Amberley Care

Amberley Care Home

Inspection report

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Date of inspection visit: 23 and 25 November 2015
Date of publication: 21/01/2016

Ratings

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

Overall summary

This inspection took place on 23 and 25 November 2015 and was unannounced. The home is registered to provide accommodation and personal care to 25 people.

On the day of our inspection 25 people lived at the home. People had a range of age related needs which included dementia. At our previous inspection in June 2013 the provider was compliant with the standards we assessed.

There was a registered manager in post and she was present during our inspection. 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 and associated Regulations about how the service is run.

People felt safe using the service and risks to their safety had been identified. Staff knew how to support people safely and had training in how to recognise and report abuse.

Staff were recruited in a safe way. We found there were enough staff to support people and meet their needs in a personalised manner.

Summary of findings

We found that medicine management systems needed some improvement so that people would receive their medicine safely and as it had been prescribed by their doctor. The registered manager addressed this on day two of the inspection.

Most staff worked in a manner that showed they sought people's consent, some staff were less consistent. People's liberty was not restricted and the registered manager had followed the legal requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) where people's safety needed this.

People were supported to eat and drink enough. The two week menu was repeative and people reported it did not provide enough variety.

People had access to routine health checks. Links with health proffessionals where people had continued health conditions such as diabetes needed to improve in order for people to experience positive outcomes regarding their health.

A complaints procedure was available for people to use. However, complaint documentation did not give full assurance that complaints had been followed through to an outcome.

People described the management of the home as friendly and approachable. Staff felt supported and the provider had carried out audits on the quality of the service and had made improvements to ensure the safety of people.

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?
The service was safe.

People said they felt safe and staff understood their role in recognising and reporting abuse. The provider had effective systems in place to protect people from harm or abuse.

Risks to people were assessed. Staff understood how to keep people safe.

There was enough staff to support people safely.

People received their medicines as prescribed. Written supporting information was needed to reflect the safeguards in place for people's medicines.

Good

Is the service effective?
The service was not always effective.

Staff had training and supervision to enable them to meet people's needs and recognise changes in people's health.

Staff knew how to seek people's consent but at times did not always seek this. Staff understood their responsibilities to protect people's rights so that they were not subject to unnecessary restrictions.

People were supported to eat and drink enough although they felt the variety of meals was limited.

People had access to routine health checks. A more proactive approach to involving other health services for advice was needed.

Requires improvement

Is the service caring?
The service was caring.

Staff were kind and caring towards people, knew them well and respected their dignity and privacy.

People were consulted about their care and enabled to express their views.

Staff understood the importance of people's relationships and visitors were made welcome.

Good

Is the service responsive?
The service was responsive.

People were involved in planning their care and staff had information on how to support people and meet their needs.

Action taken in response to complaints did not always provide an outcome.

People had access to interesting and regular activities that they enjoyed.

Good

Summary of findings

Is the service well-led?

Good

The service was well led.

People and staff spoke positively about the way the service was managed.

Staff understood what was expected from them.

Checks on the quality of the service were carried out and had led to improvements.

Amberley Care Home

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 was unannounced and was undertaken by one inspector over two days on 23 and 25 November 2015.

Prior to our inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of serious injuries to people receiving care and any safeguarding matters.

We asked for information about the home from the local authority who are responsible for monitoring the quality and funding the placements at the home.

We spoke with 11 people who used the service, the registered care manager, three staff, the cook and provider. We also spoke with a visiting health care professional and a visiting social care professional. We looked at the care records for four people and the medicine records for seven people, accident and incident records, complaints and compliments records, two staff files for training and recruitment and records related to the quality monitoring systems.

Some people were unable to verbally tell us how they found living at the home. We used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. In addition we observed staff administering people's medicines, carrying out activities and supporting people during their breakfast and lunchtime meal.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home. One person said, "The staff look after me they wouldn't let anyone hurt me". Another person told us, "Sometimes people get noisy or shout but staff are always around to deal with that".

