Care Quality Commission

Allambie Enterprises Limited

Allambie House

Inspection report

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Date of inspection visit: 12 February 2015
Date of publication: 30/04/2015

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?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 12 February 2015 and was unannounced.

Allambie House is registered to provide personal care and support to a range of people. This includes older people, people with learning disabilities, dementia, a physical disability and a sensory impairment. We found people within all of these categories living at the home. It is registered to accommodate up to 30 people and on the day of our inspection there were 26 people living there.

A registered manager was in post and was present during our inspection. 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.

People who lived at Allambie House told us they felt safe but we found improvements were needed to make sure they were kept safe. This included making sure people had access to call bells, were assisted to move safely and ensuring health and safety checks within the home were completed thoroughly. There was a lack of storage space

Summary of findings

within the home and the inappropriate storage of items impacted on people's safety. Cleanliness and management of infection control within the home also needed improvement.

People were supported to make some choices about their lifestyle and their independence was supported where possible. However, where people refused care, there was not always a clear management plan for staff to follow to make sure they worked in the person's best interests.

Care staff understood some of their responsibilities to keep people safe and the importance of reporting any suspected abuse. Staff did not have a good understanding of how the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) affected their practice. The MCA sets out how to support people who do not have capacity to make a specific decision. DoLS are safeguards used to protect people where their freedom to undertake specific activities may be restricted. We received conflicting information from the registered manager and staff about the number of people who needed support in making certain decisions.

People were mostly positive about the staff. We observed staff were sometimes caring in their approach and at other times their interactions with people were mostly based around giving instructions to carry out care tasks. We observed call bells were answered promptly but there were some occasions when there was a delay in staff responding to people's requests for staff support during the morning.

People received the support of health professionals such as the GP, chiropodist and district nurse to ensure their health needs were met. A visiting health professional was positive in their views of staff and the support provided to people.

There were some systems in place to monitor the quality of care and services provided but we did not see clear processes to seek people's opinions and suggestions to help improve the care and service they received.

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

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?
The service was not consistently safe.

People told us they felt safe at the home but we found systems for managing health and safety and risks to people were not sufficient to always keep people safe. Some people did not have access to call bells to alert staff they needed assistance.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff had completed training considered essential to meet people's needs but what they had learned was not always put into practice.

Where there were doubts about people's capacity to make specific decisions, assessments had not been completed. People were supported to maintain their health and referred to external healthcare professionals when a need was identified.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Most staff were caring towards people but opportunities to talk with people were missed and people's wishes were not always respected. People's privacy and dignity was not always being maintained.

Relatives and friends were able to visit at any time of the day.

Requires Improvement

Is the service responsive?
The service was responsive.

Staff supported people's independence, hobbies and interests where this was possible.

Where people had formal complaints, these were investigated and responded to so that where necessary, improvements could be made.

Good

Is the service well-led?
The service was not consistently well-led.

A registered manager was in post and staff told us they felt well supported by management staff and understood what their responsibilities were.

Checks and audits of the quality of service were undertaken but it was not always clear what actions had been taken in response to the findings of these. There was no clear system for people to give their opinions of the care and services provided to enable these to be considered when making improvements.

Requires Improvement

Allambie House

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.

The inspection took place on 12 February 2015 by two inspectors and was unannounced. Before our visit we spoke with the local authority to ask if they had any comments about the home. We also looked at our own system to see if we had received any concerns or compliments about Allambie House. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

To help us understand people's experience of the service we spent a period of time during the day observing lounge and dining areas. This included observing the lunchtime experience. To gain people's opinions of the home we spoke with nine people and three relatives. We also spoke with the registered manager, deputy manager, the provider, four care staff, the cook, a visiting health professional and the activity organiser.

We looked at ten people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records and social activity records. We also looked at quality audits, staff recruitment records, records of complaints, incident and accidents at the home and health and safety records.

Requires Improvement

Is the service safe?

Our findings

Four people told us they felt save living at Allambie House, but we saw practices that did not promote people's safety. For example, there were three people who did not have access to a call bell to alert staff should they need assistance. One person told us their call bell had been taken by a member of staff. A second person sitting in the lounge had no access to a call bell and told us their portable call bell was in their room and they needed assistance from a member of staff. Another told us they had been calling out because they had no call bell and needed to go to the toilet. People we spoke with told us they had to wait too long for staff when they used their call bell. They told us, "I have to wait, up to ten minutes, they definitely need more staff." Sometimes I am shouting and shouting to get help." One person told us sometimes they had to wait and sometimes they did not. When staff were made aware of one person who we saw calling out they did offer reassurance and made arrangements to assist them.

