Waterfall House Ltd

Amberley House - London

Inspection report

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10 January 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Amberley House is a residential care home providing accommodation and personal care for up to 30 people aged 65 and over, some of whom may have dementia. At the time of the inspection there were 14 people living at the home. The home is a large adapted detached residential house. There is a large garden to the rear of the property.

People's experience of using this service and what we found
People told us they felt safe and cared for living at Amberley House. We observed kind and caring interactions between people and staff throughout the inspection. Despite people's positive experience we found significant concerns around the quality and safety of care and support.

People's personal risks were not always assessed. Where risks were assessed, risk assessment documents failed to provide adequate guidance to staff. People had not been referred in a timely manner to healthcare professionals when they lost significant amounts of weight. People's bedrooms and en-suite bathrooms were not always clean, and furniture was in a poor state of disrepair. There were ineffective systems in place to identify and address the issues found during the inspection. The home did not have a cleaner and staff did this as part of their daily shifts which meant staff did not have enough time to spend with, and care for people.

People were not consulted on planning the food menu and had limited choice around what they wanted to eat.

Care plans were not always person centred and failed to document how some people's health care and support needs should be met. There was no activities coordinator which meant staff were also responsible for leading on activities. People were not consulted about what activities they would like to participate in which meant there were limited activities for people to enjoy.

There was a lack of managerial oversight of the home. There were no audits for some aspects of care and where audits were in place, these failed to identify issues found during the inspection. There were inadequate systems in place to get feedback from people and relatives. There had been a failure to learn from previous CQC inspections or to make and embed positive change.

Medicines were well managed, and people received their medicines safely and on time. Staff were recruited safely, and all appropriate checks completed before they started working at the home. Staff had been trained in safeguarding and understood how to recognise and report any concerns. We were assured the home had good infection control systems and processes.

In relation to mental capacity, people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and

systems in the service supported this practice. Staff told us they felt supported and received regular supervision and appraisal.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 May 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider considered recognised guidance on safe medicines management in care homes. At this inspection we found this had been addressed.

Why we inspected
We received concerns in relation to a lack of stimulation and activities, the quality and choice of food, several people losing weight and lack of referrals to appropriate healthcare professionals and care plans not being up to date. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Amberley House on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified 5 breaches of regulation in relation to assessing people's risks to their health and welfare, the maintenance and cleanliness of the home, how staff were used and deployed within the home, a lack of person-centred care including care planning, food choices, activities and a lack of robust governance of the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Amberley House - London

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by one inspector, a nurse specialist advisor, and four Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two Experts attended the home during the on-site inspection and two Experts made telephone calls to relatives to gain their feedback.

Service and service type
Amberley House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Amberley House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
On-site activity took place on 20 December 2022 and feedback about the inspection was provided on 10 January 2023.

We spoke with the registered manager, a senior care staff and 6 care staff, a visiting health care professional and a social worker. We also spoke with 8 relatives and 8 people using the service and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. At this home, the nominated individual was also the owner of the home. We used observations to help us understand the experience of people who were unable to speak with us. We looked at 3 staff files including recruitment records, 8 people's medicines records, 6 people's care plans and risk assessments and other paperwork related to the management of the service including staff training, quality assurance and rota systems.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection we found effective systems were not in place to monitor accidents and incidents. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 around accidents and incidents. However, we found significant concerns as documented below which meant there was still a breach of regulation 12.

