Hallmark Care Homes (Gaywood) Limited

Amberley Hall Care Home

Inspection report

55 Baldock Drive
Kings Lynn
Norfolk
PE30 3DQ

Tel: 01553670600
Website: www.hallmarkhealthcare.co.uk

Date of inspection visit:
20 January 2016
25 January 2016

Date of publication:
17 March 2016

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 was unannounced and took place on 20 and 25 January 2016.

Amberley Hall Care Home is a care home that provides accommodation, personal care and nursing care for up to 106 people. The home is split into six separate units. These are the Kensington unit that provides care for people with nursing needs, the Windsor unit that provides care for people living with dementia who have nursing needs, the Regency unit that provides care for people living with dementia with residential needs, the Balmoral and Buckingham units that provide care for people with residential needs and the Sandringham unit that provides care for people who are reaching the end of their lives. On the day of our inspection, we spent time on the Windsor, Kensington, Regency and Buckingham units. There were total a of 94 people living within the home.

The current manager had been employed at the home since September 2015. They had not yet registered with us but told us that they planned to do so shortly. 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 home is run.

At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People who could provide us with feedback felt safe living at Amberley Hall Care Home and were happy living there. They were given choice about how they wanted to live their lives, were listened to and respected and had plenty of activities to participate in to enhance their wellbeing. However, not everyone who was living with dementia had the same experience.

There was a lack of stimulation for people who were living with dementia and they were not always treated with dignity and respect. There were not enough staff to meet their needs and provide them with personalised care. The staff did not always follow the principles of the Mental Capacity Act when making decisions on behalf of people. Therefore, people's rights may not have been protected.

The staff were kind and caring but some lacked the skills to engage with people who were living with dementia effectively. Some staff lacked robust supervision which contributed to some of them displaying poor care practice. Risks to people's safety were not always managed well and some people did not receive their medicines when they needed them. This left them at risk of harm.

People received enough to eat and were supported to maintain their health. The equipment that people used and the premises they lived in had been well maintained.

The provider had not taken timely action to make sure that people received the care they needed, when they needed it. There was a lack of oversight of the quality of care that was being provided on some units. The current systems in place to monitor the quality of the care provided were not effective. This had been recognised and a number of improvements were being implemented.

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.

There were not enough staff on some units to provide people with the care they needed in a timely manner.

Risks to people's safety were not always managed well.

There was a risk that people did not receive their medicines when they needed them.

The provider had systems in place to protect people from the risk of abuse.

The necessary checks had been conducted to make sure that the staff who worked at the home were safe to work in care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not always being followed to protect the rights of people who could not consent to their care.

Staff had received training to perform their role but improvements were needed in respect of caring for people living with dementia.

People received enough food to meet their needs and were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate but on occasions, people were not always treated with respect.

People were not always encouraged to be involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs and most of their preferences had been assessed but these were not always being met.

Some people had access to activities that complemented their interests. However, there was a lack of stimulation for people who were living with dementia.

Written complaints had been recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not taken timely action to make sure that people received safe, high quality care.

Not all of the systems in place to monitor the quality and safety of the care provided were effective.

A number of improvements to the care being provided had been identified and were being worked on.

Amberley Hall 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 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 home under the Care Act 2014.

This inspection visit took place on 20 and 25 January 2016 and was unannounced. The first day of our visit was carried out by four inspectors, one of whom specialises in medicines management. An expert by experience also attended the visit. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second visit was carried out by two inspectors.

Before the inspection we reviewed other information that we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information gathered from the local authority safeguarding and quality assurance teams.

During the inspection, we spent most of our time on the Buckingham, Kensington, Windsor and Regency units. Most of the people we spoke with lived on the Buckingham and Kensington units. In total we spoke with 16 people, three visiting relatives, 13 care staff, two nurses, the chef, a visiting GP, the manager, the operations director of the provider and the provider. We spent time observing the care that people received within these units. Most of the people who lived on the Windsor and Regency units were not able to communicate their views to us. Therefore, we observed how care and support was provided to some of these people using 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.

