Home - Truro

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This inspection was unannounced.

Amberley House is a residential care home which provides nursing care. It is registered to provide care to a maximum of 30 people. On the day of the inspection 25 people were using the service. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Staffing levels met the minimum level as defined by the registered manager. Staffing arrangements helped ensure people's needs were met although people told us they sometimes felt the home was short staffed.

Staff were well trained and new employees were required to undergo a 12 week induction process. This meant people were cared for by staff who had the right knowledge and skills. Staff were not receiving formal supervision but told us they felt well supported.

The house required updating and decorating. The registered manager told us there had been plans to refurbish the building but these had not been instigated. They were waiting for funding to carry out the more cosmetic problems.

There was a system of quality assurance in place which was set by Head Office. This included audits in areas such as incidents and accidents, safeguarding and complaints.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We found the home was meeting the legal requirements.

People told us staff were kind and considerate. We found they knew the people they cared for well and had a good understanding of their needs. One person told us; “They look after me very well. Staff are marvellous!” The staff team communicated with each other regularly during the day and kept daily records in respect of people’s care. This meant they were quickly made aware if people’s needs changed.

Care plans were well laid out with clear guidelines for staff on how to support people. They contained information about people’s health and social needs. They also contained risk assessments which were updated regularly.

Staff and relatives told us the registered manager was approachable and easy to contact. We saw they had a good understanding of what was happening in the home on a day to day basis.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Some aspects of the service were not always safe.

We saw staffing arrangements were sufficient to meet people's needs. However people told us the home was sometimes short staffed.

Staff had a good understanding of how to recognise and report any signs of abuse.

Risk assessments were carried out as required. These were regularly reviewed and updated.

Requires Improvement

Is the service effective?
The service was not effective.

The environment was in need of updating. The facilities did not always meet people's needs and the home was in need of redecorating and carpeting.

People were offered a good choice of food. Any specific dietary requirements were met.

Health care professionals visited the home regularly to help meet people's day to day health needs.

Requires Improvement

Is the service caring?
The service was caring.

Staff were kind and considerate to people and knew their needs well.

Staff encouraged people to join in activities and socialise to protect them from isolation.

Staff ensured people's privacy and dignity was respected.

Good

Is the service responsive?
The service was responsive.

Care plans accurately reflected people's needs.

Communication within the staff team was good which meant staff were aware when people's needs changed.

The service provided people with a wide range of activities both within the home and outside.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

Quality assurance systems were in place to identify any gaps in the delivery of care.

The registered manager was supportive of the staff team and was aware of what was happening in the home on a day to day basis.

There were clear lines of accountability and responsibility in place which all staff were aware of.

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Detailed findings

Background to this inspection

We visited Amberley House on 7 August 2014. The inspection was carried out by an inspector and an expert-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.

Amberley House was inspected in June 2013, at that time we found there was no adequate system for staff supervision and training in place and issued a compliance action. At areview in November 2013 we found these concerns had been addressed and the service was compliant. 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. This enabled us to ensure that we were addressing potential areas of concern. Before our inspection, we reviewed the information included in the PIR along with information we held about the home. This included notifications. A notification is information about important events which the service is required to send us by law.

On the day of the inspection we spoke with 13 people who were living at Amberley House, 13 members of staff and the registered manager. We also contacted a health professional who told us about their experience of the service.

We observed people being supported in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the home was managed. This included five care plans, three staff personnel files, staff training records, staff rotas and documents in respect of the homes quality assurance systems.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

People at Amberley House told us they felt safe living there. Due to people's complex health needs we were not able to communicate with everyone verbally. Therefore we spent time observing people.

We looked at rotas covering a period of a month and saw the home was consistently meeting the minimum staffing levels as defined by the registered manager. There was a qualified nurse on duty throughout the 24 hour period. This meant there were always staff on duty who were qualified to administer medicines and nursing care. During the morning and through until mid afternoon there were five care staff on duty and four during the afternoon/evening period. At night there were two care staff on duty. Nursing and care staff were supported by cleaners, kitchen staff and maintenance staff. The registered manager was also on duty throughout the week and on call at weekends. We discussed with the registered manager how they ensured there was the right number of staff on duty in line with people's assessed need. The registered manager told us they worked out themselves how many staff they thought appropriate. They said they had talked to their area manager regarding this issue recently and were trying to identify a dependency tool which they could use to help ensure the staffing levels were sufficient to meet people's needs. They told us they believed there were sufficient numbers of staff at all times.

We saw that apart from one period shortly after lunch there were enough staff to meet people's needs. Call bells were answered promptly and staff had time to talk to people. However, people told us the home was often short staffed. Comments included; "Staff are too busy to come and talk to me." and "Staff don't have time to listen to me." We asked staff if they believed there were sufficient numbers of staff to meet people's needs. We were told peoples care needs were met but it was more difficult to meet people's social needs. One commented; "We do the best we can." We did not find any evidence of people's needs not being met at this inspection.

