Ashamber Homes Limited

Amber House - Didcot

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We undertook an announced inspection of Amber House Didcot on 15 and 22 July. Amber House is a care home for up to six people who have been discharged from hospital and who require care, support and accommodation for mental health issues.

At the time of our inspection three people were using the service. At our last inspection in December 2013 the service was found to be meeting all of the requirements of the regulations at that time.

There was not a registered manager at the service. The home had a manager in place who was in the process of registering with the Care Quality Commission to manage the service. 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.

Summary of findings

People were supported by staff who could explain how they would recognise and report abuse. However people did not benefit from a safe environment and information surrounding risks was not always accessible.

Safe recruitment procedures were not always followed at the home to ensure staff were of good character. Records relating to the recruitment of staff showed relevant checks had not been completed before staff worked unsupervised with vulnerable adults.

Staff felt they had the appropriate training to support people effectively and where encouraged to improve the quality of care they delivered through the supervision and appraisal process. These are formal one to one meetings between staff and the manager to discuss development and support needs. However records of these sessions taking place were not always completed.

No one accessing the service had been assessed as lacking capacity under the Mental Capacity Act (MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time). However the manager and staff did demonstrate a good understanding of the principles of the act and understood their responsibilities.

People benefited from a caring culture that understands the challenges of people with complex needs. One person told us. "They're fantastic, they really are caring" and '[the staff] helped me get my confidence and self-respect back".

People had their own personal rooms and staff told us they promoted people's dignity by "respecting their personal space". When staff spoke about people to us or amongst themselves they were respectful.

Care plans contained personal histories and preferences. However it was not evident that a person centred approach was continued throughout the care planning process. Care plans did not always contain up to date information.

During the inspection we observed one person who was at risk of social isolation. There was also a concern about the person's repetitive behaviour. We saw no evidence of any discussion with this person surrounding the choices they were making.

The service had a system in place to monitor the quality and the safety of the service however they were not always effective. There was a monthly quality audit that covered a number of areas in the service, however these audits did not identify the concerns we found at this inspection.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this 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?

Requires improvement

The service was not always safe. There were no systems in place to monitor infection control or food hygiene.

Safe recruitment procedures were not always followed before new staff worked with people. Staff were not always deployed in a way that met people's needs or ensured the safety of people and staff.

People told us they felt safe, and staff had good knowledge of their responsibilities around safeguarding.

Is the service effective?

Requires improvement

The service was not always effective. People were not always supported to access appropriate healthcare.

Staff where able to identify risks to people with complex needs with regards to eating and drinking. However there was no evidence of this being followed up with people.

Staff we spoke with felt supported and they were encouraged to identify training needs and access development opportunities through the supervision and appraisal process.

Is the service caring?

Good

The service was caring. People were complimentary about the care they received.

People told us staff were supportive and people were treated in a caring way.

People with complex needs benefited from a caring culture that understood their challenges.

Is the service responsive?

Requires improvement

The service was not always responsive. It was not evident that a person centred approach was continued throughout the care planning process.

Care plans did not always contain up to date information

The home had regular service user meetings and people were encouraged to feedback on things they would like to happen within the home.

Is the service well-led?

Requires improvement

The service was not always well led. Systems in place to monitor the quality and the safety of the service were not always effective.

Action from regular satisfaction surveys with people and stakeholders had not always been recorded as followed up.

Summary of findings

The service did not have a complete and accurate set of staff records to support continuous improvement in quality.	

Amber House - Didcot

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 15 and 22 July and was unannounced. The inspection team consisted of three inspectors and a specialist advisor in mental health services.

Prior to our visit we reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law. We also received feedback from three health and social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with two people who currently used the service and one person who used to live at the home.

We looked at three people's care records, the medication administration records (MAR) for all people at the home and five staff files. We also looked at records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

Risks associated to people's psychological wellbeing and behaviours which challenged were assessed by staff. We saw escalation plans highlighted signs of concern or relapse which could lead to these risks. Not all staff were aware of risks around people's behaviours despite this information being available in people's records, one staff member stated "The information is in there but it takes a lot of digging" [to find it]". We could not easily find this information in peoples care plans.

