Amber ARC Limited

Adderley House Residential

Inspection report

23 London Road
Long Sutton
Spalding
PE12 9EA
Tel: 01406 364918
Website: www.pearlhealthcare.com

Date of inspection visit: 27 February 2015
Date of publication: 10/07/2015

Ratings

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

Overall summary

We inspected Adderley House Residential on 27 February 2015. This was an unannounced inspection.

The last inspection took place on 12 August 2014 when we found that the provider was not meeting the standards of care we expected. Care was not planned or delivered to meet people's needs or to ensure their welfare. People were not protected against the risks associated with infections and systems to prevent detect and control infections were not effective. The design and layout of the service was not always suitable and the premises were not maintained to an adequate standard.

There were not always enough staff to meet people's needs. The provider did not have effective systems to assess and monitor the quality of service people received and there were no effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service. After the inspection the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we found the provider had made many improvements to the care people received and was meeting all of the legal requirements.

Summary of findings

The home is registered to provide care for 40 people. The home has bedrooms for people in the main house and a number of self-contained flats. There were 23 people living at the home on the day of our visit, 10 in flats and 13 in the main home. The home was registered to look after older people.

There was a registered manager at the home. 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. However, they were due to retire shortly and a new manager had been appointed and was working alongside the registered manager.

The provider had completed a staffing analysis and used a recognised tool to ensure they had enough staff to meet people's needs. As a result they had increased the number of housekeepers. However, at times staff were not deployed in areas where people needed assistance.

The provider used safe systems when new staff were recruited. All new staff completed thorough training before working in the home and had regular meetings with their supervisor to discuss their work. However, refresher training for staff had not been kept up to date. Staff were aware of their responsibility to protect people from harm. Staff knew how to raise any concerns they had about people's safety to their supervisor or the registered manager. However, they were not all aware of how to raise concerns directly with external agencies.

The home was clean and tidy and the registered manager attended infection control meetings with the local council to ensure they kept up to date with new guidance. Staff knew how to work to reduce the risk of infection. While some equipment did not meet infection control standards this had been recognised by the new manager and action was planned to replace this equipment.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The new manager was aware of their responsibilities under the MCA and there was no one at the home who was deprived of their liberty.

There were appropriate systems in place to obtain, store and dispose of medicines. Staff had received training in handling and administering medicines and did so competently. People and their families, had been included in planning and agreeing to the care provided. People had an individual plan, detailing the support they needed and how they wanted this to be provided. People were offered choices in the care they received and their choices were respected. There was a lack of activities at the home and people told us they would like more to do as they found it dull at times. People had also not been supported to access local community facilities such as the library.

The provider had completed a number of audits around the home and we saw they were successful at identifying concerns and issues. A quality survey had been completed, however, the provider had not reviewed the results to identify if any action was needed.

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

Some aspects of the service were not safe.

While there were enough staff to keep people safe they were not always deployed where people needed support. Staff were happy to raise concerns about people's safety but did not know how to raise concerns with external organisations.

Medicines were managed safely and infection control process had improved. The home was clean and tidy. Some equipment needed replacing so that it could be cleaned more effectively.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

New staff received appropriate training to ensure they had the skills needed not care for people. However, refresher training had not been consistently available for existing staff.

People's choices about the care they received were respected and the new manager was aware of their responsibilities under the Mental Capacity Act 2005.

People at risk of malnutrition and dehydration were monitored and referred to appropriate healthcare professionals. However, there was a lack of choice for people at the mid day meal.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff were kind and respectful to people. However, at times staff were rushed and did not consider the impact completing a task had on people.

The registered manager did not always respect people's privacy.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans were developed with people receiving care or their relatives so that they fully reflected the care people needed.

People were not supported to maintain hobbies and interests and some people were bored. There was no programme of activities and care staff did not have time to spend with people outside of providing care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Summary of findings

The provider had a range of audits available which identified concerns and ways to improve the service. The provider had also taken account of professional advice to ensure the service was safe.

People and staff did not always have their views on the service taken into account. The new manager had clear views on how to engage people and staff so that they input into how the home was run.

Adderley House Residential

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 27 February 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert 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.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with people living at the home. Some people had problems with their memory and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a cook, a housekeeper, a senior care worker and two care workers. We also spoke with the registered manager who was retiring and the incoming new manager.