We asked care staff how they kept people safe, one staff member told us, "We have to use the correct moving and handling." They said the manager and deputy watched them when they used equipment such as the hoist to make sure people were supported to move correctly and safely.

We observed the morning handover meeting where staff told us they would communicate any concerns they had identified with people during the night to the day staff. They communicated a person had fallen and had required assistance with a wound to their arm. This alerted the day staff to be aware this person was at risk of falls and to monitor them in case they had any problems with their wound. We asked staff if they used risk assessments so they understood how to deliver care without putting people at risk. One staff member was not clear what a risk assessment was and told us they used the care plans when a new person came to the home to check their care needs. They stated the rest of the time they relied on information shared at the handover meeting that took place prior to their shift starting. We saw there was some information in care plans about managing risks such as falls and health conditions to keep people safe.

We were told about one person who had been found to smoke cigarettes in their room on a number of occasions. There was no risk assessment to show how this concern should be managed to ensure a consistent and safe approach by staff. However, the manager had removed their matches to prevent the person from putting themselves and others at risk of harm.

Staff told us they understood their responsibility to report any abuse or suspected abuse of people to the deputy manager or registered manager. One staff member told us their understanding of protecting people was to keep them safe from "harm, pressure sores, accidents and abuse." Staff had completed 'safeguarding' people training to enable them to have an understanding of what they should do to protect people from abuse.

We received mixed opinions about the staffing levels in the home and staff's ability based on these levels to meet people's needs safely. Some staff spoken with felt there were enough staff on duty and others did not. One staff member told us, "They don't have enough care workers, there are too many people, I think the manager does the best she can." A relative told us, "I don't think there is enough staff, they're always rushed off their feet." A visiting health professional told us there was always a member of staff to assist them when they needed to see people in the home. On the day of our visit there were enough staff to meet people's needs however new flooring was being laid and some people were asked to stay in their rooms. This did impact on the usual routines of the home and how staff usually cared for people on a day to day basis. Those people we did observe were not rushed by staff when delivering care.

We asked the registered manager how staffing levels were agreed. She told us they were based on the number of people in the home and their needs and there were enough staff to do this. There was no dependency tool used to determine staffing levels but the manager told us she would increase staff numbers if she felt this was necessary. She gave an example of when the number of people in the home had reduced which led her to reduce staff numbers. When numbers had increased again, she had to support staff with caring duties to meet people's needs so took the decision to increase the staff numbers again. This demonstrated the manager was monitoring staffing levels to make sure there were sufficient staff to meet people's needs.

We discussed with the registered manager how recruitment was managed at the home. The manager told us that all the required checks were carried out before they employed

Requires Improvement

Is the service safe?

staff. However, information in recruitment files was not sufficient to show employment checks had been completed to support the safety of people living at the home. In one file there was no evidence a police check had been undertaken, no date of employment and no information to show their identity had been checked. In a second file there was no date of employment to be sure the police check had been carried out before they started. Staff we spoke with told us employment checks had been carried out before they started. We reported this information to the manager who was unable to give an explanation why this information was not available in the files.

We looked at how medicines were managed and saw people had received their medicines as prescribed. People told us they received their medicines on time. One person told us, "They bring me my medicine each day." We asked a staff member about one person who was on a sedative medicine prescribed "as required." They told us why the person had been prescribed this medicine and staff were aware of how this should be managed. Medicine administration records confirmed if people had taken their medicines and the registered manager told us only trained senior care staff administered these. Medicines were stored securely within a locked trolley or medicine cabinet.

Staff told us they completed infection control training so they knew how to practice good hygiene but we found the levels of cleanliness and the management of infection control were not consistently maintained. For example, staff told us one of the tasks they did each day was to change people's bedding. We saw dirty bed linen on beds in two bedrooms. Staff told us a person in one of these rooms often refused to let them change the sheets. We found there was no agreed process on how to manage this to maintain cleanliness. Staff told us they had care tasks allocated to them each day which included putting towels and flannels from the laundry in people's bedrooms. These were not available for people to use in all rooms because they had not been replaced by the staff who had removed them.

