Care Quality Commission

Tamaris (England) Limited

Amelia House Care Home

Inspection report

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Date of inspection visit: 1 and 7 April 2015.
Date of publication: 15/05/2015

Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

The inspection took place on the 1 and 7 April 2015. The inspection was unannounced. At the last inspection the service was fully compliant with the regulations we looked at.

Amelia House Care Home provides care for up to 81 older people. It is a purpose built three storey property located in a residential area on the northern outskirts of York.

The home does not currently have a registered manager although a new manager has been employed. 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.

During our inspection we identified two breaches in regulations. This related to the way risks were managed and to medication practices. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

People told us that they felt safe and we saw that staff received training in safeguarding vulnerable adults.

We found that risks were not always appropriately managed which meant that people's safety may be compromised.

We received mixed views about staffing numbers. People expressed concern regarding the high number of agency staff being used and said that this impacted on care delivery. Although a recruitment drive was in progress the management agreed to 'block book' additional staff from an agency until more staff have been employed.

We found that people using the service were not safe because they were not fully protected against the risks associated with use and management of medicines. People did not always receive their medicines at the times they needed them or in a safe way.

We found that infection control practices were not always robust and observed some poor examples of infection control during our visit.

Each person living at Amelia House Care Home had an assessment and care plan. These documents were generally well written and provided detailed information. Some areas did require review and updating.

Staff told us they received induction, supervision and training. Some staff told us they would benefit from additional training particularly in core topics, for example, dementia and supporting people with distressed behaviour.

Mental Capacity assessments had been completed for some people living at the home and some staff had received training in this area. Additional training may be required for the remaining staff.

Staff told us they required additional training in dementia care and training and support in managing distressed behaviour.

The dining experience for people did not always promote good person centred care or a relaxed social opportunity which people could enjoy.

The environment was being refurbished and we were told would be more 'dementia friendly'. However this work was in the early stages.

We some good examples of people being cared for and some negative ones. We saw people being ignored and we heard people being referred to in a negative manner. We also observed staff who were pleasant, kind and caring in their approach to people.

We found that care was very task focused and that staff did not make the most of opportunities to sit and talk with people. We saw staff knocking on doors before entering people's rooms and speaking to people politely.

The home had a programme of activities taking place and we saw people engaging in a range of activities.

The complaints procedure was displayed and most people said they would feel confident in raising concerns with the manager. Some people felt that feedback between the manager and relatives could be improved further and it was hoped that more meetings would take place and more information be displayed as some people did not feel that concerns raised were fully addressed.

The home had a new manager who told us they were intending to apply for registration at the service. We received mixed views about the manager; some very positive but some that was less positive.

The home was going through a major period of change which can be unsettling for people living and working at the home. Some people said that they could see improvements yet others felt that this was less evident and they were taking too long.

A number of audits and monitoring systems were being introduced which the manager told us would address some of the concerns raised during our visit.

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?

Inadequate

The service was not safe.

Risks to people were not always appropriately managed which meant their safety could be compromised.

Staffing levels were not considered appropriate to meet the health, safety and well-being of people accommodated and may need to be reviewed.

People did not always receive their medication safely and in line with current guidance and practice.

Is the service effective?

Requires Improvement

The service requires improvements to be effective.

The manager was aware of the Mental Capacity Act (2005) and the need to determine if care or treatment was being provided in people's best interests. However staff were not always clear of the principles of the Mental Capacity Act and had not always received training to enable them to support people who were unable to make decisions for themselves.

People's experiences at mealtimes did not promote person centred care. Mealtimes were not pleasant social experiences.

Is the service caring?

Requires Improvement

The service requires improvements to be caring.

People told us they were generally treated with dignity and respect although we found that care was sometimes very task based.

Some of the practices observed during our visit may impact on people's care and welfare.

Is the service responsive?

Requires Improvement

The service requires improvements to be responsive.

Care plans did not always evidence the most up-to-date information on people's needs, preferences and risks to their care.

People knew how to complain; however some people said that complaints were not effectively managed.

People were involved in a variety of meaningful activities which they enjoyed.

Is the service well-led?

Requires Improvement

The service requires improvements to be well led.

The home does not have a registered manager although a new manager has been employed.