The records we looked at included ten people's care records and other records relating to people's care. We tracked the care and support that seven people received. We also looked at five staff recruitment files, ten staff training records and records in respect of the management of the home. These included records regarding the premises and equipment that was used by people and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

During our last inspection of Amberley Hall Care Home on 18 March 2015, we found that there were not always enough staff available to support people in a timely manner. We asked the provider to make improvements within this area. Since that inspection, we had received some concerns that staffing levels were not sufficient and that people were not receiving the care they needed.

At this inspection, we found that the necessary improvements had not been made. Most people who lived on the nursing and residential units told us that there was enough staff to meet their needs. The staff we spoke with on these units confirmed this. However, there were not always enough staff to keep people safe or to meet their needs in a timely manner within the Regency and Windsor units.

When we entered the Windsor unit, we found one person was on the floor requesting staff assistance with personal care. There were no staff observed within the area who were available to help this person who looked anxious and upset. The maintenance person observed this and alerted a nurse to the situation. We found this person on the floor again later in the day. Again, there were no staff available to help this person who was very anxious.

Another person was regularly requesting assistance with personal care but there were no staff available to assist with this. This was because they were busy providing support to people within their rooms. We saw that this person received the assistance they required eventually but it was not provided in a timely manner. During our observation within the lounge areas of the Windsor and Regency units, there were no staff available to check people on a regular basis to make sure that they were safe. A relative we spoke with told us that they often found that there were no staff within the lounge area when they visited.

We noted that one person had fallen four times since 11 December 2015. Three of the falls had occurred within the dining room area of the Regency unit. It was recorded that each of these falls had been unwitnessed. One record stated that both staff who had been working on that unit had been assisting one person with a bath at the time and that the senior carer was on another unit. Therefore, there had been no staff available to monitor people within this communal area. It was recorded that another unwitnessed fall experienced by this person in the dining room in October 2015, had resulted in an injury that had required hospital treatment.

During lunchtime, we observed that some people in the Regency unit had to sit and wait within the dining room for over 25 minutes before they received their meal. Some people then had to wait for over 30 minutes to be assisted out of the dining room after they had finished their meal. We also saw that on occasions, people had to wait in their wheelchairs within the lounge area for staff to help them move into a chair. This was because they needed two staff to help them and only one was available. Staff were observed on both the Regency and Buckingham units to have to complete other tasks during the day in addition to their care tasks. This included taking the drinks trolley around at certain time of the day, serving people their food, clearing the tables and washing some items of crockery. All of these additional tasks impacted on their ability to provide people with the care they required.

We observed that on occasions within all of the units of the home, that people's call bells were not answered in a timely manner. We checked the call bell responses for the lower floor of the home that contained the nursing and residential units from 20 to 24 January 2016. We found that although the majority of calls were responded to within five minutes, there were 155 occasions where people had to wait over this time. It was recorded that on eleven occasions, people had had to wait in excess of 15 minutes to have their request for support answered. Four of these occurred during the first day of our inspection.

The staff we spoke with on the Regency and Windsor units told us that there were not always enough of them to provide people with the care they required. They said that staff often moved around the units within the home to cover unplanned absences which could leave them short staffed. The operations director told us that the staff were moved around the home depending on the needs of the people who lived there. The manager told us that unplanned staff absence such as staff sickness was either covered by existing staff or a bank of staff. As a last resort, the home used agency staff. We checked the staff rotas from 3 to 24 January 2016 and found that on several occasions, the number of staff required to work on some of the units within the home had not been met. This demonstrated that the current contingency plans to cover unplanned staff absence were not effective.

The manager told us that the number of staff required to provide people with care had been calculated based on people's needs. They acknowledged however, that these required revising. They confirmed that the staffing levels on the Windsor and Regency units were being reviewed and that the intention was to increase the number of staff working on them. They added that they had a full complement of nursing staff and were advertising for two night staff along with bank staff.

After our inspection visit, we were advised by the operations director that the staffing levels on the Regency unit had been reviewed and that an extra member of staff was to start working on that unit in the mornings. Also, a community nurse lead had been employed to work on the Windsor unit to make sure that staff were deployed effectively to meet people's needs in a timely manner.