Assessing risk, safety monitoring and management

- Risks to people's health, safety and welfare were not always identified or managed effectively.
- People's risks were not always assessed properly and failed to provide adequate guidance for staff on how to minimise the risks. Some people's known risks had not been risk assessed.
- One person had a 'challenging behaviour' care plan. The risk assessment failed to provide staff with adequate guidance on why the person could become distressed or how to effectively work with the person. The risk assessment also stated a behaviour chart should be completed following any periods of distress, to monitor the persons behaviour and identify any patterns. There were no behaviour charts in place.
- Two people used incontinence pads. Using incontinence pads can have an impact on the person skin integrity and can lead to a breakdown of the skin. This had not been risk assessed and there was no guidance in place for staff to understand how to monitor people's skin.
- One person had been diagnosed with a chronic mental health condition. There was a risk assessment in place around triggers of the person's mental health. However, the risk assessment contained general information about the condition and failed to document risks specific to the person.
- One person had a diagnosis of a progressive eye condition. There was no risk assessment in place or information on how this affected the person.
- One person had a diagnosis of diabetes. There was no risk assessment in place to ensure risks around diabetes were managed.
- Another person's care records stated they suffered from chronic constipation. There was no assessment to explain what the potential risks were or guidance on how staff should support the person.
- Risk assessments viewed included information around personal and oral care. However, this was generic information, and the same information was recorded in all people's personal and oral care risk assessments. This meant that people's care was not individualised to their needs.
- People's weights were recorded monthly. However, the system to document this was not effective. There was no information for staff on what amount of weight loss should trigger a referral to healthcare professionals. We found two people had lost a significant amount of weight over a short period of time

which had not been addressed.

The failure to robustly assess the risks relating to the health safety and welfare of people meant that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We had received information from the local authority, following a quality visit, that there were concerns around people's weight loss and failure to address this. As noted above, findings during the inspection supported this. The Care Home Assessment Team (CHAT) had ensured people were reviewed and referrals made where necessary. We spoke with the CHAT matron who was visiting the home at the time of the inspection to review people's weight management. There had been six people in total who had significant weight loss and been referred to external healthcare professional to address this.
● The home had up to date maintenance checks for gas, electrical installation and fire equipment.
● Accidents and incidents were documented with information on what had happened and any follow up.

● People's bedrooms were not always clean, and some furniture, fixtures, fittings and equipment were in a state of disrepair.
● Decoration in people's bedrooms was in a state of disrepair. Some people's bedrooms had peeling paint on walls and skirting boards.
● On one person's bedside cabinet, the laminate was coming off and sticking out. This created a risk of the person injuring themselves.
● One person had a sensor mat to detect falls which was dirty and had come apart. This created a significant trip hazard and placed the person at risk of harm.
● In another person's bedroom, the tread between the bedroom and en-suite bathroom was coming up. This created a significant trip hazard.
● People's en-suite bathrooms were dirty with ingrained dirt on the floors and around toilet bases. Untreated limescale was present in people's sinks and toilets.
● One person had a painted metal radiator cover in their bedroom. The radiator cover was coming away from the wall and had significant peeling paint. Where the paint had peeled there were sharp edges and large amounts of rust.
● In two bedrooms the wardrobe door fell open with one being held together with a blue plastic bag to keep it closed.
● One person's bathroom light pull cord knob was broken with sharp edges. This created a risk of the person cutting themselves.
● The registered manager had walked around with us and was shown the findings, we also informed the owner and showed them pictures of our findings during the on-site inspection.
● There was a maintenance book where staff reported any maintenance issues. None of the issues documented above had been identified or reported.

The failure to ensure the premises and equipment were adequately maintained and suitable for the intended purpose is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us they had addressed the concerns we had found around the poor condition of people's bedrooms. This is discussed further in the well-led section of this report.

Staffing and recruitment
● There were not enough staff to ensure people's needs were comprehensively met.

