Amphion View Limited

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Inspection report

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

Summary of findings

Overall summary

Amphion View provides accommodation and residential care for up to 35 people. At the time of our inspection, 33 people were resident at the home.

This inspection took place on 9 November 2016 and was unannounced. The inspection was conducted by two adult social care inspectors.

There was a registered manager in post. 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. The registered manager is responsible for the day to day management of the home and was available throughout the inspection.

At the last comprehensive inspection on 20 and 21 January 2016, we identified the service was not meeting one of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the home did not always ensure the proper and safe management of medicines and did not always effectively assess the risks to the health and safety of service users of receiving the care or treatment. At this inspection, there remained breaches in regulation within these and other areas.

The provider had made some improvements in regard to medicines but was still failing to manage medications safely. Stocks did not always tally with the amount that records said had been administered.

The atmosphere in the home was calm and relaxing. Staff had a good understanding of people's interests, likes and dislikes. People described the staff as kind and caring.

Assessments to identify where people may be at risk of harm or injury did not always ensure that the risk was minimised. Some risks had not been assessed and staff did not have the information available to refer to, if needed, to know how to minimise risks.

People had choices offered to them about what they wanted to eat and drink and were supported to maintain their health and see a GP, for example, if they felt unwell.

Staff had received training and felt this gave them the skills and knowledge they needed to meet people's needs effectively. Staff promoted people's privacy when they were supported with personal care.

People felt staff were kind and had a caring approach to them. People felt involved in making decisions about their day to day care and how they spent their time. There were planned group activities for people to take part in if they wished to do so.

The provider did not have effective arrangements in place to protect people from the risk of harm due to

infection. The condition of the premises was poor in parts. The bathrooms we checked were damaged, with broken tiles, damaged walls and unsealed floors. Cleaning records in the dining room indicated that the room had only been cleaned six times in the preceding five weeks.

People's care plans did not reflect appropriate decision making in accordance with the Mental Capacity Act 2005 (MCA.) The care plans we checked contained a generic document in relation to decision making, but there was little information about specific decisions that had been made for people, or who had contributed to the decision making.

When we inspected this service in January 2016, we found that the provider was not carrying out audits of the service at an appropriate frequency. This meant that failings in the way the service was delivered were not identified. We rated the service "Requires Improvement" in relation to how well led it was. At this inspection, we found that the provider had failed to address this, and audits continued to be ineffective.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed.

The management and administration of medicines was not consistently safe.

Recruitment checks were not always completed in accordance with current legislation.

Is the service effective?

Requires Improvement

The home was not always effective.

Staff told us they were supported and had received the training they required to deliver care according to people's needs.

The home required improvement to ensure staff adhered to the principles of the Mental Capacity Act 2005.

People enjoyed the food choices provided although the screening and monitoring of people's nutritional needs was not always carried out adequately

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were kind and caring.

People's equality and diversity needs were respected and staff were aware of what was important to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Night checks and people's weight was not always recorded with the frequency expected

People had access to activities that were important and relevant to them.

People were encouraged to voice their concerns or complaints about the service.

Is the service well-led?

Inadequate

The service was not well led.

Sufficient improvement had not been made to the provider's systems and processes to monitor the quality of the service provided.

Staff told us they felt supported by the registered manager.

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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 9 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

During the visit we spoke with the provider, the registered manager, members of care, domestic and kitchen staff. We spent time observing how staff interacted and cared for people. We looked at a sample of eight care records of people who used the service, medicine administration records and supervision records for staff. We
looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

Inadequate

Is the service safe?

Our findings

When we inspected the service in January 2016, we found that the provider was not managing medication safely. We judged that this meant people were at risk of harm, and assessed the location as "Requires Improvement" in relation to safety. We told the provider that they were required to take steps to ensure this was addressed. At this inspection we found that the provider had made some improvements but was still failing to manage medications safely.