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

Risks to people's safety had in the main been assessed. This included in areas such as falls, assisting the person to move, pressure care, the risk of not eating and the risk of choking. Most of these risk assessments contained clear actions for staff to follow and we saw that they had been regularly reviewed. In some cases, actions had been taken to protect people from the risk of harm. For example, we saw that people who were at risk of falling from their bed had beds that were low to the floor and crash mats by their bed to protect them from injury. In another case, one person had been referred to a specialist falls team for advice on how to reduce the risk of the person falling. However, on the day of the inspection we observed some unsafe practice that put people at risk of harm and that staff were not always taking the appropriate action to keep people safe.

One person was seen walking around the Windsor unit wearing pyjama bottoms that were too long. Therefore, the person kept treading on them which was a trip hazard. No staff intervened or assisted the person with this.

We observed staff using poor moving and handling techniques within the dementia units when helping one person off the floor and three other people when assisting them to move in and out of a chair. The staff were not following the instructions that were written in one person's care plan of how to assist them to move safely. The techniques used placed people at risk of injury. On the second day of our visit, one person's ability to move with staff assistance had been re-assessed and action taken to make this safer. Another

person had been referred to the occupational therapist for advice on how to assist them to move safely.

Risks in relation to people not drinking sufficient amounts had not always been assessed. There was a lack of information within people's care records to guide staff on what action to take if someone was not drinking enough. We saw that three of the people whose care we tracked were having their fluid intake recorded. Two of these people were recorded as having a low intake of fluid but the staff told us that this was not being monitored. Therefore, they had not taken any action to increase people's intake of drink. This placed people at risk of dehydration.

On the first day of our inspection visit, we saw that staff provided some people with drinks at certain times of the day but not everyone was offered a drink. We did not see that people always had a drink that they could access when they wanted one.

Our pharmacist inspector looked at how information in medication administration records and care notes within the Windsor and Kensington units supported the safe handling of their medicines. We found that people's medicines were not managed safely on the Windsor unit.

One person living in the Windsor unit of the home had not received their medicines as prescribed. The records we looked at indicated that there was a risk that this had also been the case for a number of other people. When we compared medication records against quantities of medicines available for administration, we found numerical discrepancies and gaps in records. This included insulin given by injection for the management of diabetes. Records for the administration of medicines prescribed for external application were also incomplete. We identified an incident where because of an incomplete record, a person had missed a dose of their medicine. This placed the person's health and wellbeing at risk.

We saw that the morning medicine round within the Windsor unit was delayed so some people received their medicines later than they should have. One reason for this delay was the lack of staff working on the unit to support people with their care needs. This meant that the nurse who was doing the medicine round was frequently interrupted, having to support people with their personal care needs They were also taking telephone calls for the unit which again, interrupted them.

One person prescribed medicines for the management of a condition should have received them at 8am. However they did not receive them until midday which may have had a detrimental impact on their wellbeing. We also found that when people were not given their morning medicines because they were still asleep, there were no records showing further attempts to give them to people later. In addition, records did not clearly show the times that medicines had been either given or were scheduled to be given. This placed people who required multiple doses of the same medicine each day at risk of receiving their medicines too close together. Again, this could be detrimental to their health and wellbeing.

Some supporting information was available alongside medication administration record charts to assist staff when giving medicines to individual people. This included personal identification, information about known allergies and medicine sensitivities. There were additional charts to record the application and removal of skin patches. Information about how individual people preferred to have their medicines was detailed within their care records. However, this information was not kept within people's medicine records and was therefore, not easily accessible by staff when they needed it. When people were prescribed medicines on a when required basis, there was a lack of written information available to show staff how and when to administer these medicines. There were also no records about why they were needed and when they should be used. Therefore people may not have had these medicines administered consistently and appropriately.

Oral medicines were stored safely for the protection of people who used the service and at correct temperatures. However, in areas where people were living with dementia, medicines prescribed for external application were not safely stored so these medicines could have been accessed by people placing them at risk of harm. This included thickening agents for people's drink and creams.

The manager told us that staff authorised to handle and administer people's medicines had received training. They added however, that they could not guarantee that all staff who gave people their medicines had had their competency to do so assessed. The manager confirmed that the assessments would take place by the end of February 2016.

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

Most incidents or accidents that had occurred were recorded by the staff who worked on the separate units. Actions had been taken in response to these incidents to prevent them from re-occurring. However, we did find that one incident in relation to a medicines error had not been recorded and therefore the circumstances behind it not analysed. Also, these incident and accident reports were not being analysed by the manager. Therefore, there was no formal process in place to make sure that trends could be identified and that learning could occur. The manager told us that from January 2016, all incidents and accidents would be monitored.