There was no information in relation to the risks of the environment. We observed on our first day of inspection a cupboard which was used to store hazardous substances was unlocked despite a large sign on it stating 'keep locked'. Some people's risk assessments stated they were at risk with access to these substances. Additionally, risk assessments were not in place surrounding low lighting, smoking in communal areas and the safe storage of decorating equipment.

We observed poor standards in relation to infection control and food hygiene. For example, areas of the home including bathrooms, toilets and cookers had not been cleaned for some time. There was also food stored in refrigerators that was out date or not packaged and labelled. There was no system in place to monitor this and staff we spoke to acknowledged how the absence of a system could impact on people's wellbeing.

These issues are a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff were not always deployed in a way that met people's needs or ensured staff safety. For example, on the day of our inspection there were two members of staff on duty. However one staff member was called away leaving only one staff member on duty to support three people with significant mental health needs. This staff member did not have enough time to spend with people. There was also no system in place for the manager or provider to determine that these staffing levels were safe.

There was an organisational policy on lone working, however this was not always adhered to. For example the policy stated, 'The company will provide a small pack which contains a panic alarm, small torch, small first aid kit and a mobile phone'. This was checked with the member on duty who informed us, "There is no phone in the kit and the alarm is broken".

Safe recruitment procedures were not always followed to ensure staff were of good character. Records relating to the recruitment of staff showed relevant checks had not been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. One staff member's DBS check had been carried out by an organisation a number of months before they started at the service. The provider had not always sought employment references for staff.

These issues are a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People told us they felt safe and supported by staff. One person said, "I feel safe here". The person explained how they had been kept safe by staff when the person had experienced a psychological episode.

The service had raised concerns surrounding the vulnerability of a person and liaised with the local safeguarding team to protect them from risk taking behaviours associated with their substance misuse.

People were supported by staff who had good knowledge of the provider's whistleblowing and safeguarding procedures. Staff knew how to report any safeguarding concerns and felt confident in raising any issues relating to peoples safety.

People's medicine records accurately reflected the medicine in stock for each person. Medicine stocks were checked weekly by senior support staff. These checks showed staff monitored stock to ensure medicines were not taken inappropriately and people received their medicines as prescribed.

Medicines were not always stored safely, for example we witnessed that a controlled medicine was not stored in compliance with the Misuse of Drugs (Safe Custody)

Requires improvement

Is the service safe?

Regulations 1973. We were been given reassurance from the home manager and the provider's manager of care services that they had made arrangements to obtain a cupboard that meets the regulations.

We observed staff preparing medicines for one person. Staff observed the person take their medicine, and ensured there was a focus on taking the medicine.

Medicines administered 'as and when required' included protocols that identified strategies to try before administering medicines. Staff had a clear understanding of the protocols and how to use them.

Requires improvement

Is the service effective?

Our findings

People were responsible for their own meals and were supported to cook for themselves. People told us that they had plenty to eat and drink. Staff we spoke with where able to identify risks to people with complex nutritional needs. However people did not have support to plan nutritious and varied meals, and ate meal options which were not always healthy.

People were not always supported to access appropriate healthcare. For example one person's care plan highlighted the need for support pathways and encouragement in relation to dentistry and chiropody. However there was no evidence in their support records of any follow up or referrals to other healthcare professionals. Staff confirmed that discussions had been made with this person; however no referrals had been made yet.

People we spoke with felt staff had the necessary skills and knowledge to meet their needs and improve their wellbeing. This was supported by one professional we spoke with who told us that their client had made great progress since being at the service. They told us this was due to the skills of staff. This evidence was supported in an observation surrounding bad news that one person had received, we observed one member of staff supporting this person and coming to terms with this news and resolving it.