Staff were aware of the different types of abuse and their role in protecting people. A staff member told us, "The manager tells us to report any concerns we have; if I thought people were not treated properly I would say". We saw staff had access to procedures to guide them in how to recognise and report any concerns to the registered manager and or external agencies such as the local authority or the Care Quality Commission. They had received training in safeguarding and whistle-blowing to support their understanding.

Risks to people's welfare had been assessed and we saw that staff supported people with the appropriate equipment to reduce the risk of falling or developing pressure sores. For example we saw people were assisted with the use of hoists and provided with pressure relieving equipment to protect their fragile skin. The actions needed to reduce risks to people's safety had also been detailed in their care plans. Recommendations from health professionals to guide staff on what they needed to do to support people for example at risk of dehydration were incorporated into the care plan and risk assessment. Staff were able to tell us who was at risk of not drinking enough or who was prone to developing a urinary tract infection and their responsibility to ensure they had plenty to drink. A visiting health professional told us that they were pleased with how staff followed their advice and that people's skin wounds had healed well as a result.

We saw that staff understood the approach to support some people whose behaviour challenged. For example we saw some positive interactions had been implemented when managing difficult situations. Staff we spoke with were aware of the type of situation that may result in a person becoming distressed or anxious. They had used distraction techniques to reduce the likelihood of potential harm to people's safety.

People told us that there was enough staff to meet their needs. One person told us, "Oh yes the staff are always around; someone in the lounge with us or if I need help in my room they come". Another person told us they were happy with the availability of staff and that their health had improved because of the support they had. A visiting health professional told us that a staff member was always allocated to them when visiting people to provide health care. The registered manager told us people's needs were assessed to determine staffing levels but that there had been no need to increase staff to meet people's needs. Staff told us that any sickness or absence was covered by them working extra shifts. One staff said, "I have worked extra shifts and I haven't experienced any short shifts".

Recruitment processes were in place to help minimise the risks of employing unsuitable staff. We spoke with two newly recruited staff who confirmed that reference checks and Disclosure and Barring Service (DBS) had been undertaken before they had started work. A staff member told us, "References and a police check were carried out before I was able to start work". We saw from these staff files that the provider's recruitment processes contained the relevant checks before staff worked with people.

People told us they had no complaints about their medicines, and that they had them when they needed them. One person told us, "I have my tablets at breakfast and dinner they, [staff] don't forget". We observed a member of staff preparing and administering people's medicines. She did not always ensure that she followed the procedures for the safe administration of medicines. For example we saw she prepared two people's medicines at the same time, gave both people their medicine and then signed their medicine administration records [MAR]. This practice increases the risk of errors. In discussion with the staff member she acknowledged that she had not followed the guidance and told us this was an isolated incident. We saw that competency checks were not in use to ensure that staff followed their training when administering people's medicines.

Some people needed their medicines on an 'as needed' basis. We saw there was written guidance for staff which described when these medicines should be given. Some people needed their medicine to be administered at particular times for example an hour before food, or sitting upright. A staff member was able to describe the safeguards needed before one person's medicine was administered. However this guidance was not written down to provide a consistent approach. We discussed this with the registered manager who had rectified this by day two of

Good

Is the service safe?

our inspection. We checked the balances for some people's medicines and these were accurate with the record of what medicines had been administered. We saw the storage of Controlled Drugs [CD] was secure. We found the CD register was appropriately maintained with a running balance of medicines used. We saw that where people required pain relieving patches alternate sites were used to reduce discomfort. The arrangements in place ensured that people received medicines when they needed them and in a safe manner

Requires improvement

Is the service effective?

Our findings

One person told us, "I am very happy with the way staff care for me". Another person smiled and nodded when they were asked if staff looked after them well.