Most areas of the home were very clean and well presented. This included people's rooms and the communal areas. We also saw that most equipment that people used was clean. However, we did observe that staff did not always wear protective clothing or wash their hands when they served people their food which presented a risk of cross infection. We also found that a bath remained unclean after the domestic staff had cleaned the flooring within the bathroom. The manager told us that a local authority infection control specialist had recently audited the home. They had been commended on the cleanliness of the home but improvements were required in some areas. These included ensuring there were adequate systems in place to monitor the cleanliness of the home and equipment used, the safe storage of clinical waste, removing lime-scale from a number of taps, cleaning slings regularly and improving facilities within the housekeeping room. The manager advised us that they were currently working with the local authority to make the necessary improvements.

All of the people we spoke with told us they felt safe living at Amberley Hall Care Home. Staff had received training in safeguarding adults and were able to demonstrate to us that they understood what constituted abuse. They were clear on the correct reporting procedures if they suspected that any form of abuse had taken place.

People received care and support from staff who had been appropriately and safely recruited. Staff told us the provider had sought employment references and a criminal records check before they started in their role. The recruitment records we viewed demonstrated these had taken place along with additional checks such as obtaining photographic identification.

Risks in relation to the premises had been assessed and regularly reviewed. We saw that fire doors were kept closed and that the emergency exits were well sign posted and kept clear. Testing of fire equipment and the fire alarm had taken place. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or finding someone unresponsive within their room. The equipment that people used such as hoists had been regularly serviced to make sure they were safe to use.

Requires Improvement

Is the service effective?

Our findings

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 least restrictive as possible. 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 are called the Deprivation of Liberty Safeguards. We checked whether the provider was working within the principles of the MCA.

The staff told us that a number of people who lived at Amberley Hall Care Home lacked capacity to make decisions about their care. They had varying knowledge regarding the MCA and how it affected their daily practice. Some staff had a good awareness and we saw them supporting people to make decisions about their care and asking them for their consent before performing a task. However, other staff were observed not to always follow the principles of the MCA, particularly within the Regency and Windsor units where people were living with dementia. Here, we observed a number of times where people were assumed to lack capacity to make a decision and were therefore, not always asked for their consent before a task was performed.

Where there was doubt that people were able to consent to some decisions about their care, in some cases an assessment of their capacity to do this had been made. However, this was not always the case. We saw that where people had sensor mats by their beds to alert staff to their movements, an assessment to consent to this had not taken place. Also we found that an assessment for one person held contradictory and confusing information. In one section it stated they had capacity but in another that they did not.

We also found that relevant individuals had not always been involved when making best interest decisions on behalf of people. For example, one person who was diabetic had been assessed to see if they could understand the implications of eating sugary foods. The staff found that they did not. The staff had made a decision to let the person have some sugary foods but had not involved any other parties such as the GP or a member of this person's family or advocate to discuss whether this was in the person's best interests. We also found that some care plans had been signed by members of the person's family who did not hold a health and welfare power of attorney (PoA). Relatives can only legally consent on behalf of another person if they hold a relevant power of attorney.

The provider had assessed the people who lived at Amberley Hall Care Home to see if they were unlawfully depriving them of their liberty in their best interests. Where they felt they were, they had made some applications in respect of a number of people to the local authority for permission to do so and were currently waiting to hear from them. However, some of the staff we spoke with on the units did not know which people had been assessed as being deprived of their liberty. Therefore, they were not able to take any action to reduce any restrictions that were in place, in line with the principles of the MCA. There was a risk that people's human rights were not being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People who were living within the Kensington and Buckingham units told us that they were always asked for their consent before a task took place.

During our last inspection in March 2015, we found that staff had not received frequent supervision or appraisals to discuss and evaluate their performance. We were told at that time, that plans were in place to improve this.

We found that improvements had been made and the staff told us that they were happy with the amount of formal supervision they received. We saw that staff had received some formal supervision but that not all had received annual appraisals. The manager told us that there were plans in place for all staff to have received an appraisal by March 2016.