Summary of findings

Although quality monitoring systems were being implemented some required further development so that people received feedback regarding the issues they had raised.

Amelia House 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.

The inspection took place on the 1 and 7 April 2015. It was unannounced.

The inspection team consisted of two inspectors from the Care Quality Commission and an expert-by-experience (on day one). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had specific experience of services for older people or people living with dementia. We were also supported by a pharmacist inspector who looked at medication management within the home on day two.

Prior to our inspection we looked at information we hold about the service. This included notifications and other information. We also asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed this form; however on the date of our visit we had not received it. We were given a copy on the day of the inspection.

During our inspection we spoke with 17 people using the service, 13 relatives/visitors and 17 staff. We also spoke with commissioners of the service to seek their views. We carried out a short observational framework for inspection (SOFI) which is a formal tool used to gain the experiences of people who may be unable to communicate their views to us directly.

We looked at records including five people's care records, medication records, staff training and recruitment records and records used to monitor quality within the service.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. Comments included; "I'm not aware of any abuse occurring at this home" and "I feel safe, yes." Comments from relatives included; "Mum's safe here. I've no worries about any of the possible kinds of abuse happening here. I'm here very often and have never seen any sign of it with Mum or indeed anyone else." Another person told us "My relative is safe here." At which point their relative who was living in the home made a fist, smiled and said "They wouldn't dare."

The staff we spoke with were clear about safeguarding. They had received safeguarding vulnerable adults training as part of their induction programme or as an update. They were able to describe different forms of abuse, what they would look for and what they would do if they had concerns. They all said that they would feel confident in reporting any issues to the manager or senior member of staff on duty. Staff were aware of the whistle blowing policy but had not had to use it. One person said that they had thought about using it but the staff member who they considered reporting had left.

We looked at how risks were managed. People had individual risk assessments in their care files. Risk assessments covered areas such as mobility, nutrition, pressure care and supporting people with distressed behaviour. We did find that some of the information recorded within care files was basic and could contain more detail to reflect how people's individual needs should be met.

The home had a computerised system which was used to record any incidents, accidents, complaints and near misses. This included an investigation process which detailed any lessons learnt and any actions required to minimise the potential for re-occurrence.

During the morning we saw a good example of staff responding to risks. We were given a coffee and were going to put it on the table in the entrance foyer. A staff member reminded us that with people nearby this could be knocked over and there was a risk that people could be burnt. We were struck by this staff member's foresight, vigilance and attention to people's safety.

We saw examples where risks may not be well managed. This included someone who had a pain assessment completed in May 2014 and since then they had developed a pressure sore. The pain assessment had not been updated to reflect that they may now be experiencing some pain.

We also observed one individual who had a large bruise to their face and head. We looked at this persons individual records. There was very little recorded to clarify what had happened other than a suggestion that the bruise could be an 'old' bruise. There was no evidence to demonstrate what had been done in response by the home to clarify how the injury may have occurred.

We found that in most public areas including toilets the red alarm pull had been tied up way above head height by the ceiling and out of reach of people. This meant that people may not be able to summon help when needed. We saw that one of the electrical sockets in an individual's bedroom was badly damaged. Due to possible health and safety risks regarding this we showed the manager and asked that action was taken immediately to replace the socket. This socket was replaced.

One relative raised concern regarding their relative as they were supposed to wear a supportive neck collar and when they had arrived earlier that morning they found their relative with their head slumped to one side with no support. We checked the care plan for this individual and it did state that a neck collar should be worn. The relative also raised concerns about some unexplained falls. They told us that the home did not always inform them when their relative had fallen.

This was a breach of Regulation 12 (a)(b) and (c) in safe Care and Treatment which states that you must not be given unsafe care or treatment or be put at risk of harm that could be avoided.

We carried out a tour of the premises. We saw that the home was reasonably well maintained. A major programme of redecoration and refurbishment was in progress. We saw that the lounge on the top floor was being decorated. This work was being completed at night so that minimal disruption was experienced by those living at the home. We were told that the entrance hall and corridors had been painted and that there were plans to make the environment 'dementia friendly.'

Inadequate

Is the service safe?