There was a lack of storage facilities across the home which meant some areas were cluttered and restricted people's space and movement as well as impacted on the cleanliness of the home. This included boxes being stored in a dining/lounge area for the duration of our visit. There were also two people who had collected a number of items which were clearly important to them but these were piled high in their rooms. This meant it was difficult for them to access their possessions as well as enable their rooms to be cleaned properly to prevent the spread of infection. In one room there was a strong unpleasant odour and a full urine bottle which remained there for most of the day unemptied.

We found improvements were required to ensure that people in the home would be safe in the event of a fire. For example a mattress blocking one of the fire exits which would have prevented people exiting the building in an emergency. The registered manager was not aware it had been placed there. Personal evacuation plans were not available in all care files to show how people may need to be supported in the event of a fire or emergency. Staff spoken with knew to move people to a safe place and knew which people in the home could walk. One staff member did not know how a person who could not walk would be moved. The registered manager told us that those people who could not mobilise would remain behind fire doors until they could take advice from the fire brigade. An evacuation slide was available on the upper floors in the home for those people not able to walk unaided.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The MCA protects people who lack capacity to make certain decisions because of illness or disability. DoLS is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

We asked staff and the registered manager how many people within the home lacked capacity and received conflicting answers that suggested staff were not clear on those people who may need support to make decisions. There were no mental capacity assessments on the care files we viewed of those people with a learning disability and diagnosis of dementia, to show how they may need support with some decisions. It was not clear how restrictions placed on these people were being managed. For example, the front door contained a keypad lock and most people were restricted from leaving because it was considered they would not be safe. The registered manager understood the principles of the MCA and DoLS but they had not been fully put into practice. The manager stated it was a complex area for staff to understand and they would benefit from further training which she would need to arrange.

Staff told us bedrails were in use for two people because they were at risk of falling. The registered manager told us one of these people came into the home from hospital with an instruction for bedrails to be used due to the risk of them falling. This person's records showed these had been in place since 2012 and the risk assessment to check that this was the least restrictive practice had not been reviewed since this date. We were told the person did not have capacity and no 'best interest' meeting or DoLS referral had been made to agree if this restriction was in the person's best interests to keep them safe.

The lack of actions in regard to the MCA and DoLS meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they felt staff had the skills to care for them appropriately. Two people told us they felt staff had the skills needed to care for them as they expected. One person told us, "I have never had any problems, they do a good job." Staff told us they received training considered essential to meet the needs of people safely and records confirmed most staff had completed their essential training. However, we observed that some of the training was not effective. For example, staff had completed moving and handling training but were not confident in using the hoist without instruction from the manager. It took around 15 minutes to move a person with the manager providing instructions and guidance to staff on how to do this. This meant people who needed a hoist to be moved could not be certain staff were competent to use this safely.

We asked the registered manager if staff completed training specific to the needs of people who lived in the home, such as training on diabetes and learning disabilities. We were told diabetes was covered in training provided on "Diet and Nutrition" however, a member of staff we spoke with was not aware of the symptoms associated with this condition and how to respond to them. Five of the eleven care staff had completed training on how to support people with learning disabilities. The registered manager told us she ensured staff put into practice what they had learned by observing their practice and arranging for additional training if this was felt necessary. She advised that she was in the process of arranging for staff to attend additional training linked to people's needs.

At lunchtime most people ate their meals in their rooms as they were unable to access the lounge or dining room due to new flooring being fitted in the corridor. We asked people if they enjoyed their meals and received mixed views. People told us, "Food is pretty good." "I'm not keen on the dinner, it's swimming in gravy." "We've been having tough meat, you can't chew it." The cook told us people were offered a choice each day and the menus were changed every two weeks so that people had a variety of choices.

There were some people with special dietary needs. This included some needing a vegetarian diet and some a reduced sugar diet due to being diabetic. The cook told us these people were provided with alternative choices in accordance with their needs. We saw there were two nutritious main meal choices on the day of our visit but there were no records to show people had a varied balanced diet. One person told us menus were not provided and stated, "They have a list but I only know if I

Requires Improvement

Is the service effective?

ask them, it's always the same." We spoke with two people who told us their food choices were not provided or rarely provided although the registered manager stated their choices had been discussed with the cook and had been provided.

People had access to health professionals when required and a visiting health professional was positive in their views of the staff support provided to people. Staff told us about one person who would not eat, so action had been taken to refer them to a Speech and Language Therapist (SALT) so they could seek advice on how to manage this risk. One person we spoke with told us they had seen a doctor, nurse, chiropodist and dentist when needed. Another told us, "Yes they get the doctor to see me, several times." Care records confirmed referrals had been made to health professionals.