The staff we spoke with told us they had received enough training to provide people with the care they needed. However, some of our observations did not always support this. For example, we saw some staff using unsafe moving and handling techniques when supporting people to move. When we spoke to staff about this, they did not understand why the techniques they were using were unsafe. Some staff demonstrated poor infection control practice. Also, some staff did not always engage effectively with people who were living with dementia.

From the staff training records, we found that most staff had completed an e-learning course in dementia. The operations director told us that a number of staff had recently received face to face training on dementia but agreed that further training was required. Plans were in place to source this training and to also train two staff to become dementia coaches. This would enable them to become specialists within this area and to then train other staff within the subject. The operations director also advised that staff were to complete 'through their eyes' training. This was training where staff would experience what it was liked to be hoisted or assisted to eat so they could empathise with the people they provided care for.

New staff who started working for the home completed induction training. The manager told us that new staff's competence was evaluated before they started working on their own. One new staff member we spoke with confirmed this. In the three staff files we looked at in relation to staff who had started working at the home within the last six months, only one had a record to evidence that they had been assessed as being competent to work independently before going on to do so.

Some checks regarding staff's competence following their training had recently been completed. However, these had only covered hand hygiene practices and assisting people to eat and drink. No other checks of staff's competency had taken place to make sure that their care practice was safe and effective. Therefore, improvements are required within this area to make sure that staff have the necessary skills to provide effective care.

We observed that the mealtime experiences were very different within the units. Within the nursing and residential units, the tables were laid with cutlery, condiments and flowers. People were seen chatting and enjoying the time together. However, in the dementia units, there were no flowers on the tables, condiments or cutlery. The staff gave people their cutlery when they gave them their meal. There was little interaction between people and meals were eaten mostly in silence. Although we saw that some people were shown the meals on offer to help them make a decision about what to eat, this did not happen in all cases.

When we spoke with the staff in the dementia units about this, they told us that people often picked up the

cutlery and walked around with it and that it then disappeared. They also said they felt this was a safety issue although no risk assessment regarding this had taken place.

We also saw that when people were served their meal, this was not completed a table at a time. This meant that some people had to wait for their meal whilst watching another person eating theirs. This may have been unpleasant for people if they had been hungry. The manager told us that she was aware of the need for improving the mealtime experience within the dementia units and that plans were in place to make improvements within this area.

The people we spoke with told us that they liked the food. One person said, "The food is very good." Another person told us, "I'm always looking forward to my dinner."

People were provided with a choice of main meal and alternatives were given when people did not like what was on the menu. Where people required assistance with their food, this was received. Some people needed a specialised diet to meet their needs and this was provided.

Risks in relation to people not eating enough were assessed regularly. People who were of low weight were having their food fortified with extra calories and most were receiving supplements. They had also seen a specialist healthcare professional for advice. The staff told us that they offered these people regular snacks throughout the day and the chef confirmed that milky drinks were made for these people in the afternoons and evenings.

The chef had a good understanding of people's likes, dislikes and any allergies they had. They told us that the communication from the staff was good so that they could make sure people received the correct diet to meet their needs. This included people who had any cultural dietary requirements. We were therefore satisfied that people's nutritional needs were being met.

GP's visited the home regularly to check on people's health and to see people if they were unwell. People also had access to other healthcare professionals such as occupational therapists, physiotherapists, chiropodists, dentists and district nurses. We saw that these healthcare professionals were called in a timely manner when people became unwell or required support with their health. We were therefore satisfied that the staff supported people with their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with on the Buckingham and Kensington units told us that the staff were kind, caring and treated them with respect. One person told us, "They [the staff] are a lovely group here." Another person said, "The staff are lovely, they laugh and joke with you." This was echoed by the relatives we spoke with. We saw some people within these areas being involved in daily tasks such as setting the tables for lunch.

We saw some good examples of staff being caring, kind and compassionate to people who lived in the home and treating them with respect. A staff member noticed that a person's hearing aid had fallen out, they explained this to the person very discreetly and fetched a pair of gloves to put it back in, all the while explaining what she was doing and checking that the person was happy with this. We also saw staff holding people's hands and smiling with them when they engaged with them in conversation. When assisting people to move, some staff were heard advising people what they were doing and why. Those who required assistance with their meal were provided this in an unrushed and calm manner and most staff knocked on people's doors before entering into their rooms.