People living at the home and their relatives had been involved in deciding on themes which would be displayed on the walls within the home. They had chosen themes which were meaningful to them.

The home was spacious, purpose built and appeared to be well equipped. People's individual bedrooms were personalised. We could see that some people had memory boxes on their door to help orientate them to their individual bedroom.

We looked at staff rotas and talked to staff and relatives about staffing levels. We talked to staff on each of the units. On the first day of the inspection there were five carers and one nurse on duty supporting people on the second floor. However one carer left the unit as they were supporting an individual to attend a hospital appointment. This left four people on duty plus the nurse who was giving out medication. An additional member of staff arrived from another home who was not known to anyone and who said that they did not know the people living on the unit. On the first floor there was a senior carer and five care staff on duty. On the ground floor there was a nurse and five care workers on duty. We received mixed views about the staffing levels. Some people said they were sufficient unless staff were sick or on holiday. Other people said that staffing levels were insufficient; this was particularly the case on the second floor.

Staff comments included "Even when management know that there will be a shortage they don't always book an agency nurse or sometimes when they do it is someone with very little experience."

We asked staff what the impact was if staffing levels were reduced. They said that they couldn't support people to eat and drink at the same time or they would leave people in wheelchairs at mealtimes., Other staff said that appropriate moving and handling equipment was not always used and one member of staff made reference to people being 'drag lifted.' They said "No-one intentionally puts people at harm but there's not a lot of thought goes into things. Sometimes staff drag lift, they have got used to it." The staff member said that qualified staff were aware of this and then commented "You can tell it's not pain free for people, it's uncomfortable, some look very uncomfortable, people think it is quicker." We shared this with the manager during our visit.

We were told that a high number of agency staff were being used and that this sometimes impacted on the quality of care being provided. Comments included "The staff are very good but there's never enough of them. There's been a large turnover of staff. A lot of new faces. People have left regularly over the past few months. Whether they leave or move upstairs I don't know. There is so few staff they're run off their feet. Often residents are left just watching TV. My relative has sometimes had to wait thirty minutes for help to go to the toilet. Inevitably there have been 'accidents."

The provider told us within their PIR that "Within the next twelve months we propose to continue to maintain a robust recruitment drive, to identify any shortfalls in staffing at the home that are currently covered by regular agency staff. This will ensure a more continuous and seamless provision of service for residents within the home."

They told us that a recruitment drive was in progress. When we shared the feedback from the inspection we were told that additional agency staff would be 'block booked' so that additional staff were available to provide support at the home.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for eight people living in the home. Overall, we found that appropriate arrangements for the safe handling of medicines were not always in place.

We observed people being given their medication. We saw that one individuals 12.00 medicine was given on time;, however we observed the staff member attempting to feed the liquid via a spoon. Another staff member told us that it was written in the care plan that a syringe should be used. They added that the individual had difficulties swallowing and said that they sometimes mixed this liquid medicine with yoghurt too. The staff member giving the medicine then went to get a syringe so the medicine could be administered as per the guidance in the individuals care plan.

Most medicines were supplied in blister packs with clear, pre-printed MARs and it was clear to see that these had been given correctly. However, it was not possible to account for some medicines as the records were incomplete. Care workers had not always accurately

Is the service safe?

recorded the quantity of medicines carried forward from the previous month or those that had been disposed of. As we could not work out how much medicine should be present, it was impossible to determine whether or not these medicines had been administered correctly.

We saw that the medicines ordering system was generally effective and people had adequate supplies available. The majority of medicines were stored securely in locked trolleys and cupboards within a dedicated clinical room and the keys to these held safely by the nurse or senior on duty. Most creams and external preparations were kept in people's private bedrooms and bathrooms, but there were no risk assessments to determine whether this was safe and no records of the temperature at which these were stored. A care worker told us that one person would sometimes 'wander into other people's rooms and take their creams' and in two rooms we found creams that were not prescribed for the person living in that room. This meant that care workers would not always be able to find people's creams easily and therefore there was a risk that they may not be used. There was little or no information available for care workers to follow regarding how, where and when the creams should be used. When asked, one care worker told us she didn't know how the cream was supposed to be used. The records for the use of creams etc. were incomplete and it was not possible to tell whether these products had been used as prescribed.