Requires Improvement

Is the service caring?

Our findings

Some people told us staff were very caring, one person told us, "All are very, very nice, you could not want for better staff." Others told us, "No, staff are not always caring." "Some carers are nice, some are not, they can be abrupt." We observed staff assisting people during the day, most were caring in their approach. Staff were busy during the day but did not rush people when they provided care and support. However, there were missed opportunities for staff to socially engage with people when they provided care. Staff interaction was mostly based around giving instructions or was focused on the care task being carried out. We asked staff about their role of caring for people. One staff member told us communication was a problem as some staff were not able to interpret information correctly. They told us sometimes passing on messages proved difficult and sometimes people got "frustrated" when they could not get staff to understand what they wanted them to do. We noted that not all people working in the home had English as a first language and when we spoke with some staff there was a need rephrase some questions so they were able to answer them. The registered manager was aware there were some issues regarding staff communication such as how they dealt with telephone calls and as a result they had been told at a recent meeting how to improve.

People told us they did not always feel they were listened to and we saw examples of this during our visit. For example, when we arrived one person in their bedroom with their door open asked to be moved to the lounge because of noise from workmen in the corridor. This did not happen and the person was left anxious and unsettled in their room during the morning. During the afternoon, the person was assisted to move into the main lounge and they were smiling and speaking with other people and seemed much happier. Another person had a hoist and medication trolley stored in their room and told us staff had not asked them for their permission first.

Staff knew to protect people's privacy and dignity and told us when delivering care they would close doors and use towels to keep people covered. One staff member told us they would explain to the person what they were going to do and if the person was having a shower would get everything ready first and make sure they were fully dressed when completed. However, in practice there were instances when people's privacy and dignity was not always respected. We saw one person had dirty nails and was wearing dirty clothes which did not promote their dignity. We were told this person was resistant to personal care. From speaking with staff there was no agreed plan of care on how this should be managed to make sure the person's needs were met. We found a person's care plan containing personal information had been left in a communal area where other people could access this as opposed to being kept securely. One person had no soap, toothbrush or towel in their room to attend to their personal hygiene for the duration of our visit. They told us they had washed with a sponge that morning (this was seen on their wash-hand basin) but had not had a towel to dry themselves with. We observed inappropriate practice by one staff member who was assisting a person to eat in their bedroom. The person was sleepy and the staff member tapped them on their nose several times and asked them to wake up to eat. This was reported to the registered manager who told us she would investigate this.

We observed staff were not always working in accordance with people's needs and wishes and this also compromised their dignity. For example, there were CCTV cameras in use in the communal areas of home where people could be observed. We were told these images could be viewed on portable devices and outside of the home environment. We found people had not been asked for their consent to use the cameras and the correct protocols in line with the Information Commissioners Office (ICO) Code of Practice had not been followed. The provider told us they were originally installed following an incident in the home three years previously. They also stated that the main objective was to protect people and they checked it every day.

People's relatives and friends were able to visit at any time of the day and people were supported to use the telephone to maintain contact with relatives.

Good

Is the service responsive?

Our findings

People told us that staff gave them choices about the care they received. For example, one person told us they had chosen when they wanted to have a shower and staff had assisted them at that time. Another person told us being able to maintain their independence was important to them. We noted they had a mobility aid and had been allocated a room they could easily access using this. The person told us staff supported them to maintain their interests and hobby which made them happy. They had not seen their care plan but stated, "I do my own thing" which suggested their independence was being respected. A visitor we spoke with was positive about the care provided and told us they were kept regularly informed about their relative.

People's needs were assessed and reviewed regularly and care plans detailed people's individual care needs, the support they required and how this was to be provided. Staff we spoke with were able to describe people's needs as reflected in the care plans. For example one staff member told us, "[person] is still in her room. She likes to get up later. It's her preference and she makes her own breakfast."

The registered manager told us she aimed to meet people's social care needs and had arranged for one person to attend a day centre in the community to complete activities they enjoyed. The manager told us how this was soon to come to an end and it had caused the person a lot of distress and had impacted on their mental health. In response to this arrangements had been made for the person to be supported by a mental health professional. The manager had also taken time to source another community activity class similar to the one they had been attending so the person could continue to enjoy their activity. One person told us the manager had agreed they could bring their pet cat into the home which they were pleased about.