We saw that staff supported people in an appropriate manner when using hoist equipment and transfers were completed safely. We saw staff knew how to defuse some behaviour that could challenge and training records showed some staff had training that enabled them to safely disengage from situations. One staff said,"I'm happy with the training". Training records showed that staff had also completed varying levels of recognised qualifications in health and social care to a level to meet people's current and changing needs. A visiting health professional told us that staff had applied their knowledge and skill effectively when managing the risk of people developing pressure sores and this had supported the healing process and reduced risks.

Staff told us they had a three day induction when they started work which included working different shifts so that they became familiar with people's needs and routines. We spoke with two newly recruited staff who confirmed their induction included shadowing established staff. There was documentary evidence that an induction process had taken place. The registered manager told us they were intending to implement the new Care Certificate to enhance their induction process. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people's care.

Staff told us that they felt supported on a day to day basis. We saw that they had regular one to one supervision to support their learning and reflect on their care practice. The registered manager told us that she carried out observations to monitor how staff put their learning into practice although this was not recorded.

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 interest 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 hopsitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found from speaking with staff they understood the principles of the Mental MCA. We saw most staff sought people's consent and accepted their refusal of care. A person told us, "They will ask me if I want to do something before they do it". We saw people made their own decisions about where they sat, what time they got up or went to bed and what they ate. We saw some examples where the staff member did not seek consent but carried out tasks without asking people first. For example after lunch a staff member moved around the room spraying each side table and wiping it down without communicating with people her intensions or reasons. We also saw people's medicines were taken to them and administered; we did not hear the staff member ask people if they wanted it. This demonstrated that although staff understood the principles of the MCA they did not always reflect this in their practice and at times reverted to a task based approach. Documentary evidence showed where people lacked mental capacity to make decisions about aspects of their care appropriate family members and their doctor had been consulted to ensure that decisions were made in the person's best interest.

Staff understood that it was unlawful to restrict people's liberty unless authorised to do so. We saw that people's movements were not restricted by the placement of furniture and that they moved around the home freely. Although the door was locked we saw people could leave the building and access the garden. A staff member told us, "We have a person who says they will leave the home but they still go out in the garden and have not attempted to leave, I think they have capacity". We saw the registered manager had taken appropriate action to submit a DoLS application for a person to be restricted. These actions reduced the risk of people having their everyday rights unlawfully restricted.

People we spoke with told us that they had a choice of meal each day and we saw people were offered choices and shown meals so that they could choose what they

wanted to eat. There was a rolling two week menu. Some people told us the choices were limited. One person said, "The foods okay but it doesn't vary much from one week to another". Another person said, I think it [the menu] changes every few weeks; they [staff] ask us what we like in meetings". We found the two week menu limited the variety of meals offered.

We found that where people were at risk of weight loss or had difficulty swallowing staff referred them to the dietician and speech and language specialists. People's weight was monitored to identify any risks but the most recent weight for one person had not been transferred to their care records. We observed a telephone call where an external health professional asked for the most recent weight of a person and the staff member referred to the person's file. If weights are not consistently recorded in the right place it would make it difficult to identify a weight loss or share correct information. The provider rectified this oversight by day two of the inspection.

Staff we asked knew which people needed specific diets. We saw for example that one person with a health condition that compromised their ability to swallow had their meal prepared in a way that made it safer for them to manage. Staff had followed instructions given by the health professionals to improve the person's food intake.

We saw that a drinks trolley was taken around the lounge areas throughout the day with a choice of hot and cold drinks, biscuits or cake. The cook said that fresh fruit was also taken around on the trolley. We saw staff took the time to support people to finish their drinks and records showed staff were monitoring people's fluid intake. People had appropriate utensils and crockery to support them when eating. The cook had information about people who needed their meals fortified to increase their nutritional intake as well as people who were on a controlled diet for their diabetes or pureed food to support their swallow mechanisms. Cultural diets had been catered for with family enhancing this by bringing in homemade foods.