Many people living in the home were prescribed medicines to be taken only 'when required' e.g. painkillers, laxatives and medicines for anxiety. These medicines needed to be given with regard to the individual needs and preferences of the person and would not necessarily fit in with the main medicines rounds. There was not always clear information available for care workers to follow to enable them to support people to take these medicines correctly and consistently.

The service had a policy for keeping and administering 'homely remedies' – medicines that may be given without a prescription. We saw that some stocks, including paracetamol 500mg tablets, had originally been prescribed for people living in the home and the labels had been crossed out or removed. This is unacceptable practice and we reminded the manager that the service must purchase medicines intended for this use.

The manager showed us audits (checks) that had been carried out to see how well medicines were handled. She told us a new system for auditing was to be introduced shortly. It is essential to have a robust system of audit in place in order to identify concerns and make any improvements necessary to ensure medicines are handled safely.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely. This was a breach of Regulation 12 (f) & (g) in safe care and treatment

We looked at infection control practices across the home. People told us and we saw that the home looked clean and there were no unpleasant odours noted during our visit. There was a domestic on duty on each floor of the home each day.

Staff told us that there was a problem with the ordering of disposable gloves which meant that they had almost run out. One staff member said that they didn't have the correct size for their hands and another staff member said that they had had to go down to another floor to get some. They did say that there had been **"**A mix up with the delivery and that there was a shortage of gloves."

We did see care staff carrying out domestic duties on the second floor. They told us that this was because the domestic who should be working was re-decorating the home at night. We spoke with a domestic who told us they had a range of cleaning duties to complete each day.

We saw that a number of cleaning audits were completed and that the manager had introduced other audits to monitor the control of infection. This included things like mattress audits.

We saw some examples of poor standards of infection control. We observed a staff member serving cake to people. They were not wearing gloves and were putting cake into people's mouths and then going to the next person without washing their hands in between. We shared this with the manager during our visit.

We recommend that the home considers The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

Requires Improvement

Is the service effective?

Our findings

People told us that staffing levels were impacting on the effectiveness of the service. They told us that the number of agency staff being used was impacting on care delivery.

One person initially raised a concern about the equipment available; they said "My only issue is that my relative needs her own wheelchair to get around. She likes to go to Tesco. In the past she's had to share one that was rickety, pinched and catching. They need to get a new one and one just for her in her own right." They then went on to say "I'd better just check they haven't got her one." They looked in the en-suite and saw there was a brand new wheelchair sitting there. "There you go then. That's progress. We can go to Tesco again now."

We asked for a copy of the staff training plan and record. We were shown a copy of the online learning portal which is used to record the training staff had received. This highlighted when any training was due to run out. The training included a number of different topics. Examples included malnutrition care and assistance with eating, equality, diversity and human rights, dementia care, infection control, medication awareness, safeguarding vulnerable adults, MCA and DoLS. In addition to the core training provided, service specific training was also planned. This included training in topics such as positive behaviour support and dementia awareness. One member of staff told us "I have had manual handling, first aid, health and safety and fire training."

Staff told us that they had undertaken induction training and said they had received regular updates for mandatory training. However, the majority of staff spoken with said that they had not received training in how to support people with dementia. Some staff said that they had not had any recent training. One carer said that they have been promised additional training but had been told it's "When we get the staff" And another member of staff said "I haven't had any training this year and I couldn't tell you when I last did training."

One relative said. "All the training and the qualifications don't count for a lot if you don't have the patience. There's been a marked improvement, my mum gave them a note saying what he likes, and told staff that noise upsets him. He's happy sitting watching people come and go. They do seem competent with lifting and using hoists, he's always clean." We observed staff moving this gentleman using a lifting belt and they explained to him what they were doing throughout.

Care staff told us that they had received regular supervision from the nurse on the unit. One staff member said that further training had been discussed with them including the potential for undertaking their level 2; they were not sure what this meant but said that they would like to undertake further training. We were shown records to confirm that staff were receiving regular supervision.