During our observations we saw a care worker was left on their own to support a room of approximately six people shortly after lunch for a period of at least 10 minutes. The staff member was a new worker who was still in their induction period. One of the people in the lounge area was at high risk of falls and required support at all times. In line with the homes induction process the new employee should not have been working without the support of a more experienced member of staff. We discussed this with the registered manager who acknowledged the care worker was inexperienced and should not have been left alone.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We spoke with the registered manager about recent changes to when DOLS applications should be made. They told us that, although they were aware of the changes, they had not gone into it in "any depth." They said they had not needed to make any DoLS applications. We saw in people's care documentation mental capacity assessments had been carried out to establish whether people had capacity to consent to care. In addition there were check lists in people's files which were completed on a monthly basis to assess if there were any restrictions being put in place which might lead to the need to make a DoLS application. Records showed that staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us they had a good grasp of the principles underlying the legislation although only one was aware of the recent changes.

We spoke with three members of staff about what action they would take if they suspected abuse was taking place. They told us they would have no hesitation in reporting it to the manager and were confident their concerns would be acted on. All of them were also confident about where they could take their concerns outside of the organisation if they felt they were not being taken seriously.

Risk assessments were carried out in respect of a wide range of areas. For example mobility, skin integrity and fluid intake. We saw risks were identified and guidelines outlined for staff so they would know how to minimise against risk. The assessments were kept within people's care documentation alongside the relevant section. For example, a section on mobility would cover the person's individual needs and if this identified a risk an assessment would follow. This meant staff were able to find the relevant information quickly. Risk assessments were regularly reviewed and updated as people's care needs changed. Staff we spoke with talked about the necessity of keeping people safe whilst helping them to maintain their independence. This showed us the service had systems in place to protect people from individual and external risk.

Requires Improvement

Is the service safe?

We found the system in place for the recruitment of staff was safe. All staff completed a formal application process and had their backgrounds checked to help ensure they were safe to work with vulnerable people. We looked at three staff files and saw they contained documentation in respect of recruitment. For example, we saw job applications and job offers, interview notes, Disclosure and Barring Service (DBS) checks and photo identification. One file for a newly recruited member of staff only contained one reference. We discussed this with the registered manager who spoke to the staff member immediately to rectify the situation.

Requires Improvement

Is the service effective?

Our findings

During the inspection we were concerned that environment did not always meet people's needs. For example, there was only one communal area which was crowded despite many people being in their rooms. There was a dining table in the communal area but this was covered with boxes and equipment for activities. The registered manager told us people could choose to eat at the dining table if they wished but all chose to have their meals at small tables next to their chairs. However we did not hear this option being offered and it would have been an upheaval to arrange it.

The accommodation was on three levels. There were stair lifts on both stairways. One of the staircases had an extra three stairs after the landing which meant people needed to negotiate these in order to access that floor. This meant people were reliant on staff support. We discussed this with the registered manager who told us they ensured the more physically able people had rooms on this floor.

The home's décor required attention. The décor was grubby and a member of staff commented; "I'd like to get a paint brush and do it myself!" Carpets were stained and had worn thin in places. Bathrooms were being used as store rooms when not in use and were cluttered. A staff member said; "We do the best we can but look, it's not exactly purpose built!"

We discussed the problems with the building with the registered manager. They told us there had been discussions with head office about refurbishing the building, including installing a lift but this had never come to fruition. They agreed the home was in need of redecorating and carpeting and told us they were awaiting agreement for funding to start the work.

At previous inspections in January 2013 and June 2013 we found low levels of staff supervision. Consequently, in June 2013 we issued a compliance action. At a follow up review in November 2013 we found all staff had received, or were booked to receive, supervision. During this inspection the registered manager told us face to face supervisions were not happening regularly, particularly for the day staff. However, staff told us they felt well supported and were able to talk to the registered manager at any time if they had any concerns or suggestions. One staff member said; "She'll talk to you any time. She will talk to you in private if you want." We looked at supervision records for night staff and saw these gave staff an opportunity to raise any concerns as well as enabling management to identify any training needs. Staff were updated on any organisational developments and policies and procedures. We were told support from management was generally good despite there being no formal system in place.

People were supported by staff with the knowledge and skills necessary to carry out their roles effectively. During our visit we observed people being moved from wheelchairs to armchairs with the use of equipment. This was done safely and in a caring and reassuring manner.