Staff we spoke with felt supported. Comments included, "I love working here" and "I feel really supported [in my work]". Staff were supported to improve the quality of care they delivered to people through the supervision and appraisal process. These are formal one to one meetings between staff and the manager to discuss development and support needs.

Staff were supported to identify training needs and access development opportunities. For example one staff member had highlighted an area of development surrounding carrying out supervision sessions with other staff, this was acknowledged and training was put in place.

Staff told us training they received was adequate to support their roles. We observed that staff had received training and the home provided regular refresher training. Staff completed an induction process, one new member of staff told us they were happy with the induction process and that it had involved "on the job learning" a lot of "shadowing" and some fundamental training surrounding fire, first aid and moving and handling.

No one accessing the service had been assessed as lacking capacity under the Mental Capacity Act (MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time). Staff understood their responsibilities under The Mental Capacity Act 2005 and associated codes of practice. Staff had a good understanding of MCA and understood what to do if someone showed signs of lacking capacity. One staff member stated, "We consider everyone to have capacity until proven otherwise".

Staff understood the Deprivation of Liberty Safeguards (DoLS). DoLS is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety. No one in the home was subject to a DoLS.

Good

Is the service caring?

Our findings

People told us they liked living at the service and were complimentary about the staff. Comments from a person who had moved to live independently in the community told us. "They're fantastic, they really are caring" and '[the staff] helped me get my confidence and self-respect back".

Professionals we spoke with felt staff were caring, this was supported by our observations. For example, one person became distressed. The staff member was empathetic and understanding and clearly supported this person to feel better.

During the inspection it was one person's birthday, we observed how staff acknowledged this and had plans in place to have a barbecue the following day. Staff had arranged for friends and other people using the service to attend. Staff had also gone out and bought the person a cake.

We reviewed the care of one person with complex needs surrounding their personal hygiene. This person benefited from a caring culture that understood the person's challenges, the person had been involved in creating a specific plan. The level of understanding of this persons needs supported their hygiene and respected their dignity. We spoke with this person's care coordinator who told us they were "very happy [with the persons] care and support that they are receiving".

People were supported to be independent. One person needed encouragement and support to go to town on the bus, this was to enable the person to travel independently when they felt confident. A person who used to live in the home told us that if it wasn't for the caring staff at the home then they would not be where they are now.

People had their own rooms which enabled them to maintain their privacy. People were encouraged to personalise their rooms and rooms that we saw had been made to look homely. Staff knocked on people's doors and waited to be invited in before entering, staff had agreements with people that would enter their rooms on the mornings where people had early appointments to ensure they had enough time to get ready. Staff told us they promoted people's dignity by "respecting their personal space".

We saw information in peoples files on how they could contact an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns. Whilst defending and promoting their rights and responsibilities.

We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Staff we spoke to were knowledgeable about the care people required and the things that were important to them in their lives.

Information relating to people and their care was held in the office. The office had a locked door ensuring people's information remained confidential.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed when they entered the service. This assessment was used to develop care plans that contained information regarding people's support needs. Staff told us care plans had recently changed to incorporate people's involvement and to adhere to the key principles of person centred planning. Person-centred planning (PCP) is a set of approaches designed to assist someone to plan their life and support needs.

Care plans contained personal histories and preferences. However it was not evident that the principles of PCP were continued following the review of people's care. Care plans did not always contain up to date information. For example, we spoke with one person who had an on-going medical issue they described as making them feel 'anxious and conscious [of]' this had been treated for the last eight months by medical professionals however there was no record of it in their care plan. This person was due to have a review of their care in June 2015. However this had not taken place.

People's care plans did not contain information about their social care needs. One person was supported to attend groups in the community at MIND (MIND are a national charity who provide advice and support to anyone experiencing a mental health problems). It was not always clear that other people using the service benefited from the same approach. For example there was no evidence in care plans that were activities had been identified they had been followed up.