However, we also observed on occasions, that people who lived on the dementia units were not always treated with dignity and respect. Staff helped one person sit in a chair within the lounge. They asked the person if they were comfortable. The person told them 'No'. The staff member responded by saying 'oh dear' and walked away. They made no attempt to find out why the person was uncomfortable. We noted that another person's slipper had come off their foot whilst they were sitting in their chair. Staff walked past this person three times before noticing this and assisting them to place the slipper back on their foot. Another person spent 90 minutes wandering around one of the units in their pyjamas. These were very thin and therefore see through. Staff did not attempt to assist this person to protect their dignity.

Some staff were heard to refer to people who required assistance with eating as 'feeds' rather than by their names. We also observed a conversation between a person and a staff member being interrupted by a member of the management team when they were talking to a person about their breakfast.

At our previous inspection in March 2015, we found that when a person pressed their call bell to request assistance, that this rang throughout the home rather than just on the unit the person lived. This resulted in people throughout the home being disturbed by the ring of the call bell. We were advised at the last inspection that this would be rectified. We found during this visit that improvements had been made but that the call bell had only been restricted to ringing on individual floors. The operations director advised that they had tried to isolate the call bell sound to each unit but that this was not possible.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and/or their relatives were involved in making decisions about their care when they first moved into Amberley Hall Care Home. Some people told us they were able to make their own decisions about the care they received and were happy that they were listened to by the staff. Reviews of their care had taken place

where they had been consulted for their feedback on their care. However, people who lived within the dementia units were not always included in these reviews. The staff told us that only family members were involved. Therefore improvements are required to make sure that all people were able, are encouraged to contribute to making decisions about their care and treatment.

Amberley Hall Care Home had no set visiting times and people's friends and relatives could visit as they pleased. The home had a number of areas where people and their visitors could sit in private and there were facilities in place for visitors to make refreshments.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2015, we found that care was not being delivered to meet people's individual needs. We found during this visit, that the necessary improvements had not been made as people still did not always receive personalised care and staff were not always responsive to people's needs.

Some people's preferences had been assessed before they moved into the home. These included the gender of carer they preferred, their preferred way to be addressed and whether they liked to have a bath or shower. However, there was not always information about people's preferred times for getting up or going to bed and the information regarding bathing had not always been completed. Two of the three relatives we spoke with said that although they were generally happy with the care received, they felt that it could be improved to be more personalised for the individual. Staff in general told us that they could meet most people's preferences and we found that some of these preferences were being met. For example, some people could get up when they wanted to or were able to eat in a place of their choosing but we found that this was not consistently the case.

One person told us how they were often not given assistance to get up in the morning until after 11am which was not their preference. A relative told us how their family member wanted to have more baths than one per week but that this was not received. When we spoke to the staff about this, they told us that they were only able to offer people a bath or shower once per week. It was recorded in another person's care record that they liked to be clean shaven but we found that they had not received support with this.

One person told us how they had requested help with their eating as they had found this increasingly difficult. This had been noted within their daily notes. However, no action had been taken to help this person and we saw them struggling to eat their lunchtime meal. We also observed one person regularly shouting out in a communal area but staff did not interact with them at all during the hour long observation. Another person was also seen shouting out, looking anxious and in signs of distress but again, no staff acknowledged this or tried to comfort the person. A further person was seen coughing after eating some food and trying to have a drink but their glass was empty. The staff did not notice this so we had to alert them to this fact so they could assist the person.

People within the dementia units were not always given a choice or consulted about the care they received although we saw that this regularly occurred on the other units. For example, we saw one member of staff open a window within a lounge area without asking the people in there whether they were happy with this. The same staff member turned the television over without consulting the person who was watching it. People were brought cups of tea but were not asked if that was what they wanted. During an activity, head scarves were tied onto people without them being asked first if they were happy with that. One person told us about how a window was opened in their room and they said they were cold but were told by staff that they needed the fresh air.

We also saw that people who were sitting within some of the lounge areas in the dementia units were not asked if they wanted to take part in a particular activity. Loud music was put on and people were

encouraged to join in with the activity. Some people participated but others had been asleep and were woken suddenly by the noise. Others had to move out of the lounge as they did not want to participate. On one of the dementia unit's, gravy was poured onto everyone's food without them being asked if they wanted it. Everyone's food was being fortified with extra calories even if they did not require this. The care record of another person stated that they liked to be in the lounge or dining room but spent four hours in bedroom. We saw that they had been left in bed after lunch in an inappropriate position looking uncomfortable.