There was an induction training programme in place for new employees. Two care workers were in the very early stage of their induction having only been employed for a matter of days. The registered manager told us the process comprised of an initial two day in-house induction when new members of staff familiarised themselves with the workings of the home and various policies and procedures. They would then be partnered with a senior care assistant for mentor support. The overall induction period lasted for 12 weeks during which they would be required to complete the training identified as essential for the service. One of the new employees was a registered nurse and we saw them working alongside another nurse as they carried out the medicines round. This meant people were protected from the risk of not receiving their medicines in line with their prescriptions due to the inexperience or unfamiliarity of staff with their routines.

Training records showed staff were up to date with their training in areas essential to the service such as first aid, moving and handling, infection control and safeguarding adults. We saw the nursing staff were all up to date in training for the administration of medicines. In addition training had been given in areas specific to the needs of the people at the home, for example dementia awareness. This meant staff had access to training relevant to their roles.

The chef showed us a record of people's likes and dislikes which was kept in the kitchen. We saw copies of menus which were rotated on a four week basis. People were offered choice and the chef told us if people wanted anything that was not on the menu they would try and accommodate their requests. Two people had special dietary needs and these were catered for. One person commented "The kitchen staff go out of their way to make sure we get what we want."

Requires Improvement

Is the service effective?

We observed people during the lunch period and saw the meals were well presented and looked appetising. Staff were attentive and encouraging to people who were not eating, one care worker spent the whole lunch period gently persuading someone to eat and drink.

Care records contained information in respect of people's nutritional and hydration needs. For example, we saw in one person's care plan it was recorded that they 'needed encouragement with fluids.' This meant staff were aware of people's individual needs and were able to support them appropriately. During the inspection we observed staff offering drinks to people regularly.

People had access to healthcare services when needed. The registered manager told us a chiropodist, optician and dentist visited the home regularly. All people were choosing to use their services although people could to continue using their own practitioners if they wished. Care plans contained details of health professionals such as GP and district nurse. Records of health professional visits were on individual files and we saw these occurred regularly. A health care professional we contacted told us: "Generally, it is always a pleasure to visit any patient in Amberley House, the manageress, receptionist and nurses are very friendly and helpful. Communication works well as I first come in contact with the office to gain the necessary information about my patients before I am shown to the patient's room." This demonstrated that the service engaged with health and social care agencies to help ensure people's health needs were met.

Good

Is the service caring?

Our findings

People told us the staff were caring in their attitude towards them and they were happy living at Amberley House. Everyone we asked said staff were respectful towards them. Comments included; “Staff are marvellous”, “they look after me very well” and; “I don’t think you’ll find a better home anywhere.” A relative said; “We are so pleased with (my relative’s) care. We are completely satisfied with his care, we have no complaints at all.”

Throughout the day staff were chatting, laughing and joking with people, both as a group and on an one to one basis. We saw people being supported during the lunch period as their needs required. For example one person was visited by a GP just as the meal was being served. Staff assisted them to leave the room so they could talk to the GP in private. The meal was taken back to the kitchen to be kept warm and brought back on the person’s return. Staff checked to see if the food was still hot enough for the person. People were asked if they wanted to use an apron during the meal. We heard two people decline and this was respected by the staff member.

When people required assistance to be moved using hoists this was done in a caring and respectful manner. People were given reassurance and full attention throughout. Staff asked people before they carried out any care and ensured people were happy and consented to any care, treatment and support.

We spoke with some people in their rooms. Staff knocked before entering and asked people if they were happy to speak with us. They gave us time to speak privately and in confidence. This showed us people’s privacy was respected. Rooms were decorated to reflect people’s personal tastes with photographs and pictures on display. People had brought pieces of furniture with them in order that they would feel more at home.

We saw from the homes records people had their religious observance needs met by clergy that visited the home. For example, a Methodist minister visited regularly to give communion. The registered manager told us representatives from other faiths also visited. We were able to confirm this in the daily records. This showed us the service supported people’s diverse beliefs.

People were able to choose where in the home they spent their time with some people opting to stay in their rooms and others spending time in the communal area. One person told us; “Staff know that I like to sit in my room most of the time so they make sure they clean it when I go to the lounge.” This demonstrated staff ran the home according to the needs of the residents. Staff told us they encouraged people to come out of their rooms and mix with others where possible. During the inspection we heard staff ask people if they wanted to join others in the communal area. This showed us staff tried to protect people from the risk of social isolation.

We found staff and particularly the registered manager, were knowledgeable about the residents in terms of both their health care needs and their social needs. They spoke fondly about people they cared for and were able to give us quick descriptions of people before we met them. For example, they told us how people liked to be addressed, who might prefer us not to go to their room and who might be anxious about speaking with us.