During the inspection we looked at the care records of four people who lived at the home and other records related to their care such as daily notes and food and fluid charts. We also looked at staff training, complaints and the quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 12 August 2014 we identified that people were not protected against the risk of infection. Systems designed to prevent, detect and control the spread of infection were not effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 cleanliness and infection control. The provider sent us an action plan which set out how they planned to address the areas highlighted.

The standards of cleanliness and infection control had improved since our last inspection. One freezer had been replaced and foods such as meat and dairy products were stored separately to avoid cross-contamination. The cook told us and records showed they had been awarded the highest star rating in food hygiene in November 2014. This meant they were meeting all of the local authority regulations for handling and storing food.

We spoke with the cook, the housekeeper and the staff member in charge of the laundry. They were all clear about the infection control policy and were able to describe a thorough cleaning regime. Staff wore protective clothing such as aprons and gloves when providing personal care and we saw these were available in various areas of the home. Staff had taken appropriate action to minimise the risk of cross infection when people were ill.

However, we saw there were still some infection control risks present. For example, there were cracks under some of the commodes which could harbour bacteria. The new manager was in the process of setting up a maintenance schedule to replace old and damaged equipment.

The registered manager had attended the local council infection control meeting, this meant they were kept up to date with changes in legislation and best practice.

The provider was no longer in breach of the regulation.

At our inspection on 12 August 2014 we identified that there were not always enough suitably qualified, skilled and experienced staff to meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 staffing. The provider sent us an action plan which set out how they planned to address the areas highlighted.

The provider had completed a staffing tool in December 2014 to see if they had an appropriate number of staff to care for people. As a result they had increased the domestic staffing numbers.

At this inspection they were 23 people living at the home with the same number of care workers as at our last inspection when there had been 31 people in the home. This meant that staff had more time to care for people. Staff we spoke with told us that they had more time to care for people and that this had improved since our last inspection.

However, we saw that staff were not always deployed appropriately. Three people chose to have their lunch in the upstairs lounge. There were no staff to keep them company and to ensure that people were supported.

The provider had systems in place ensure the staff they employed were suitable and safe to work with the people living at the home.

The provider was no longer in breach of the regulation.

Staff had received training in how to keep people safe. Staff we spoke with were able to describe the different types of harm people may be exposed to and how that may affect them. Staff were clear about reporting concerns internally. However, staff told us they did not know how to raise concerns with the local safeguarding authority.

Risks to people while receiving care had been identified and risk assessments were in place and contained information on how staff could reduce the level of risk people faced. For example, we saw that people's risk of developing pressure sores had been assessed and pressure relieving equipment was in place. Risk assessments were reviewed on a monthly basis or sooner if people's needs had changed. We looked at four care plans and in three saw risk assessments had been update appropriately. However, in one care plan we saw the risk assessments had been completed to show an increase falls and pressure sores risk. Care had not been reviewed to see if additional measures were needed to keep the person safe.

Medicines were administered appropriately, with the senior care worker checking that people had their medicines as prescribed. Where people were prescribed medicines such as pain relief which they could take as and when required, we saw that they were offered a choice of whether they wanted it and how many they wanted within the prescribed

Requires Improvement

Is the service safe?

limit. The medicines were signed for as administered once the senior care worker had ensured that they were taken. However, when 'as required' medication was offered, this was signed for but the number taken was not recorded. This meant that if someone required more pain relief, there would not be a record of how many had been taken that day.

When people needed medicines quickly, for example, when a person needed antibiotics for an infection, systems were in place to ensure medicines were collected from the pharmacy in a timely fashion.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 12 August 2014 we identified that people were not protected against the risks of unsafe premises as the design and layout was not suitable and the maintenance of the premises was inadequate. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 safety and suitability of premises. The provider sent us an action plan which set out how they planned to address the areas highlighted.

At our inspection on 27 February 2015 we found the provider had taken steps to improve the safety of the environment. For example, the provider had taken the actions advised by the fire safety officer and the building now met the current fire safety regulations.

The provider had also continued with a redecoration and maintenance plan, more of the flats had been refurbished including new windows. While some areas of the main house still needed attention the provider had plans in place for the work to be completed.

This meant the provider was no longer in breach of the regulation.