There was a lack of stimulation and meaningful activity provided to people who were living with dementia. On the first day of our inspection, staff did not interact with people very often and most people sat in the communal areas either asleep or gazing at the television. There were no sensory items for people to touch or look at. Although we saw some dolls and hats in the dementia units, none of these were being used. We saw one person picking up folders and polishing the tables with their hand. The staff did not respond to this or give the person something to do to keep them occupied. On the second day of our visit, things had improved and staff were encouraging people to take part in painting and knitting. The staff told us that when there were enough staff on duty, they could spend more time with people but that this was difficult when they were short of staff. The manager had recognised that improvements were required to enhance the well-being of people who lived at the home who were living with dementia and plans were being formulated with regards to this.

Most of the staff on the Windsor unit had a primary language that was not English. We saw that this meant on occasions, there were difficulties in communication between the people who lived there and the staff. A relative told us how this had resulted in a mix up when they has requested their family members glasses for them to put on, only for the staff member to bring them a glass. We spoke to the manager about this who agreed to review where they placed staff to make sure that communication could be more effective.

People's care needs had been assessed and there were plans of care in place to guide staff on how to meet these needs. Most care plans contained clear information about what care the person required. However, some held either incorrect or conflicting information or not enough information about the action staff should take to provide safe care. This led to a risk of people receiving incorrect care which could be unsafe or compromise their dignity, particularly from staff who were not familiar with the person's needs. For example, one person's care plan said they required support to walk with two people and a frame. However, on the first day of our inspection they were using a wheelchair. This was not documented within their care record. Another person's care record stated they needed a soft diet when they were having a pureed diet. It was also not recorded in their care record how often they should be assisted to move to reduce the risk of them developing a pressure sore although we saw this was occurring. A different person's care record indicated that they needed prompting with their drinks but a staff member told us this was not the case. In another care record, two different amounts of thickener required in a person's drink to protect them from the risk of choking had been quoted. This led to confusion. One staff member told us they would give the person one of the amounts quoted within the care record but another staff member was observed to give them too much.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The home employed three staff members to provide activities for people living at Amberley Hall Care Home. At the time of our inspection, one of these staff members was not currently working. The operations director advised us that a third person had been recruited to provide people with activities and that they were due to commence working shortly.

There was a varied programme of activities and lifestyle programmes that people could participate in if they

wished to. These included knitting clubs, films in the cinema, a gentleman's club, Holy communion, coffee mornings and musical memories. Most people we spoke with were happy with the level of activities on offer. One person told us, "My mother taught me to cook and I like learning here." Another said, "I love it. There's so many things happening. Cooking, exercises. Song and dance." We observed people within the residential units participating in activities, laughing and enjoying themselves. We also saw that some people had been involved in raising money for a local charity and that a garden fete had been held in the summer.

We received mixed views from people in relation to how their complaints were dealt with. Most people were happy that any complaints they dealt with would be sorted out and they knew who to speak to if they were concerned. However one person told us how they had to wait for over two hours when they had complained about the temperature of their room. A relative told us about a complaint they made in July 2015. They said, "There is no complaints form, you go to the main desk and you can talk to the manager. They sorted it out but it wasn't sorted out until October 2015."

The manager had a record of written complaints that had been received from November 2015. Complaints prior to this date had been archived. We saw that the complaints received had been fully investigated and a response give to the person who had complained. However, verbal complaints were not recorded. Therefore, improvements are needed to the complaints process to make sure that all complaints are documented and investigated.

Requires Improvement

Is the service well-led?

Our findings

The last registered manager left the service in March 2015. A temporary manager was in place after this date but they did not register with us and stopped performing that role in September 2015. Another manager was then recruited from September 2015 who has not yet registered with us which is a requirement by law. Plans are in place for them to do this.