There were no personal histories in care plans. We discussed this with the registered manager who told us they were in the process of developing people’s life stories with the support of relatives where possible. They showed us an example of one they had nearly completed. This was informative and full of rich detail which helped get a picture of the person. It contained information on their likes and dislikes in respect of music, politics and information as to their past life experiences.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. Care plans recorded information about the person which meant staff had the knowledge and guidelines they required to deliver personalised care. As well as sections on areas such as nutritional needs, skin integrity and medication and symptom control the plans also had sections which covered people's social needs. For example, recreational assessments and information regarding people's religious beliefs. People's likes and dislikes were recorded. One plan stated; "[The resident] is especially fond of the Psalm 23." This showed us the service took into account what was important to the person.

Care plans were updated regularly with each section having a evaluation sheet which was signed monthly to confirm the information was still current. There was evidence people were involved in the development of care plans. The plans were signed by people and there were completed consent forms for various aspects of care. For example we saw evidence one person had consented to the use of bed rails.

Staff told us communication between the team was good and they were confident they were kept aware of people's changing needs as necessary. There was a daily 'report' or verbal handover when a shift change took place. This gave staff an opportunity to inform others of any changes and helped ensure people's needs were met appropriately. One member of staff told us: "Information is passed on really quick." In addition daily records were maintained for all residents. We looked at these and found they were filled in appropriately and accurately. As well as any specific health needs they recorded people's moods and general demeanour. This showed us the service took account of people's social needs as well as their health needs.

In addition to care staff the service employed two recreational therapists, one acted as activities co-ordinator/organiser and the other offered more therapeutic activities such as hand massages and exercises. We saw in the PIR that people who chose to stay in their rooms were checked on regularly and the activity co-ordinator took time to sit and talk to people individually. We confirmed this during the inspection when talking to people.

People had access to a range of activities. On the day of the inspection we saw staff arranging to take someone out for a walk. They rang relatives who they knew were due to visit and arranged to meet them in the town. This showed us the service helped people maintain relationships with friends and families.

People told us they went out on trips and we saw photographs around the home which recorded these events. For example we saw people had visited the theatre, National Trust gardens, a local beach and a boating lake.

The activities co-ordinator organised activities both in and out of the home. In addition to trips out for one or two people they hired a mini bus on a monthly basis for trips out. We spoke to several people who were very complimentary about the outings saying they really looked forward to them. During the inspection we saw the activities co-ordinator running a game of bean bag quoits. People were smiling and enthusiastic. They were encouraged to use their weaker arms as well as stronger. We observed the co-ordinator was very encouraging and involved all the residents who wanted to take part.

There was a satisfactory complaints procedure in place which was made available to people on admission to the home. There were no on-going complaints for us to review. People and relatives told us they had not had reason to complain but would know how to and would not hesitate if they wished to. One person told us; "I have no complaints at all." Another said; "If I had a complaint I would talk to the matron, but I haven't had any complaints."

Good

Is the service well-led?

Our findings

The registered manager was required to fill out a monthly quality report which was then submitted to the providers head office. This covered areas such as audits for accidents and incidents, care plans and medicines. Any gaps or trends in the quality assurance process were highlighted and this was followed up by an action plan which was the responsibility of the registered manager. The process was monitored by head office. This meant that quality assurance was important in the service and people's care was protected as a result.

The registered manager told us the area manager visited the home once every one to two months. They also had daily telephone contact with them and told us they felt well supported and were clear about the lines of accountability throughout the organisation. The connection with the area manager and head office meant the registered manager was able to keep up to date with developments and best practice guidance.

The registered manager told us, and we saw from the rotas, they worked shifts throughout the week and were also available through an 'on-call' system if needed. They told us this rarely involved them covering shifts but was more often used if staff wanted advice. The registered manager had a good understanding of what was happening within the home on a day to day basis. A relative told us they thought the home was; "Professionally run. They keep good records."

Within the home there was a system whereby a senior care worker had oversight of two key workers. Key workers are staff who oversee the care of named residents. This meant people were cared for by staff who knew them well. There were clear systems in place which meant staff were clear about who was responsible for what.

We saw in the PIR that people were asked to complete satisfaction surveys on a monthly basis and this was also recorded in the care plans we looked at. Surveys were sent to relatives at regular intervals. Five had been sent out and returned during July and all the results were positive. We saw a sign on a notice board in the foyer which stated the manager held a 'surgery' twice a week if people or relatives had any problems or concerns they wished to discuss. The notice also stated the home had an 'open door' policy and the registered manager was available at other times if that was more convenient for people. This meant there was a culture where people were encouraged to share their views on the service provided by the home.

There was a suggestions and comments book in the foyer. We saw this had been used by a relative to ask that a doorbell be put on an external door which was used by people who went into the garden to smoke. This had subsequently been done. The registered manager told us another request had been to improve the internet connection to allow one resident to use video messaging to keep in touch with family. Head Office were reviewing this and looking at how to provide this service. This showed us suggestions were listened to and acted on.