We reviewed feedback sent to us from relatives who had 'shared their experiences' with us. Two of these people had shared concerns with us about the home, such as examples of poor care being given to people and the cleanliness of the home being poor.

We looked at the arrangements for recording medication. Each person had a medication administration record, often referred to as a MAR chart. Some of these had handwritten entries rather than entries pre-printed by the pharmacy. When medication is recorded on a MAR chart by hand, there is a risk of errors being made, for example in relation to the dosage or frequency. To mitigate this, the provider required that an additional staff member countersigned the MAR chart to confirm its accuracy. This had not always taken place, and some were not signed by any staff, meaning that there was no accountability.

Medicines were stored safely. There were records showing that the temperature of the storage room and medication fridge were regularly checked, and records showed that the date of medicines being opened was checked.

The systems in place for monitoring stock of medicines to be taken on an "as required" basis, often referred to as PRN medicines, were inadequate. We checked a sample of these and found that stocks did not tally with the amount that records said had been administered. This meant that these medicines were not being safely managed.

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

We looked at eight people's care plans to check that risk was managed safely, but found that the provider was failing to take appropriate steps to protect people from harm. One person's records showed that they presented a risk of harm to other people due to inappropriate behaviour. There was no assessment of this in their file, and no guidance for staff in relation to how to manage this behaviour to prevent the risk of harm. Some people had risk assessments which were contradictory. For example, on person's file showed that they were at high risk of falls, which could cause harm or injury. However, they also had a risk assessment which stated they were at low risk of falls. It was unclear which assessment was accurate, and therefore how staff should safely support the person to protect them from the risk of harm or injury.

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

We looked at the arrangements in place for recruiting staff. Staff had interviews and the provider obtained references. Checks of the staff member's ID and checks of their right to work in the UK had been undertaken. All staff underwent a Disclosure and Barring Service (DBS) check before starting work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The provider did not have effective arrangements in place to ensure the environment was cleaned to an appropriate standard in all areas and protect people from the risk of cross infection. The condition of the premises was poor in parts. The bathrooms we checked were damaged, with broken tiles, damaged walls and unsealed floors. This meant that they could not be hygienically cleaned. We looked at the cleaning records of some of the rooms but found they were either incomplete or evidenced that cleaning was not taking place frequently. For example, the cleaning records in the dining room indicated that the room had only been cleaned six times in the preceding five weeks. Staff we spoke with told us that people ate in the dining room three times per day. Another lounge area was noted to be unclean when we arrived on the morning of the inspection. This lounge was used by people throughout the day, and yet it was not sufficiently cleaned at any time during the day of the inspection. In the kitchen area we noted that mops were stored in buckets, rather than hanging up to drain, and we saw that the mop buckets contained dirt and debris. Many parts of the home were malodorous throughout the inspection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records held by CQC about the provider, and information from other sources such as the local authority. We saw that there had been an incident recently where a person using the service came to harm, and the provider had failed to act appropriately. This was assessed within the local authority's safeguarding arrangements, where it was determined that the provider had perpetrated abuse against the person.

Requires Improvement

Is the service effective?

Our findings

We asked two people using the service about the food available in the home. They were positive about their experience of the food. One person's relative told us that the food was good, and one person using the service said they always enjoyed the food offered. There was a choice of food available although we noted there was little use of menus in a pictorial format, which can be helpful for people living with dementia to understand the options available to them'. The Social Care Institute for Excellence guidance titled; Dementia Gateway; Eating Well states, "menu picture cards or menus that have visual images of food, rather than traditional written menus, seem to encourage people with dementia to eat."

We carried out an observation of a mealtime in the home. People were given appropriate support to eat if they required it, and staff did this discreetly and respectfully. Staff took time to ensure people were offered choices of food and drink. During the meal, staff were checking that people were happy with their food and whether they wanted anything else to eat.

We spoke with the cook about the allergens in food. Recent regulatory changes mean that food providers are required to display information about which of 14 known allergens are in each item of food produced. We saw that the home's manager had spoken with the cook about this previously, however, this information was not available. The cook did not have a good knowledge of this requirement.