Some people raised concern about the communication skills of some of the staff working at the home. They told us this was frustrating and we did observe people shouting out for help and staff failing to respond appropriately.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. The staff we spoke with said they had not received training in this area although they were able to give examples of when this legislation may apply. We saw that mental capacity assessments had been completed and were held in people's care files. The manager showed us recent applications which had been made and were due to be sent to the local authority. This demonstrated that people's mental capacity was being considered. Some staff members were aware of the concept of DoLS but not what mental capacity meant. Other staff seemed to be vague about DoLS and what this meant in terms of restricting people's liberty.

We recommend that the provider considers whether additional training for staff is required in this area.

We saw some examples of staff supporting other people to make decisions. This included decisions about their meals or about the activities they wanted to participate in. A carer told us that people had a choice about when they got up and went to bed and said that staff would support them in choosing what clothes to wear.

We asked people how they supported people with distressed behaviour. We saw from the PIR that only ten people had received training in positive behaviour support and no staff were recorded as having received training in

Is the service effective?

control and restraint. This meant that staff may not have the skills and knowledge necessary to support people. Staff told us that they would benefit from further training in understanding how to support people with dementia. They said that they had been booked on to a course in the future but were unaware of the dates of this. One staff member said that most difficult thing about the job, was knowing how to manage different behaviour displayed by people. "There's been no full training in how to handle aggression, I'm just used to it now, it's not about me, they can't help it but we don't manage it, it would be good to have effective methods, there's so much more I could do."

We recommend that the provider considers whether additional training for staff is required in this area.

We observed the dining experience on all three units on the first day of our visit and on one unit on the second day of our visit. We saw that people were offered plenty to drink both during and after their meal. People on all of the units were offered a choice of food. This involved staff taking both plated menu options so that people could see visually what was on offer.

We saw both positive and negative examples of staff interactions during lunch. Some staff made real efforts to talk with people and to interact with them during mealtimes. Others did not make the most of the opportunities given to them to interact with people and to make the dining experience a social experience.

We observed staff across the units supporting people with their meals. Generally we found that staff members took their time and were patient in slowly and carefully assisting people to eat their meals. That said, we found that assisted feeding was rather mechanically done with very little verbal and indeed non-verbal communication.

However, during our observations of lunch on the first floor we observed the following. We saw that some people were asleep at the table and no effort was made to remove them from the table or to take them to bed. We observed a staff member stand next to someone, offer them a fork full of food then move to another person on a different table and do the same. This did not promote people's dignity and did not support good person centred care. We observed some people eating their meal with their fingers. Where people require finger food it may be beneficial to offer them a choice of suitable food which could be picked up easily and eaten by hand.

We observed a member of staff offer an individual some sauce to put over their main course. They handed the individual the bottle of sauce and whilst this person found the process rather awkward, it was positive that they had been given choice, control and independence to do things for themselves and in the way they wanted.

People told us about the effective, timely healthcare they receive from doctors, opticians, chiropodists and other allied health professionals. We were told that the doctor did a weekly surgery at the home.

The home was spacious. Most furnishings and carpets looked clean. Most bedrooms seemed very homely and were well personalised by people. The bedrooms and communal rooms were all situated on one floor. There were 2 communal lounges and 1 dining room. Corridors were wide enough for the access of wheelchairs. Floor surfaces appeared to be smooth for people to be able to wheel themselves around the building. One lounge had been adapted to be a cinema with a large screen, red curtains and film memorabilia. Staff we spoke with said that this was used although one staff member said that the red carpet was not a good colour for people with dementia.

We saw that an extensive programme of redecoration and refurbishment was underway. That said, we thought the corridors were rather dull and bare, with only a few generally uninspiring prints on the walls. We saw some attempts by the home through signage to respond to some of the needs of people living with dementia. We heard about the activity coordinator's heightened awareness of sensory stimulation but there was little to evidence that the home was demonstrating good dementia care practice. Although the manager and staff were able to tell us of plans to make the environment 'dementia friendly' this work had barely commenced.

Requires Improvement

Is the service caring?

Our findings

One person said "Staff (name) looks after my relative very well" They then added that other staff were also wonderful."

We saw both positive and negative examples of person centred care during out visit. Some of the observations completed during our visit did not support a person centred ethos of care towards people living at the home. For example, we heard some staff referring to people as 'feeders.' This labelling does not promote people's personhood or respect people as individuals.