People's had access to routine health care checks and said that they saw the doctor when they needed to. A visiting health care professional told us staff recognised when they needed to alert them about deterioration of people's skin and had followed their recommendations to promote people's health. Links with health proffessionals where people had continued health conditions such as diabetes needed to improve. This would have avoided unnecessary practices for one of the people. On day two of the inspection the registered manager informed us they had spoken with the doctor and rectified this concern.

Good

Is the service caring?

Our findings

People told us they liked living at the home, one person said, “The staff are very good to me”. A visiting social worker told us the family of one person were pleased with the caring approach of staff.

We spent day one of our inspection in the lounge and saw staff interacted with people in a caring manner. We saw staff respond to people’s attempts to communicate. We saw that when people reached out to staff who were passing, staff stopped and held their hand or spoke with them.

There was a friendly and relaxed atmosphere in the home with staff conversing with people. We saw lots of occasions where staff sat beside people and initiated conversation; some people unable to verbally communicate responded with smiles showing staff understood the importance of caring for people in a kind and compassionate way. One care staff said, “We know some people really well so although they can’t tell us things we know when they are happy, content, sad, or low or in need of a cuddle”

People had access to their own bedroom for private space and one person told us; “I prefer time in my own room and staff respect that”. A visiting professional told us that staff had politely sought entrance to a person’s bedroom whilst they were talking privately with them by knocking the door and waiting for a response. People told us and we saw that they had a key to their bedroom door for further privacy. We also heard that people’s relatives could pre-book a meal at the home and enjoy this in the privacy of a second dining area. This showed staff understood the importance of people’s relationships and their need to have privacy to maintain these.

We saw that people were asked if they needed support with personal care in a discreet manner. We saw staff respected people’s refusals and approached later which enabled people to decide if they wanted support. We saw staff had supported people to ensure their appearance was as they preferred. People’s clothing was well laundered and appropriately fitted. People’s personal grooming including nail care was observed to be maintained. Some ladies had been supported to wear their jewellery as this was important to them. We saw staff adjusted people’s clothing to protect their dignity when assisting them with the hoist. One gentleman told us, “They [the staff] help me with a shave, they are very good”.

Visiting times were flexible and staff made people’s relatives feel welcome. One person told us that their family was made to feel welcome by staff when visiting. Two visiting professionals also shared this view.

We saw that staff knew people well and what they needed to do to reduce people’s anxiety. We saw staff understood some people’s need to express their maternal needs. The use of dolls clearly provided comfort and reassurance to these people and we saw staff respected them in this role complementing them on their care. For example one staff told a person, “Well done you’ve got her to sleep now” and the person smiled.

Most people had family members to support them with decisions with their care. Information about obtaining the services of independent advocacy was available. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes.

Good

Is the service responsive?

Our findings

People were happy with the service provided. One person said, “I think it is a nice home they look after me well”. Another person told us, “They know me well and try and I’m happy with the way they look after me”. A social worker and health professional visiting the home both said they were happy that the staff tried to deliver care which was responsive to people’s individual needs.

A person told us, “Before I came here they asked me questions about my needs and when I came into the home they asked other things”.The registered manager told us and records showed that prior to people moving in an assessment of their needs was carried out. We saw that people and their relatives were involved in this process. A visiting social worker confirmed that staff had obtained all the person’s wishes and preferences and had provided care in a way that met the person’s needs.

Staff were able to tell us about people’s individual support needs. They knew about people’s daily routines, preferences and how they liked their support to be provided. People told us that they were involved in care planning and we saw that care plans were very detailed and personal to the individual. They provided information in a way that showed the person’s preferences and how their medical condition might impact on their life. For example we saw how a person’s mood may affect their decision making and how staff should approach and support the person. We saw staff followed this to guide them in supporting the person. We saw they respected the preference of the person to have time on their own and that they responded with minimal contact unless the person initiated this. Staff told us this helped them to reduce the anxiety that led to the person becoming agitated. We saw that people’s care plans were reviewed regularly and we saw changes were updated and staff were kept informed at staff handovers.

