Amore Elderly Care Limited

Amberley House Care Home - Stoke-on-Trent

Inspection report

358 Ubberley Road
Bentilee
Stoke On Trent
Staffordshire
ST2 0QS

Tel: 01782331200
Website: www.priorygroup.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 March 2017. At out previous inspection in August 2016 we had concerns that the service was not consistently safe, effective, caring, responsive or well led and we had found five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made in all areas, however, further improvements were required.

Amberley House Care Home provides nursing care to up to 74 people. At the time of the inspection 54 people were using the service. The service was split into three areas, a nursing care area, an area for people living with dementia and a special care unit.

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.

Risks of harm to people were assessed however people's risk assessments were not always followed to ensure they remained safe. Not all the equipment that people had been assessed as requiring was being used safely.

The systems the provider had in place to monitor and improve the service were not consistently effective.

People had comprehensive care plans to inform staff how to support them when at times they were anxious or aggressive. Staff had received training to be able to support people safely at these times.

People's medicines were stored and managed safely and there were sufficient numbers of staff to keep people safe. New staff had been recruited through safe recruitment procedures to ensure they were fit and of good character.

The principles of The Mental Capacity Act 2005 (MCA) were being followed to ensure people's rights were being upheld. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves

People were being cared for by staff who were supported and trained to fulfil their roles effectively.

People's health care and nutritional needs were met. People had access to a range of health care professionals when they became unwell or their health needs changed.

People were treated with dignity and respect and their right to privacy was upheld. People's right to make choices was respected.

People received care that was personalised and met their individual preferences. There were hobbies and activities available to people who wished to join in.

The provider had a complaints procedure and people knew who to speak to if they had any concerns about their care.

There had been improvements to the quality of the service since the last inspection and staff and people who used the service told us that the registered manager had affected change.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not always reduced as staff did not consistently follow people's risk assessments.

There were sufficient numbers of suitably trained staff to safely meet the needs of people. New staff had been employed through safe recruitment procedures.

When suspected potential abuse was reported, concerns were acted upon and referred to the appropriate agencies for further investigation.

People's medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

The principles of the MCA 2005 and DoLS were being followed to ensure that people who lacked mental capacity were being supported to consent to their care.

People's nutritional needs were met and people were supported to maintain a healthy diet.

Staff were supported and received training to be effective in their roles.

People received health care support when they became unwell or their needs changed.

Is the service caring?

Good

The service was caring.

Staff demonstrated a kind and caring manner and treated people with dignity and respect.

People's privacy and right to make choices was always respected.

People and their relatives were encouraged to have a say in how the service was run.

Is the service responsive?

Good

The service was responsive.

People received care that reflected their individual needs and preferences.

There was a complaints procedure and people knew how and who to complain to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Risks to people were not always being managed as systems in place to manage risk were not consistently effective.

Improvements had been made since the last inspection and the quality of care had improved for people who used the service.

People, their relatives and staff felt the registered manager had been effective in bringing about improvements to the standard of care.

Amberley House Care Home - Stoke-on-Trent

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 6 March 2017 and was unannounced. It was undertaken by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of this type of service.

We reviewed information we held on the service such as the last inspection report and the action plans the provider sent to us following the last inspection. We also reviewed notifications we had received from the provider. A notification is information about important events which the provider is required to send us by law.

We spoke with eight people who used the service and six relatives. We spoke with six members of the care staff, four nurses, the dementia coach, the registered manager and quality manager. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at seven people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, three staff recruitment files, staff rosters and other documents to help us to see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 12 as people were not always receiving care that was safe. At this inspection we found that some improvements had been made and they were no longer in breach of this Regulation. However, further improvements were required.

At our previous inspection we had concerns that risks of harm to people were not always being minimised as staff were not following people's risk assessments. At this inspection we found that some improvements had been made and staff mostly knew what to do to keep people safe. We saw that action had been taken by the registered manager to ensure that people were being supported to mobilise safely by reinforcing people's risk assessments with staff and visitors. We saw if people had an accident that action was taken quickly to minimise the risk of it happening again. For example; one person had recently fallen out of bed. We saw an assessment had been completed and the person now had bed rails in place to prevent them from falling from their bed again. However, we saw that one person had been assessed as requiring thickened fluids as they were at risk of choking. We saw on two occasions after we had identified that the person had been given an unthickened drink with the staff that the person was given more unthickened drinks. The clinical lead told us that this was because the person had only recently been assessed as requiring their drinks thickened and staff were still getting used to this. This put this person at risk of choking due to staff not following the person's risk assessment.