● The registered manager confirmed there was no dependency tool in place to determine appropriate staffing levels. The registered manager told us there had been one several months previously, but this had not been used as the number of people living at the home had not changed.
● Care staff were passionate about working at the home but told us they felt there were not enough staff to support people. Comments included, "No [not enough staff], not at the moment, there should be more. We need more time to do things with the residents" and "Sometimes when the pressure is so much and maybe the staff is not enough, the pressure comes to the staff, maybe they go sick and then there is more pressure. If we have the proper staff [levels] we could give the best care to the patients."
● There was no cleaner or activities coordinator employed by the home at the time of the inspection. This was confirmed by the registered manager. Staff were expected to clean people's bedrooms, change beds, clean communal areas and bathrooms as well as support activities. The registered manager also confirmed when the chef was away, staff also did the cooking for people living at the home. Activities are further discussed in the responsive section of this report.
● A relative told us a person had missed important blood tests due to a lack of staff to support the person attending appointments. The relative said, "[Person's] health care is not as good as it should be, she has missed hospital appointments on a couple of occasions. The home is short-staffed…so she is missing appointments."
● Staff did not always have time to chat with people. One person told us, "The staff are always busy they don't have time to talk."

The lack of adequate staff to ensure people's full care and support needs were met meant that the service was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people told us they did not have to wait long if they used their call bell or needed help. People commented, "You don't wait long", "I call them, and they come" and "When I slipped on floor, they were there in a short time and hoisted me up." However, one person also said, "It takes time for them [staff] to see everyone."
● Staff were recruited safely. Staff files showed a range of recruitment checks including two written references, an application form with any gaps in employment explored, proof of identity and a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Despite the failings listed above, people were protected from the risk of abuse.
● Relatives told us they felt their loved ones were safe from abuse. Relatives commented, "Everything is OK, [Person] is safe there" and "[Person] has lived there four years. I couldn't be happier with the home; I can't fault them."
● Staff had received training in safeguarding and understood how to recognise and report signs of abuse. One staff member said, "In case there is any issue about residents being abused. I would report it to the manager and make sure it is taken seriously. We can [also] phone the [local authority], there is a number on-line for whistleblowing."
● We found concerns around learning when things go wrong. This is discussed further in the well-led section of this report.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on administering medicines and act to update their practice. The provider had made improvements.

● Medicines were managed consistently and safely in line with national guidance.
● People's medicines were reviewed by the GP. A person told us, "They review tablets."
● There were systems in place to manage stock control, ordering, safe storage and disposal of medicines.
● Records of medicines administration showed people received their medicines promptly and safely.
● Staff received annual updates to their medicines training. After training, the staff underwent evaluations to make sure they could administer medicines safely.
● There were checks of medicines and audits to identify any concerns and address any shortfalls. However, we did find action recommended from an external pharmacy audit had not been completed. This is discussed further in the well-led section of this report.
● We observed staff were kind and caring when they were administering medicines. A person told us, "I have to have tablets. [Staff member] comes in the morning with the lady who gives the proper tablets. They wait with you [whilst you take them]."

Preventing and controlling infection
● There were systems and processes in pace to protect people from the risk of infection.
● Staff had access to appropriate Personal Protective Equipment such a masks, aprons and gloves.
● Staff were encouraged to be vaccinated against COVID-19 and seasonal flu.
● At the time of the inspection we found communal areas were clean. However, we found people's rooms were not always clean as discussed in the safe section of this report. People told us, "Yes, they [staff] clean. One of the staff just came up. But I buy bin liners and they say, "No I'm too busy [to take it down] at the moment" and "I will ask them to clean the room."