A member of staff who had recently joined the service told us they had received a good induction which involved training by staff and training in specific areas such as infection control, person-centred care and end of life care. The care worker was not able to undertake care on their own until their training had been completed. For example, they had been shown how to use the hoist but were not allowed to do so until they had completed the moving and handling training. They felt if there was an area they did not understand, or a gap in their knowledge, they could ask their supervisor.

Other members of staff told us they had received some updated training to ensure they were skilled in their role. However, records showed and the new manager had identified that there were gaps in staff training. The new manager had plans in place for a full programme of training in April 2015 around issues such as falls prevention and continence so that staff would have the right skills to support the needs of people living at the service.

Staff told us they had regular meetings with their supervisor. They said they found them useful as they could raise any problems relating to care, equipment or staff.

Some staff had received training in the Mental Capacity Act 2005 and the new manager was in the process of assessing which staff still needed training. The new manager described how they had concerns about a person who may lack capacity to make important decisions for themselves and they were working with the local authority to ensure that an appropriate assessment was undertaken. The registered manager ensured that people were consulted when making decisions about their care. If people were unable to make decisions, relatives were involved in the decision making process, ensuring that staff proceeded correctly in each individual case. The home had a policy regarding the use of restraint which referenced the Mental Capacity Act and Deprivation of Liberty Safeguards. The policy was very clear that the least restrictive option should be considered in all cases. At the time of our inspection no one was deprived of their liberty.

The cook was aware of people's individual dietary needs and knew who had diabetes and who required a soft diet. They told us, "I know everybody off by heart, even what tea or sugar they take." The cook was able to describe how a person who required a soft diet did not like soft or blended foods, so the cook made soups to support this person to have nutritional meals. The cook checked on a daily basis whether people's needs had changed or whether new people had come to live in the home.

People's ability to eat safely had been assessed and where concerns were raised people had been referred to appropriate health professionals for advice. Where people were at risk of not eating enough, systems were in place to monitor the amount of food and drink they had. Where people were unable to maintain a healthy weight they were referred to the GP and had food supplements to ensure they received enough calories.

People were supported to access appropriate medical advice when needed. For example, we saw people had seen the doctor and the district nurse visited while we were at the home. Where needed, people were appropriately referred to other health professionals. People were also supported to make a choice about where they received care. For example, we saw on person's care plan recorded which hospital they wanted to be taken to in an emergency.

Requires Improvement

Is the service effective?

Health care professionals told us that staff accompanied when they visited people and were good at following any instructions they had been given and that they raised concerns appropriately.

Requires Improvement

Is the service caring?

Our findings

People's privacy was not always respected. The registered manager told us to use a specific bedroom to meet with visiting health professionals. We thought this was an unused bedroom, however, we discovered this was a person's bedroom. This meant we had infringed a person's privacy and showed that the registered manager did not respect people's privacy. The registered manager told us they also used other people's rooms if a community nurse needed to take blood from a person.

We saw that the new manager, although she had been in post for only a few days, knew people's names and stopped to chat with them when she walked through communal areas. All staff, regardless of their role, told us they tried to spend time with people living at the service.

We saw staff took the time to reassure people and to make sure they understood what was happening in the home. For example, one person was having a new window fitted in their room on the day of our visit. This had made them anxious but staff reassured them they would let them know as soon as they could return to their room. One person was concerned about their appointment with the community nurse and we saw staff took the time to reassure the person and inform them when the nurse would visit them.

However, we saw that staff were not always supportive of people. For example, lunch appeared to be rushed and people's deserts were put in front of them before they had finished their main course. Staff were unable to tell people what was for pudding, even when they were putting it in front of people. This meant people were unable to make an informed choice if they wanted a dessert or not.

We also saw that some staff were task orientated and did not consider their impact on people. For example, we saw two people were engaged in an activity at a table in the dining room. However, we saw they were interrupted when a member of staff came to set the table for Lunch. This was at 11:30am and lunch was not served until 12pm. This meant the people sat at the table for half an hour with nothing to do when they could have still been engaged in their activity.

People were supported to make choices about the care they received. For example, a care worker we spoke with described how they would support a person who had communication difficulties to make choices by showing them the different options. Staff listened to people when they expressed a preference about their care. One person who was assessed as needing a special cushion to help prevent pressure sores refused to use the item and staff respected their decision.