Previously we had seen that several people were using 'Kirton' chairs with no foot rests. Foot rests should be in place to ensure that people have a base of support and only used without foot rests if prescribed by an occupational therapist. At this inspection we saw that people had been individually assessed for the use of the Kirton chairs and only one person had been assessed as not requiring foot rests. However, we saw there were still people not using foot rests and their legs were left with no support. We discussed this with the clinical lead and registered manager who told us that they had reinforced this with staff and would address this again.

Previously staff told us they had not received training to be able to support people when they became anxious and aggressive due to their dementia. They told us they were being regularly assaulted whilst supporting people. Since the last inspection the provider had arranged training in the 'management of challenging behaviour'. Staff we spoke with told us they felt more confident in supporting people who became anxious and aggressive. We observed that one person was resistive to personal care so the staff member calmly told them they would return later and try again. The clinical lead told us: "The training informs staff how to walk away and try again and other distraction methods". We saw people's risk assessments in relation to their challenging behaviour were clear and comprehensive and staff we spoke with knew people and knew how to support people at these times. Individual incident records were kept to ensure that people's behaviour was monitored.

At our previous two inspections we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staff to keep people safe. At this inspection we found that improvements had been made and they were no longer in breach of

this regulation. People told us they didn't have to wait too long to have their care needs met. One person said: "I don't have to wait long before someone comes to me", and a relative told us: "I think there's enough staff, if we ask the staff to come and do something then they come quite quickly, we never have to wait long". Staff we spoke with told us there were enough of them to be able to meet people's needs in a timely manner and we observed that no one had to wait too long for staff support. One staff member told us: "I think staffing levels are ok, we get time to stop and talk to people instead of just going from one job to the next". A member of staff had been recruited to a twilight shift in the special care unit (SCU) as previously it had been identified that people required more support during that time due to 'Sundowning'. Sundowning is a symptom of Alzheimer's disease and other forms of dementia and means that people may experience heightened confusion and agitation in the late afternoon and evening. Staff in the SCU told us there were enough of them to be able to meet people's needs in a safe and timely manner. We observed that no one had to wait to have their needs met and there was a safe level of supervision for people who were at high risk of falls or who may need extra support when anxious and agitated. However, we did observe that on the nursing unit in the afternoon there was a short time where no staff were visible. We were told by the clinical lead that this was because staff were supporting people with personal care and other staff were on a break. The registered manager told us that consideration to the staff break times would be reconsidered to ensure that staff were always available.

Staff were recruited using safe recruitment procedures. Staff told us and we saw that that safe recruitment practices were followed. This included references from previous employers and Disclosure and Barring Service (DBS) checks to make sure that staff were safe and suitable to work at the home. The DBS is a national agency that keeps records of criminal convictions.

People told us they felt safe. One person told us: "I sometimes get scared at night but the staff will leave my light on and my door open so I feel safe". A relative told us: "My relative has been in other homes before this and here she is very safe". Staff we spoke with demonstrated that they knew what to do if they suspected someone had been abused. The registered manager had raised safeguarding referrals with the local authority when they had suspected abuse. We saw that staff recorded on 'body maps' when they had identified bruising or injuries to people. However, these records remained on people's daily care records and no action was taken to investigate the injuries. The registered manager informed us that they would take action to ensure that any recorded injuries and bruising were investigated.

People's medicines were stored and administered safely. Medicines were stored in a locked trolley in a locked clinical room. People's medication records, stated how people liked to have their medicines. For example; it was recorded on one person's record 'prefers to take medicines at tea time and swallows better with milk'. We observed medicines being administered and saw that the nurses knew how individual people liked to have their medicines. We checked that the recorded total of medication recorded on some people's medication records was correct with the balance of stock in place and found it was. We saw that people had protocols for 'as required' medicines such as pain relief. This meant that people would be able to have their medicines as they needed them as staff knew when people may be in pain.

Good

Is the service effective?

Our findings

At our previous inspection we had found that the provider was in breach of Regulation 11 of The Health and Social Care Act (Regulated Activities) Regulations 2014. The principles of The Mental Capacity Act (MCA) 2005 were not being followed to ensure that people who lacked mental capacity were being supported appropriately to consent to their care, treatment and support. Some people's relatives had been making decisions for people without the legal right to do so. The 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.

Since the last inspection we found that improvements had been made. People's relatives had been asked to provide evidence to support their legal powers over their relative, such as lasting power of attorney documents. This had been completed and discussions with relatives had taken place to ensure that people who lacked the mental capacity to make decisions were being supported appropriately.