On the day of our visit most people were either sitting in their rooms or the communal areas with the television on. There were some people who took part in a group colouring activity by choice. We spoke with a staff member whose role was activity co-ordinator for the home. They told us, "I ask people what they want to do." They explained this may be exercises, board games, colouring or a one to one chat with someone. They told us they had taken one person out on a shopping trip and they had outside entertainers that came into the home. There were activity records kept to show what activities people had participated in and there was evidence these had happened such as pictures around the home that people had created.

We noted some people had formed friendships in the home and staff made sure these people sat together in the lounge during the afternoon so they could talk with one another and not become socially isolated.

People's care files contained information about their care needs and how staff needed to support them. There was a "This is my life" section which contained information such as the person's interests and family background to help staff deliver person centred care. We saw evidence that people were supported with their interests as detailed in their care plans. For example, art and craft activities.

People we spoke with told us they would speak with the registered manager if they had any concerns and felt their concerns would be acted upon. They told us, "It's alright here, if you have any complaints they listen to you." "I know the manager, I can talk to her if I have a problem." "If there is a query they will find the answer for you." There was information in the entrance hall telling people how they could raise a complaint if they were not happy about something. This included information on how to contact the provider and us if they were not happy about how their complaint had been responded to by the registered manager. We were told there was an 'easy read' complaints procedure to help some people in the home more easily understand how to raise a complaint but this had not been made available to them. However, people felt confident to raise any concerns they had with the manager. Complaints that had been received had been responded to and improvements made such as repairing a leak identified in one person's room. Records indicated if people were satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

There was both a registered manager and deputy manager responsible for running the home. People knew who the registered manager was and told us, "The manager is approachable, you could not want for a better person". "I could not complain (about the manager) she is all for the people."

The registered manager was open with us about challenges she faced at the home. For example, the improvements needed to the training provided. Staff told us they felt well supported by management staff and understood what their responsibilities were. They were given opportunities during supervisions to discuss their training needs so these could be addressed. The registered manager told us staff were regularly observed to check they were working to the required policies and procedures to keep people safe. Where staff had not performed to expectations, such as not maintaining confidentiality, action had been taken by the registered manager. This included reminding staff of their responsibilities to maintain the standards the provider expected so people's personal information was kept secure. Staff told us the managers would tell them when they had "done something wrong" so they would know not to repeat their actions.

Staff had the opportunity to discuss issues related to the running of the home to help the ongoing improvement in the care and services provided at staff meetings. Notes of a staff meeting held in November 2014 showed areas for improvement which included health and safety (such as fire and hazard awareness), infection control, 'upholding dignity and respect' and confidentiality. At this visit we found improvements were still needed in these areas demonstrating actions taken had not been effective in ensuring improvements happened. The notes did not show staff had been asked for their opinions of issues raised and it was not clear how the issues for improvements identified were to be followed up to ensure they happened.

The registered manager and deputy manager told us they carried out various quality audits of the service and home to check people's health and safety was protected. These included audits of the environment and kitchen as well as monitoring when and where people had fallen. The audit of falls completed by the manager showed she had monitored the number of times people had fallen within the home so that lessons could be learned from these. An analysis also completed by the manager showed one person had fallen a number of times within a short timescale. As a result of this, action had been taken to refer this person to the falls clinic so they could be assessed for a walking aid to support them to walk safely and independently.

We found that whilst checks were completed, sometimes concerns were missed or there were missed opportunities to learn from the findings of these. We found information we needed was difficult to locate in files and some of the information we looked at was out of date. Some information the registered manager was unable to locate and where shortfalls in care and services had been identified, we found the actions put in place did not always address them properly. For example, we requested to see the electrical wiring check for the home. This could not be located on the day of our visit but was located following our visit and was found to be six months out of date. The provider had acted on this by arranging for the electrical wiring check to be completed, however there was a six month period when the home was potentially not insured against fire risks.

The provider and manager told us of their commitment to provide good quality care and services to people. We found there were some arrangements in place to assess and monitor the quality of the service. These included discussions with people and their families, audit checks of care/services and provider quality monitoring visits. We found the actions required following quality checks were not always clear This meant it was difficult to be sure changes required to bring about improvements happened and that lessons were being learned by staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services who have their liberty restricted have not been appropriately assessed to determine whether the restriction is lawful under the Deprivation of Liberty Safeguards. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 13 (5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.