● At the time of the inspection, there were no restrictions on visiting in the home. A relative told us, "The restrictions are lifted now so I can visit him in his bedroom." A person said staff were kind to visitors and told us, "Family visit, [Staff] treat them in a friendly sort of way."
● However, restrictions had only been lifted a couple of weeks before the inspection date, despite government guidance stating restrictions had been lifted in April 2022. The home had been allowing visits in a visiting room and visitors were not allowed into the homes' communal areas or people's bedrooms. Following intervention by the local authority, the home lifted the restrictions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink. However, we found concerns around the provision and choice of food.
- There was a four-week rolling menu in place. The registered manager told us this had not been updated for 18 months. Service users had been consulted when the menu was created 18 months ago but they had not been consulted since. People received a choice of two meals and alternatives were available. However, the main menu did not change.
- We asked the registered manager why the menu had not been changed and they told us, "I have no idea, it's kept that way and I have just carried on. I do change it some days giving different options for lunch. However, what is printed out is the same."
- Staff confirmed people were given a choice of food each day according to the menu. One staff member said, "The menu is already done by the manager but there is no preference from the residents to say I would like this. But she is giving options on the menu, and they have to choose between the two. We ask them what else they want but it needs to be something quick to prepare. We give what they ask, like sandwiches. Otherwise, they have to comply with what is given."
- On the day of the inspection we observed lunch time. One person had a baked potato, cheese and beans with bread. We asked if the person had chosen this and they said, "Nah." We spoke with a member of staff who told us the chef could make something else but was unable to provide any alternatives.
- We also observed there were two options for lunch, shepherd's pie and cabbage or cauliflower cheese and cabbage. However, we only observed the Shepherd's pie being offered. There was no second meal offered.
- People told us there was not always a choice of what to eat outside of the two meals offered. People said, "No [no choice]" and "There is choice since you people started coming in."
- Other people's comments about the food included, "The food is good produce, poorly prepared and poorly served, it needs improvement" and "Lunch is at 12.30pm but if you get a meal before 1 o'clock you're lucky!"

The lack of involving people in choosing what they wanted to eat and ensuring person centred care means that the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Food choice was one of the concerns raised to us by the local authority prior to the inspection. At the time of the inspection, the local authority was sending a member of their quality team to the home to regularly observe mealtimes.

● Some people told us they were happy with the food choice and said, "Meals are fine. I get a choice" and "They would have some choice, can't complain." A relative commented, "[Person] has a choice of meals. They give her a soft diet because she needs dentures."
● Relatives told us they felt people had a good diet and were offered choice. Relatives said, "[Person] has a Halal diet, it is vegetarian based, she does not like all the food, especially the potatoes. She is as healthy as she has been for years, she is eating fresh food and is offered plenty of drinks" and "The food is varied and well-cooked, my mother is not usually fussy but she has gone off green vegetables, so they give her baked beans to make sure she gets her fibre."
● Where people required special diets such as pureed or soft food, this was provided. The chef and staff were aware of each person's specific dietary needs.
● We saw information displayed in the kitchen around people's dietary needs and any allergies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed in line with guidance and the law.
● People received an assessment prior to starting with the service to make sure their needs could be met.
● A care plan was created using the information gathered during the assessment. Relatives told us they had been involved in assessments before people moved in.

Staff support: induction, training, skills and experience
● There were systems in place to support staff through induction, supervision and training.
● Staff received an induction when they started working at the home. This included training in mandatory subjects such as safeguarding, mental capacity and manual handling. Staff also shadowed more experienced staff for a period of time before being allowed to work alone.
● Staff told us, and records confirmed, they received regular supervision every two months. Staff had also had an appraisal within the last year. A staff member said, "We do have supervision and appraisals. I think it's a good connection with the manager and we can discuss things."
● Staff received training which was refreshed regularly which was a mix of on-line and face to face. However, staff also told us whilst they felt there was enough, they felt they needed more training. Staff commented, "Every year they arrange a person and they come in and do the basic trainings but there is nothing specific." Two staff told us they would like training on working with people living with dementia.
● Relatives told us they felt staff were well trained. One relative said, "I recognise most of the staff, they are well-trained and know what they are doing. Nothing is too much trouble, they have so much patience."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to access healthcare when required.
● One person we spoke with expressed concerns about seeing a dentist and said, "I want something done about my teeth. I don't care what!"
● Two relatives raised concerns around their loved ones getting their toenails cut. Another relative said a person had a long-term eye condition, monitored by the hospital but had not had any information from - the home on if they were attending regular appointments.
● People did not always receive timely referrals for health care. We had concerns around monitoring of people's weight, weight loss and people not being referred to appropriate healthcare professionals. This is discussed further in the safe section of this report.
● People told us staff were responsive when they felt unwell and sought medical help. People told us, "They called a doctor to check me (when I fell)" and "If there is anything wrong, they will take you to the doctor."
● People's files showed generally, people were supported to access healthcare such as opticians and dentists. The GP had regular contact with the home. People were seen by the local authority CHAT team

when there were recognised concerns around their health.