Data management systems in the service were not always robust. Information was stored safely but was not always accessible. For example, people's care plans did not always contain daily records that were legible.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

One person was at risk of social isolation. We observed this person who exhibited a repetitive behaviour throughout our inspection. We saw no evidence of any discussion with this person surrounding the choices they were making. We spoke to this person and asked if there was much to do during the day and they stated "no there isn't. I've gone to groups outside, they weren't for me" and "I tend to just [carry on with this behaviour]". Whilst staff were respecting this person's decision an absence of a person centred review meant creative options to promote this person's wellbeing were not being considered.

There were times when people could not do the activities that they wanted. For example a member of staff described to us how one person's desired activity surrounding going to bingo had been stopped due to organisational policies surrounding spending allowances on gambling. The staff member told us that there had been a couple of occasions where they had taken the person and paid for it themselves.

We observed staff speaking to people in a way that was appropriate and empathetic. However during the inspection we saw one person left alone for over two hours without any social interaction. Staff missed opportunities to support the person and prompt with meals, as outlined in the persons care records.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Feedback surrounding activities from people and staff included comments like "They were great at interacting with me and getting me to go on days out" and "Doing activities and getting out really helped me especially when they took me to snooker which I really enjoy".

The home had a large, well maintained garden area for people to enjoy. Access to the garden was unrestricted for people. We saw evidence of where one person had been encouraged to grow tomatoes in the garden area, it was evident from talking to this person that it was something they were very proud of.

The home had regular meetings with people using the service. These meetings were structured to encourage people to feedback on things they would like to happen within the home. Minutes from the last meeting included suggestions on outings that people would like to go on, however there was no evidence that these suggestions had been acted on by the provider..

People knew how to raise concerns and were confident action would be taken. Comments included. "I have no concerns and I would raise them if I had" and I would speak

Requires improvement

Is the service responsive?

to [the manager]". Information on how to complain was on display in the home. Staff we spoke with were aware of the complaints procedure and told us they would assist anyone needing to make a complaint.

Requires improvement

Is the service well-led?

Our findings

The service had a system in place to monitor the quality and the safety of the service however these systems were not always effective. There was a monthly quality audit that covered a number of areas in the service, however these audits had not identified the concerns we found at this inspection. The audits had not identified the lack of evidence around people's health needs and information surrounding risks was not easily accessible for staff.

Regular satisfaction surveys had been carried out with people and stakeholders such as care managers and nurses. However, these actions were not always recorded as being followed up therefore there was no evidence of improvements being made, sustained and embedded. For example we noted that one professional stated "Some staff would benefit from further training in managing certain conditions [and] communication with clients". The analysis identified the need to access training. Actions following this feedback stated "manager looking into it", we spoke with the manager about this and they informed us that it had been actioned and training had been arranged, however there was no record of this.

Staff files were not up to date and not all actions were fully recorded. For example four of the five supervision files that we looked at did not align with the organisational policy surrounding the frequency of supervisions. We discussed this further with all four members of staff, who informed us that they were in fact receiving regular supervision which took place every 2 months. This was raised with the manager who stated 'I am behind with record keeping. Therefore the service did not have a complete and accurate staff records to support continuous improvement in quality.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People and staff were very complimentary about the manager and the day to day running of the home. Comments included "It's great, I love it here, [the manager] always listens and is approachable".

Staff felt they were able to raise concerns with the manager. For example, staff had raised a concern about the level of input from another professional in the care of a person. The manager followed this up with the professional and continued to challenge appropriately until there was a resolution that met the needs of people and staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager of the home had informed the CQC of reportable events.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that care and treatment is provided in a safe way for service users. This includes assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks. The service must also be assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated (12) (1) (2) (a) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service needs to ensure that the designing and reviewing of the service users care not only includes their but also ensures their wider needs are being discussed (9) (1) (b) (c) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service needs to ensure systems that are used to improve the quality and safety of the service is effective. The service needs to ensure that records are accessible and legible The service needs to record action surrounding feedback they receive (17) (1) (2) (a) (c) (e) (f)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service needs to ensure that suitable staff are deployed effectively (18) (1)

This section is primarily information for the provider

Enforcement actions

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