We saw on both days of our inspection that people were engaged in different planned activities; we saw people responded really positively to a Gospel singer who regularly visited them. People joined in the singing, clapped and tapped their feet. We saw spontaneous fun and games with some people enjoying ‘catch’ with a ball. One person was sitting with a metal type puzzle provided by staff and told us, “I like things like this not the group type things”. We saw there was a poster displayed with a variety of activities planned for the month. People told us their ‘favourites’ were discussed with them in meetings. We saw staff spent meaningful time chatting with people and there was very little reliance on the TV. People looked alert and happy. People’s religious needs had been catered for. We saw staff were able to describe how they observed particular rituals. There had been a death in the home on the day of our inspection and we saw staff were observing and respecting the deceased person’s religious wishes.

Some people told us they knew about the complaints procedure and would feel confident to raise any matters of concern. A number of people would be unable to say if they were unhappy. Staff told us they would advocate on behalf of people if something upset them. The complaints procedure was on display in the entrance hall but this was not in a large print or pictorial version which would enable people with poorer sight to access this. The provider had a system for responding to complaints so that corrective action could be taken. A complaint had been made about the service however the outcome of this complaint, [which was recorded in a person’s care records] was not documented. Without this detail the provider may not be able to identify patterns or trends to alert them of action they may need to take. We saw the majority of people would need someone to advocate on their behalf. The registered manager had displayed information about advocacy so that people and or their representatives were aware of this support.

Good

Is the service well-led?

Our findings

The registered manager was visible around the home and she spoke with and interacted with people. One person told us, "We see her every day and she asks me how I am".

There was open communication with people because the registered manager and her team regularly spoke with people and visitors about their satisfaction. We saw that people were involved in quality assurance because compliments had been received from people, their families and external professionals via surveys, comment cards and a compliments book. These showed people's views had been captured and that they were happy with the service provided. A number of compliments were evident in the compliments book indicating families and visitors had the opportunity to provide their feedback.

Staff meetings had taken place on a regular basis and staff told us this enabled them to share their views and opinions as well as learn about new initiatives. We saw that information had been communicated effectively to staff via staff meetings so that this could be used to improve the quality of the service. For example the registered manager had implemented a falls risk assessment and monitoring tool to further enhance people's safety. Staff told us the registered manager provided them with support and that they could approach her to discuss any concerns they had. One staff member said, "She does get things done and we know what is expected from us".

There was a clear leadership structure which staff understood. In addition to the registered manager there was a deputy manager and senior care staff who had delegated responsibilities. Staff said they could contact the registered manager if they needed assistance. We saw the provider regularly visited the home to oversee how the service was being run and we saw from our discussions with them that they were aware of events within the home and had offered support to the registered manager.

Staff were familiar with the provider's whistleblowing policy and safeguarding procedures and how to raise any concerns to external organisations if people's care or safety was compromised. The provider met their legal requirements and notified us about events that they were required to by law. This showed that they were aware of their responsibility to notify us so we could check that appropriate action had been taken.

The provider and registered manager had kept themselves up to date with new developments and requirements in the care sector. Our discussions with the registered manager showed they were aware of the new Care Certificate and they told us they were planning to introduce this with new starters to improve the induction process. The registered manager was aware of the new regulation regarding the duty of candour.

Whilst the registered manager was able to tell us what action had been taken in response to any complaints some improvement was needed to ensure all complaints were reviewed and the action taken in response to them was recorded.

We saw the registered manager carried out weekly and monthly checks on the quality of the service and shared these with the provider to ensure any shortfalls could be identified and action taken to reduce risks to people's safety. Checks on people's medicines, accidents and falls were evident. Whilst there was a detailed record of incidents maintained in people's daily records, the analysis of these needed further development to show action the registered manager was taking and how decisions were reached where people's safety could be compromised. We saw that the registered manager had reviewed people's care records and we saw these were detailed and personal to each person and contained sufficient details to guide people's care and review the delivery of care to people.