Adapting service, design, decoration to meet people's needs
● There were adaptations within the home to accommodate people with any physical disabilities.
● People had accessible en-suite bathrooms. Where people did not have an en-suite bathroom, there was an adapted wet room on the ground floor.
● People told us, and we saw, they were able to bring items of furniture and things that meant something to them to help personalise their bedrooms. One person said, "I can go to my room any time I want. I have everything I want in my room. I brought a few things from home."
● The home was not dementia friendly. Some bedrooms had people's names on their door However, there were no other identifying things to help orientate people. Such as, memory boxes, or information about people on their doors or any colour scheme to help them identify their bedroom or differentiate between areas of the home.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider was working within the principles of the MCA-
● For all people's care plans we looked at, mental capacity was documented in their care plans and if they were subject to a Deprivation of Liberty Safeguard (DoLS). We have discussed this further in the responsive section of this report.
● There was a system in place to ensure DoLS were renewed in time We saw follow up emails checking the status of renewals by the registered manager.
● Staff had received training on the MCA and were able to explain what this meant for the people they worked with. A staff member said," If residents don't have capacity, you need an assessment and best interest if they can't make decisions."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not consulted or supported to take part in activities that were meaningful to them.
- Activities were not person centred and people were not involved in planning activities. The registered manager told us they had planned activities for people and people had not been involved in creating the activity timetable. The registered manager told us, "I have done an activity chart with exercises and all that. At times, it depends on the day, the staff then change it in the day, they may try and do simple and quick exercises."
- People's hobbies, likes and dislikes were briefly documented in their care plans. However, this information was not used to plan activities.
- The registered manager confirmed people did not leave the home unless they were attending an appointment. There were no activities or social events outside of the home. People were not supported to go out for things such as lunch, shopping or a walk. We asked the registered manager why people were not given the opportunity to go out and they replied, "I have no answer to that." A person said, "They don't let me [go out]. Someone says you can't."
- During the inspection we observed four people in the main lounge when we arrived. Aside from going into the dining area, they did not leave the lounge. We observed very little staff interaction with these people. A visiting healthcare professional commented, "I find it just quiet. It's not like other homes, it could do with staff being more interactive."
- On the day of the inspection, we arrived at 8.35am. There were nine people in the dining room area finishing their breakfast. We conducted a further observation at 1.45pm. The same nine people were still in the dining area and had not moved, except to receive personal care. Staff were doing some table-top activities with people, including a jigsaw puzzle and colouring which had been placed in front of them. People did not appear engaged with the activities taking place.
- The registered manager confirmed staff had not received any training in providing activities and how to work with people to ensure meaningful and person-centred activities.
- Staff told us they felt if there were more staff, they would be able to do more meaningful activities with people. One staff member said, "They have to put more staff so we can do more things. We could do a lot more than we are doing now, it would make a lot of difference."
- Relatives told us they were concerned about the lack of stimulation for people. One relative told us they felt there were very few activities on offer, mainly puzzles or colouring and that their relative had never been taken out, although they were taken into the garden in the summer. Other relatives commented, "I don't think [person] is mentally stimulated, they do not know her well" and "She is never taken out, I think she would like that. There are no activities which she could participate in" and "My concern about the home is that there is no stimulation, she is sitting around all day doing nothing."