We checked eight people's care records to look at information about their dietary needs and food preferences. Each file contained details of people's nutritional needs and preferences, however, screening and monitoring was not carried out adequately. For example, one person's risk of malnutrition had increased, but this was not referred to in their care plan. Another person had lost weight, meaning that their risk of malnutrition had increased, but their assessment stated that they had not lost weight. We did not see that this had negatively impacted on people however the contradictory information could result in risks to people's health and wellbeing not being appropriately managed.

We looked at records in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We checked people's files in relation to decision making for people who are unable to give consent. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. People's care plans did not reflect appropriate decision making in accordance with the MCA. The care plans we checked contained a generic document in relation

to decision making, but there was little information about specific decisions that had been made for people, or who had contributed to the decision making. One person's file stated that they weren't able to communicate and their family did not visit often, and therefore they could not give consent to their care. We asked the assistant manager about this. They told us that an external advocacy service was available, so it was unclear why this service had not been contacted to assist in decision making for the person. Some of the records we checked indicated that people's relatives had given consent to their care and treatment despite them not having the correct legal authority to give this consent.

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

We checked staff training records and saw that staff had received training covering the needs of older people, including training in moving and handling, dementia awareness and safeguarding. However, we noted that some staff had not received training in some key areas, including infection control and dignity.

Requires Improvement

Is the service caring?

Our findings

People described the staff as kind and caring. One person told us, "I'm being looked after very well." Another told us, "I'm happy here, it's homely."

When we spoke to staff they had a good understanding of the history of people living in the service and how this impacted on how people wanted to live their lives. Most people chose to spend the majority of their time in communal areas. One person told us, "I like to be around people." We spoke with a visitor. They told us, "They provide good care and the staff are friendly." They told us they were always made welcome by the staff, and described the atmosphere as "homely." This demonstrated that staff were caring for people in a person centred way and listening and respecting people views and wishes. However we found that some assessments and care plans contained contradictory information and could result in people not receiving the care that met their individual needs.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them.

Meetings took place for people using the service. We checked the minutes of these and saw that some people had requested a tuck shop to be provided at the home. This had been implemented, meaning that people had been able to have their say in the way the home was run.

The atmosphere in the home was calm and relaxing. Signage was available throughout the home to help orientate people. Toilets were clearly visible and people's bedroom doors had their individual names on them. Throughout the inspection, people were seen navigating the home, making their way to their bedrooms or the toilet independently.

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. A relative told us, "I visit regularly so I am always kept up to date." However we had been contacted by relatives who had expressed concerns about the care their relative had received.

We undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. By carrying out a SOFI we observed that people experienced interactions from staff which were warm and patient, and that staff tried to enable people to make choices and decisions. The staff approach was person –centred, which meant that they considered the person's experience when they were being cared for.
Observations of staff interacting with people showed that people were treated with dignity and respect. Staff we spoke with had a good knowledge of the importance of treating people with dignity. One staff member said, "Dignity is a priority, and you must be a caring person." People were assisted to their bedroom,

bathroom, or toilet whenever they needed personal care that was inappropriate in a communal area. This support was discreetly managed by staff so that people were treated in a dignified way in front of others. Staff members also made sure that doors were kept closed when they attended to people's personal care needs. Where staff needed to discuss care tasks this was done quietly and discreetly, to ensure that people's confidentiality was respected.

People's equality and diversity needs were respected and staff were aware of what was important to people. However due to contradictory information in some peoples records there was a risk that people's needs may not always be identified. We also found concerns in relation to obtaining consent in relation to the Mental Capacity Act which could mean that consent in relation to the care they received was not lawfully obtained. People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting and being welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

We looked at a sample of eight people's care plans to assess whether the provider was responsive to people's needs. Each care plan we checked showed how frequently people's weights should be checked and recorded, however, we found that this was not carried out at the required frequency. One person's care plan stated that they should be weighed on a weekly basis, but there was no record of any weights been measured for the preceding three weeks. Another person whose records also said they should be weighed weekly had no weights recorded for a one month period.