During our last inspection in March 2015, we found that action was required to make sure that people received good quality safe care. We were told that plans were in place to make those improvements. The plans included the revision of staffing levels, improvements to the levels of supervision staff received and to the activity provision for people living with dementia. However, during this inspection, we found that the provider had failed to make all the necessary improvements that were required. We again found concerns within these areas that were having a direct impact on the safety and wellbeing of some people who lived at Amberley Hall Care Home. We also found other concerns during this visit regarding the management of people's medicines, people not always being treated with dignity and respect and protecting the rights of those people who were unable to consent to their care.

The provider was not acting in a timely way to protect people from the risk of experiencing harm or poor care. The manager told us they had recognised some of the issues that we identified during this inspection visit. These included the lack of staff on the dementia units and the lack of stimulation that some people received there. However, no immediate action had been taken to correct this. Therefore, people within these units were on occasions receiving care that was task led rather than personalised to their individual needs. This meant that people did not always receive the care they needed.

We found that the oversight of risk to people in general was not managed in a proactive way. Although the senior staff on the units kept records of incidents and accidents and conducted some analysis on these, they were not analysed by the manager or provider. Plans were in place to do this from January 2016. Verbal complaints were also not being recorded. Both of these represented missed opportunities for learning for the benefit of the people who lived at the home.

Some audits were undertaken to monitor the care provision that was delivered. These included audits of people's medicines, accuracy of care records and people's dining experience. However, as a result of the concerns we have identified during this inspection, it was apparent the provider was not effectively assessing and monitoring the quality of service provision.

The operations director told us that the responses to the call bells was monitored and analysed and that these had improved. However, we found this still to be an issue. We found that a number of records we looked at were inaccurate or incomplete. This included some information within people's care records, medication records and charts used to record people's food and fluid intake or when assisting people to move. Audits of people's care records had taken place but as only a few were completed each month on each unit, these issues had not been identified.

We were advised that plans were in place to improve the quality monitoring processes throughout the home. These included the introduction of a new weekly and monthly reporting initiative from January 2016 on areas such as people's weights, pressure care and incidents, leading to the development of an overall a service improvement plan. We saw the latest audit that had been conducted by an external consultant in January 2016. This detailed a number of areas that required improving and had identified some, but not all of the concerns we found during this inspection. An action plan was in place and the manager was working towards completing these actions.

The provider stated within their Statement of Purpose document (this is a document which tells us the visions and values of the home) that 'the home offers all residents a person centred approach to care' and 'residents may chose the number of showers/baths they have'. However, it was clear from our observation of some staff interactions with people on some of the units and our findings, that this vision of the home had not yet been fully embedded.

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

Most people we spoke with felt that the home was well led and they all told us that they could raise issues with the senior staff without fear and that they felt listened to. This was echoed by the staff we spoke with who said they felt well supported by the management team to perform their roles.

The manager told us that it had been difficult to recruit the number of staff they needed to the home, but that they were confident that improvements had been made regarding the quality of care provided and that these would continue to be made.

People and relatives were asked for their opinion regarding the quality of care received through meetings, the last one of which was held in December 2015. The manager told us that some of the suggestions were being trialled such as the use of new bedding. However, it was not clear what other actions had been taken as there was no action plan in place following the meeting. The manager had recognised that these meetings were not well attended and was taking action to try to increase attendance. A survey was due to go out to people and their relatives in February 2016 to obtain further views on the care received. The last survey had been sent out in September 2014.

The manager had developed a number of links with the community and was looking to increase these. These included links with representatives from the local church who visited often to see people. Some people attended the local over 60s club and links with the rotary club were being made. The manager was also looking to hold quiz nights at the home that people from the local community could attend if they wished to.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment service users received was not always appropriate, met their needs or reflected their preferences. Care was not always designed to meet people's needs or preferences. Regulation 9 (1) (a) (b) (c) and (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Not all service users were treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always delivered with the consent of the relevant person. The Mental Capacity Act 2005 principles had not always been followed. Regulation 11 (1) (2) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's safety had not always been assessed or action taken to mitigate these risks. People's medicines were not always managed

safely. Regulation 12 (1) (2) (a) (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed to meet people's needs. Regulation 18 (1).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor, improve the quality and safety of the care provided or to mitigate risks to people's safety. Some records were not accurate or complete. Regulation 17 (1) (2) (a) (b) and (c).

The enforcement action we took:

We have sent the provider a warning notice and told them they must be compliant with this Regulation by 15 March 2016.