There were no structured activities in place to ensure that people were supported to reach and maintain a state of wellbeing. The lack of person-centred care placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite out concerns around activities, people told us they did take part in the activities on offer. People said, "The activities are really good" and "The exercise is generally sufficient." Relatives said, "They encourage her to do puzzles, she used to enjoy them at home, so I am quite pleased. A nun takes her in communion from time to time" and "They have found different ways to get her involved, she loves bingo and singing, they know what she likes. They made friendship bracelets which she quite enjoyed."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Whilst care plans showed elements of person-centred care, we found significant shortfalls in care plans we reviewed which meant staff may not fully understand people's care and support needs.

● For many of the service users' medical diagnoses, care plans contained the same generic information. Whilst this gave staff an understanding of what the condition was, it failed to ensure care plans were person-centred and did not document how each service user experienced their condition.

● One person's care plan noted they had been diagnosed with dementia, type 2 diabetes arthritis, hypertension (high blood pressure) and lymphoedema (swelling, predominantly in the legs, caused by accumulation of lymphatic fluid). There was information in the person's care plan about these conditions. However, the information was generic and not personalised to the person's care and support needs. This meant staff may not have been aware of how to support the person appropriately.

● Other people had been diagnosed with conditions such as glaucoma, osteoarthritis, schizophrenia, asthma and under active thyroid. Aside from the diagnosis, there was no further information in their care plans around how people experienced their conditions and how staff should work with people to maintain their wellbeing.

● Where people had been diagnosed with dementia, care plans provided minimal information on how each person experienced their dementia and what it meant for their quality of life.

● Another person's care plan stated they had a falls sensor mat in their bedroom as the person could become confused. However, there was no information in their care plan about why they could be confused and why this may contribute to them falling.

● We saw care plans were reviewed and updated when any changes occurred. However, where care and support needs had failed to be documented the care plans were not reflective of people's needs.

● People's mental capacity was documented in their care plans. However, there was no information in service user care plans viewed, what areas of their lives service users were able to make decisions about. Care plans failed to ensure information on people's capacity was person-centred.

● A relative was concerned their loved one cultural needs were not being met and told us "[Person's] ethnic and cultural needs are not met, this affects her although she does not come across as unhappy."

The lack of person centred care planning means that the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans had section on people's backgrounds such as family and previous work. This gave an overview of each person as an individual.

● A local nun visited the home to visit people and take communion for those who followed their faith.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's care plans had a section on people's communication needs. This documented information staff needed to know about people's communication needs. This included how people with dementia communicated.
● Where people required aids, such as hearing aids or glasses, this was also documented.

Improving care quality in response to complaints or concerns
● The provider had procedures for dealing with concerns and complaints.
● People told us they knew how to make a complaint. People said, "I would report it to someone here. Thank God I haven't had severe complaints. No one likes to. So far, I have had no complaint. I don't like to make life difficult" and "If I had a complaint I would bang on the door and tell manager, but I have not done that. I have no complaints."
● Relatives told us they knew how to make a complaint. One relative said, "I'd like to think it would be taken seriously."

End of life care and support
● At the time of the inspection, no one was being supported with end-of-life care.
● End of life wishes were inconsistently sought and documented. Some people's care plans documented where people had end of life wishes. However, some relatives told us this had not been discussed. Comments included, "Choices for end-of-life care has not been discussed" and "I helped provide the family history for her care plan but end of life wishes have not been discussed."
● Where appropriate there were do not resuscitate orders [DNACPR) in place. People, where able, had been consulted. For people that were not able to consent, best interest meetings had taken place and relatives involved.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found effective systems were not in place to monitor the quality of care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not have appropriate oversight of the home. We found significant and repeated failings during this inspection as documented within this report.
- Whilst we were assured people's weight loss was being addressed following local authority intervention. There were no audits that reviewed people's care files including monitoring of weights. The lack of oversight of people's weight and failure to identify this placed people at risk of harm.
- Following the inspection, we spoke with the registered manager. The registered manager confirmed there were no audits of people's care files or staff files. They told us they checked these daily but did not document this. The lack of effective auditing of people's care files meant the lack of robust risk assessments and issues found with care plans as documented in this report had not been identified.
- Health and safety audits failed to identify the issues found around disrepair in people's bedrooms and cleanliness of the home.
- An external pharmacy audit dated 12 September 2022 found there were no protocols in place for paracetamol being used as an as needed medicine for one person. We found this was still the case when we inspected on 20 December 2022. There was a failure to act on the guidance provided by the external pharmacist.
- Maintenance of the home was not well managed. We saw the maintenance book where issues for repair had been documented. However, the maintenance book did not identify any of the issues we found during the inspection.
- There was a deputy manager in post at the time of the inspection. However, the registered manager remained responsible for completing all care plans and risk assessments. There was insufficient support for the registered manager particularly around administrative tasks. This was a concern that had been identified at the last inspection and the provider had failed to address appropriately.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was not a positive culture within the home and outcomes for people were not inclusive or empowering.