Previously we had seen that several people who lacked mental capacity had a Do Not Attempt Resuscitation order (DNAR) in place. A DNAR form is an outcome from a process of discussion and consent taking place either directly with the patient, or with their representatives and carers if they lack capacity. We could not see that these orders had been discussed and agreed with the person themselves or their legal representative. We saw that the DNAR's were still in the process of being reviewed and that care plans had been put in place where able, to ensure that people or their representatives were aware that there was a DNAR in place. The registered manager told us that the review of people's DNAR's was on-going and reliant on people's GP's to visit and review.

Previously several people were using 'Kirton' chairs which restricted their ability to mobilise. We could not see that the principles of the MCA had been followed to ensure that this was the least restrictive practice and in their best interests. 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 (DoLS). At this inspection we found that a mental capacity assessment had been completed for each person and an agreement made for the use of the Kirton chairs to ensure that they were in the best person's interest and the least restrictive way of keeping the person safe. The principles of the MCA and DoLS were being followed to ensure that people were not being unlawfully restricted of their liberty.

People were being supported by staff that were effective in their role. One person told us: "The girls are really lovely, they do work hard". Staff we spoke with told us that they felt supported. One staff member told us: "I've done challenging behaviour training, safeguarding and dignity training recently and we get refresher training every 12 months. I have supervisions every few months with the nurse". We saw since the last inspection staff had begun to receive training in how to support people who may demonstrate challenging behaviour. Staff we spoke with told us that this training had been useful. On the day of the inspection we saw that some staff were receiving training in 'dementia' and dignity training.

People told us that the food had improved. One relative said: "The new chef is very good. The pureed food is much nicer than it was". Another relative told us: "When my relative was poorly the food was mashed up, it was tailored to her needs. They are on the ball with residents' needs". People were offered choices at all meal times and we saw that when people required support to eat and drink this support was available to them in a patient, unrushed manner. We saw action was taken when people lost weight or experienced difficulty in eating with referrals to the dietician and Speech and Language Therapist (SALT) being made. If people were prescribed food supplements people were supported to have them. We observed one person required lots of prompting to drink their supplement and this was given to them in a kind way until they had drank it all.

People told us and we saw that their health care needs were met. When people became unwell we saw that action was taken to get the person health care support as soon as possible. A relative told us: "Medical help is called in, in good time". There was a weekly visit from a GP who visited people who were identified by the nurses as requiring a visit. People had access to a range of health care agencies including dentists, opticians, district nurses and their community psychiatric nurses when required.

Good

Is the service caring?

Our findings

People told us that they felt well cared for. One person told us: "I'm well cared for I wouldn't go anywhere else". Staff were in the process of receiving dignity training from a dementia coach and we observed positive interactions between staff and people. We saw that staff were chatting, laughing and singing with people. When people had difficulty in communicating we saw staff were patient and made an effort to understand people. We saw staff reassured people when they became confused and staff put their arms around people's shoulders or their hand on the person's back for reassurance.

People were supported to maintain their personal hygiene and dignity. Staff told us that some people were resistive to personal care such as having a wash or a shave. A staff member told us: "We just keep trying when people say no, we go back or someone else will try". A relative told us: "The staff look after my relative really well, I've never had any concerns about them. They always looks smart and are always clean." We observed that most people looked clean and well cared for.

People's choices were respected and consideration to people who lacked mental capacity to make day to day choices had been made. For example; one person who was unable to communicate due to dementia had an advocate to help them in making decisions. We saw that in the SCU it had been agreed to trial a lounge area. Most people in the SCU would not be unable to communicate an opinion on this due to their dementia so a care plan had been put in place for staff to record people's reactions to the new lounge area to monitor for a negative effect. This showed that people were being involved in the decisions about their care.

People had their own rooms where they were able to spend time alone if they chose to. We saw that people's choice to remain in their room was respected and that staff knocked on people's doors before entering. Relatives were free to visit when they wished and we saw several visitors throughout the day.

There were regular meetings for people who used the service and their relatives to be able to contribute to the way in which the service was run. The registered manager informed us of plans to improve the dining experience for people in the nursing unit making it more pleasurable. They told us that they were going to speak to people about opening up the dining room in the main lounge and make the environment more conducive to a relaxed informal setting. We had noted that the current dining experience for some people who used the dining room in the nursing unit lacked atmosphere and staff presence.

Good

Is the service responsive?

Our findings

At our previous inspection we had found that not all people received care that was personalised and met their individual needs. At this inspection we found that improvements had been made.

We saw that people had clear and comprehensive care plans which were regularly reviewed with people and their relatives or representatives. One relative told us: "We met last week to discuss my relative's care". The care plans detailed people's individual likes, dislikes and preferences. For example; [Person's name likes a shower] and [Person's name] likes to look smart so offer a choice of clothing. One person told us: "I prefer female carers and I always get female carers". There was information being gained about people's life history. Where people were unable to communicate their relatives were being asked to contribute information about their loved ones past.