People had limited choices about what to eat as there was not a lot of variety in the menu, for example meals on Wednesdays would be the same each week, as were the Friday meals, although the puddings were different each day as the cook was able to decide on these. There were no choices for lunchtimes, although if someone had a particular dislike to a food on the menu, the cook would try and find an alternative. In the evenings there was a choice of sandwiches with a cooked tea three times a week. One person told us, "The food is good and you get a choice but not at lunch time."

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 12 August 2014 we identified that people were not protected against the risks of receiving care that was inappropriate as care was not planned or delivered to meet the person's needs or to ensure their welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 care and welfare of people who use services. The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found the provider had made improvements in the recording of people's care needs. A senior care worker told us that they identified people's individual care needs by asking people or their families. They told us when they completed a person's care plan they sat with the person to discuss their needs. Care plans were reviewed monthly or sooner if a person's needs changed.

We looked at four care plans and could see that they accurately reflected people's individual care needs. For example, people's daily routines were recorded in their care plans. This included what time they preferred to get up or go to bed and where they liked to spend time during the day. Where people had specific communication needs these were recorded in their care plan. For example, we saw one care plan recorded that staff needed to explain things two of three times for the person to understand what was happening. Staff were able to tell us about people's individual care needs. This matched what was recorded in their care plans.

Care plans also recorded people's ability to make decisions about the care they needed. For example, care plans recorded if people were able to say if they were in pain and able to request pain killers. We saw staff asked how many painkillers a person wanted to take.

The provider was no longer in breach of the regulation.

At the time of our inspection there was no dedicated activities co-ordinator. The registered manager told us that care staff would support people in between providing care. However, people told us this was not working. One person said, "Staff are trying, but nothing goes on and it's boring." We saw how two people who enjoyed spending time together planned their activities throughout the day. However, we say they were the same activities every day. they told us this was because there was nothing else on offer. Another person told us how they enjoyed reading and would like to go to the library but were not supported to do so. The new manager told us they were in the process of recruiting an activities co-ordinator for the home.

The provider had a formal complaints policy which explained how to raise a complaint and how quickly the provider would respond to the complaint. The registered manager told us they had received no formal complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 12 August 2014 we identified that there was no effective system to monitor the quality of service provided or to identify, assess and manage risks to the health, safety and

welfare of people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision. The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we saw that the provider had regularly completed audits to monitor the quality of service provided. Care plans had been audited and areas where extra information was needed were highlighted for action. There was an infection control audit in place and it had identified issues in the home. Plans were also in place to complete a hand hygiene audit. There was a cleanliness audit in place and any issues identified were raised with the domestic staff.

In addition to the audits the provider completed regular visits to the home where they reviewed the quality of the environment and care. Action plans were developed from these visits to ensure appropriate action was taken to resolve any issues identified.

The provider was no longer in breach of the regulation.

We were told that the registered manager would be retiring shortly after our inspection and the newly appointed manager was working alongside the outgoing manager during the transition period. Although the new manager had only been in post a couple of days at the time of our visit, we heard people being complimentary about them. Staff had welcomed the new manager and were positive about the future. One staff member said, “She has made an effort to fit in.”

Staff did not always feel listened to. For example, the cook felt that the menu was repetitive and was limited in what they could do as they had limited support. They had approached the management but nothing had changed. We saw that following a staff meeting, a ‘suggestion box’ had been implemented so that staff could provide ideas to improve the running of the service, but on the day of our visit it was in the registered manager’s office as it was broken.

The new manager was looking at how best to deploy staff, such as the maintenance worker, who had not previously worked to a planned schedule. She was planning to hold residents’ and relatives’ meetings so that people would have an opportunity to share their views about the service. The registered manager had confirmed that attempts to hold meetings of this nature had been unsuccessful in capturing people’s interest. The last recorded residents’ meeting had been held in March 2013. The new manager was exploring ways of ensuring that the meetings would appeal to people, rather than being formal meetings.

The new manager was clear about which areas of the service needed to improve and was exploring ways to undertake and embed improvements, such as the effectiveness of staff handovers. The building was a grade two listed building and the new manager planned to look at ways of using space better but in consultation with people who live at the service and their relatives. The new manager told us that the providers were supportive of this review.