● The registered manager had not ensured people were involved in planning their care. The registered manager told us people had not been involved in planning activities. People had been involved in planning the rolling menu 18 months ago but had had no input since.

● There were no documented regular residents' meetings. One person told us, "I only remember one residents' meeting here in 8 years."

● The registered manager told us there had been some questionnaires to get feedback sent out a few months prior to the inspection. However, results had not been collated and there was no action plan completed to show how they would act on any feedback.

● Some relatives we spoke with told us they had not received a questionnaire to give feedback on the home. However, some relatives told us prior to COVID there had been relatives' meetings which they hoped would soon restart now that restrictions had been lifted. One relative said, "I have not been informed of any relatives meetings or a questionnaire."

● Relatives told us they felt communication by the home could be improved. Relatives said, "They communicate by email, I would like them to re-start the relatives' meetings, I am not aware of any residents' meetings" and "They call me when she needs new clothes or toiletries but apart from that nothing, the communication is letting the home down."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Continuous learning and improving care

● There was a failure to ensure continued learning to improve the quality of care for people using the service.

● Despite the provider fixing issues following the inspection around the condition in people's bedrooms, we remain concerned about the systems in place to identify these concerns. At our inspection in June 2019, we found similar concerns around the poor condition of furniture fixtures and fittings. Although this had improved at the last inspection in May 2020, there had been a failure to maintain these improvements.

● The registered manager had failed to follow government guidance when restrictions on visiting in care homes was withdrawn by the government. Restrictions were only lifted following intervention by the local authority. The visitor's policy had not been updated to reflect current visiting procedure.

● There has been a failure to learn from previous issues identified by CQC during two consecutive inspections and to embed positive and lasting change. This inspection was the third consecutive time the service has been in breach of regulation 17.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

● Despite the concerns found during the inspection, we found some positive aspects of the care provided. Staff were passionate and committed to working with the people living at Amberley House. We observed kind and caring interactions throughout the inspection.
● People told us they felt cared for and said, "People who work here are very good and careful and understanding", "They [staff] are very nice. They look after you", "They lift me out of bed kindly" and "Staff are kind." Another person commented, "There is a lovely person in the kitchen. She has been away. I am happy to see her back." We observed the person greeting the member of staff and smiling whilst hugging them.
● We also receive positive feedback from relatives about the care people received. Relatives said, "The carers are very nice and polite, they are helpful and respectful. They tell me that my friend likes to choose what she wears each day", "The carers have told me they think the world of [person]" and "The staff are always smiling and there always seems to be a carer there to help them."
● People told us they felt the registered manager was approachable and was visible around the home and could often be seen in the home at weekends.
● Staff told us they felt supported by the registered manager. Staff said, "I do think I have support that I need, and I feel confident in my role there" and "We are a good team and we understand each other when we are working. If we face any problem we sit down and discuss. The manager is aware and involved in that."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The registered manager was aware of their legal responsibilities to notify CQC of any concerns or incidents.
● The home had been working in partnership with the local authority to help improve the quality of care.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to ensure people's needs were met.