Staff we spoke with knew people's needs and told us they were kept informed of any changes at handovers at every shift. One member of staff in the SCU told us: "I don't often work in here so I have had a handover and I have looked at the 'snapshot' record of people's immediate needs". They showed us a record that detailed the basic needs of people and their preferences. They went on to say: "I ask one of the more experienced staff if I'm unsure before I do anything". This meant that people would receive care that met their assessed needs and reflected their preferences.

Staff were responsive to people's changing needs. We saw several examples of where people's care had changed to meet their needs. For example a relative told us: "The staff do everything we ask them to. They were very good after my relative fell, they put some equipment in place to try to stop it happening again, but they didn't get on with it, so now they have a crash mat and floor sensor and its working well."

People's religious and cultural needs were met. One person was from a minority cultural background and at times due to their dementia reverted back to their language of birth. We saw that an interpreter and an advocate had supported the person in planning their care and in making decisions. A language book had been put in place for staff to recognise some of the key words the person would say when they chose to speak their language.

People were encouraged to engage in hobbies and activities of their liking. Some people chose not to join in and spent time in their rooms, reading and watching television. The registered manager told us that they had recently recruited a second activity coordinator so there would be two full time staff employed to support people in activities. We saw there was a planned activity timetable throughout the service and people told us they had entertainment and hobbies they could participate in.

People and their relatives told us they felt able to complain if they needed to. A relative told us: "I mentioned a few little niggles when my relative first came in, but they were sorted straight way and I've not had anything else to complain about since." Another relative said: "I've never had to complain about anything, they always do a really good job but I would go to a nurse if I had concerns." The provider had a complaints procedure which was visible in the reception area. The registered manager told us that there was one formal

complaint currently being investigated by the provider as their policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found that the provider had been in breach of five Regulations of The Health and Social Care Act 2008. We had served two warning notices in relation to Regulation 17 (Good Governance) and Regulation 18 (Staffing) and asked the provider to improve. At this inspection we found that some improvements had been made and the provider was no longer in breach of these Regulations. However further improvements were required as the service was not consistently safe and well led.

We found that the systems the provider had in place for reporting and acting upon potential abuse were not always effective. Records of injuries were not always being seen by a nurse or the registered manager for them to be able to investigate the causes. Staff were recording the injuries on body maps and they were putting them in people's individual care records. The body maps were not always being seen by the management team to be able to investigate the injures. This meant that potential abuse may not be reported and investigated. However, when safeguarding concerns were brought to the management teams attention they were acted upon appropriately.

We found that there had been improvements in the way in which the risk of harm to people following incidents and accidents was managed. Prompt action was taken to minimise the risks on most occasions. However, we saw that one person's risk in relation to their dietary needs was not being managed safely and put the person at risk of further harm. This meant that people's risk assessments were not being followed consistently.

We saw that action had initially been taken to ensure that people sitting in 'Kirton' chairs were doing so safely. However we saw some people who had been assessed as requiring foot rests did not have them in place. This had not been monitored and addressed by a member of the management team and not all people were using the 'kirton' chairs safely.

Since the last inspection a new manager had been employed and they had registered with us (CQC). People and the staff told us that since the registered manager had been in post there had been improvements in the quality of the service. One staff member told us: "[Registered manager's name] seems to want to make the changes needed to get the home where it needs to be." A relative told us: "She is straight but I think that is what this place needed as there have been improvements". Another relative told us: "This is by far the best home my relative had been in". There had been regular resident and relatives meetings to gain feedback on the quality of the service. Annual questionnaires were also in the process of being sent out to staff, people who used the service and their relatives.

Staffing levels had been increased and the registered manager was able to show us that the amount of falls in the SCU had reduced. We saw that prior to the increase in staff there had been an average of 11 falls per month and since the increase there had been an average of 3 falls per month. This showed that the management had identified that the unit required more staff and improvements had been made in the quality of care.

Since the last inspection training had been arranged for staff to help them in supporting people with challenging behaviour. Staff we spoke with told us they felt more confident in caring for people when they became anxious and sometimes aggressive. We observed that staff used the training effectively when required and were more confident in supporting people when they were anxious. Staff told us they had regular meetings to be able to discuss any concerns or ideas for improvement. This meant that the quality of care these people were receiving had improved as staff were effective in supporting them at the times they needed them to.

The registered manager had notified us (CQC) of any significant events such as serious injuries and safeguarding concerns. This showed they understood what was required of them and followed the legislation.