We looked at how the provider was caring for people during the night. One person's care plan stated that they should be checked every hour, however, the records of these checks showed that they were not been checked every hour. One person's file stated that their risk of injury through fall should be evaluated every month, however, it had not been evaluated for over two months.

Some of the care plans we looked at contained conflicting information. For example, one person's care plan stated they enjoyed a healthy, well balanced diet and ate independently, yet within another assessment it had been recorded that they were at risk of malnutrition. This meant that the person's needs had not been properly or accurately assessed. One person's care plan had not been reviewed for six weeks, although there was information within it which stated that it should be reviewed every month.

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

There was a board displaying the activities available, and the home employed an activities coordinator. Staff told us that activities within the home were plentiful, although we did not observe anybody being supported to participate in activities during most of the inspection. The provider told us there was also a well-attended café which took place every Wednesday, this did not occur on the day of the inspection as an evening party had been organised with a visiting singer attending. There were other events planned, including a regular pub night and themed food evenings.

The provider used various methods to communicate with people using the service, including meetings which took place regularly and enabled people to give feedback about the way the home was run. There was also a communications board, telling people which staff were on duty and held information about forthcoming activities.
We looked at the arrangements for making complaints. The provider had a file which recorded where people had made complaints and showed the provider's responses. We noted, however, that guidance given to people about how to make a complaint did not contain the correct information in relation to external remedy.

Inadequate

Is the service well-led?

Our findings

When we inspected this service in January 2016, we found that the provider was not carrying out audits of the service at an appropriate frequency. This meant that failings in the way the service was delivered were not identified. We rated the service "Requires Improvement" in relation to how well led it was. At this inspection, we found that the provider had failed to address this, and audits continued to be ineffective.

We looked at the provider's systems for gaining assurance that the quality of service provided was good. We found that these systems were inadequate. At the beginning of the inspection, the home was being managed by an assistant manager as the registered manager was on annual leave. During the inspection, the managing director, who is also the Nominated Individual, a role which is a requirement of a provider's registration attended, as did another senior manager. None of them could access the audit systems as these were only accessible by the registered manager. The registered manager then attended the home despite being on annual leave, but again could not access the audit systems due to IT failure. There was no back up plan in place.

There were some audits available, however, these had failed to address shortfalls in the service. For example, the condition of the premises was audited, but the conclusion of these audits was that the premises were in good condition. This was not the case. The medication arrangements were regularly audited but they had failed to identify the failings within the way medicines were managed within the home.

We looked at the arrangements in place for auditing care plans. The management team told us that care plans contained a document which showed that they had been audited. Of the eight care plan we looked at, only one contained this document. All the care plans we checked contained errors and omissions which put people at risk of receiving poor care. This meant that the provider was not carrying out adequate audits.

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

It is a requirement of law that providers display their CQC ratings, both within their premises and on their website. We checked the provider's website prior to the inspection and found that they did not display their ratings. Additionally, the provider's website stated "We have the highest Care Quality Commission rating." This was factually incorrect given that the location had been rated "Requires Improvement" at the time, and had the potential to mislead members of the public. During the inspection we also found that the provider was failing to display their rating within the premises. We raised these failures with the provider on the day of the inspection and they were addressed. However, it was not clear why the provider had placed misleading information on their website as they were aware it was incorrect.

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 11 HSCA RA Regulations 2014 Need for consent The care plans contained generic documentation and little information about specific decisions that had been made for people, or who had contributed to the decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Areas of the home were damaged and had unsealed floors meaning they could not be hygienically cleaned.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems in place for monitoring stock of medicines to be taken on an "as required" basis were inadequate. Care plans contained contradictory information. Care plans did not contain appropriate steps to protect people from harm.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not sufficiently robust to identify shortfalls in care and medication documentation.

The enforcement action we took:

Warning Notice