Whilst standing outside a bedroom we observed a staff member cleaning an individual's room. The person was in bed. The domestic did not speak to the individual throughout the cleaning process, not even when the person shouted out "Who is that."

During our observations in communal areas, although staff were present they did not always respond to people when they requested help.

One person said "I'm a bit deaf so have to use a hearing aid. Well it went wrong a while ago so I asked the nurse to look at it. She said it needed new batteries. It may have but there was something else wrong with it too. The nurse wouldn't have it. It's got a little bit better with the new batteries but it's still not right. I'd still like it looked at."

One person told us that upon returning from hospital they were met by a staff member who had an "angry attitude" towards them.

A relative said "We sent mum a card and package for mother's day. Mum got the card and a member of staff told us they remembered seeing the package in the Home but Mum never got it. It's worrying."

Although we found that throughout the day we some many instances of carers providing 'practical' help to people, we did not see carers sitting with or talking more leisurely or for any meaningful period of time with people. Care was observed to be very task based and we saw lots of lost opportunities where staff could have sat and interacted with people.

We spoke to a relative who said that their relative was really looking forward to the imminent bingo session in the lounge. She was somewhat concerned however that time was moving on and no carers had come to transfer their relative into a wheelchair so they could get to a session.

The relative walked with us to the room where the session was being held and found that it was well underway. They said "I guess the carers must be busy helping other residents." We noticed that a further five minutes passed before the person was brought in to join the session. We later asked the activity coordinator why staff hadn't ensured that people got to the start of the bingo session. They said "I asked staff to collect residents for bingo but they must be busy and it all got delayed."

Throughout the day we noticed that staff always knocked on people's bedroom doors prior to entering, which was a small but important sign of respect by staff to residents. Later, standing by a closed bedroom door we overheard a staff member talking to a person in their room. They were providing personal care. We were struck by their personable, caring and patient manner. We saw an example of a carer encouraging independence for an individual during lunch. A relative told us "If my relative needs help the staff are pretty fast in coming. They pop in to check on the problem and if it's not urgent say 'I'll be back in a couple of minutes'. That's fine as far as I'm concerned."

During the afternoon we noted another positive example of staff providing care and support to an individual. The person was distressed and we asked staff to come and provide some assistance. They handled the situation very well. They spoke in a gentle reassuring voice telling them that they had just woken up, reminded them where they were and gave them a choice as to what they wanted to do. This was not a rushed conversation and it took approximately 10 minutes for the staff member to provide the individual with support so that they could calm down, orientate themselves and decide what they wanted to do. We later spoke with this staff member and it was clear that they knew the individual and their current needs and issues well. It was clear from this conversation that the staff member was trying to value and empower them.

We saw some positive examples of carers involving people. Some staff who we observed during the day were caring and when they spoke with us they demonstrated their knowledge about the people they supported. They were

Requires Improvement

Is the service caring?

able to describe people's needs in detail. We observed staff interacting and found that some staff were patient, talked kindly with people and had jokes and banter. One staff member said **"**I do care about them and you have to think that they could be your own parents."

Carers told us that **"**Resident of the day**"** had started the day before the inspection. When we asked what this involved we were told that it was ensuring that the person was showered and dressed, sorting out their wardrobe and changing their bedding. They said that already it was a struggle. When we asked whether it involved any social or emotional support or activities they said that they didn't think so. It was about ensuring the person was tidy and their room was sorted out.

We spoke to the manager and other staff about "Carer of the day". They told us that this had been implemented so that time could be spent reviewing everything to do with the individual. Their care records would be checked to see that they were up to date.

We saw signs welcoming relatives that visited the home and people confirmed that they could visit anytime. They said they hoped to develop a monthly newsletter to update people on news and developments within the home. The manager told us within the PIR that people had access to an external advocacy service if this was required.

Staff gave examples of the ways they promoted privacy and choice and how they aimed to ensure that people's independence was maintained. The care plans we looked at referred throughout to practical ways in which people's need would be met.

Requires Improvement

Is the service responsive?

Our findings

People received a full assessment prior to moving into the home to check that the service was right for them. We looked at five people's care records and saw that each of them had an assessment prior to them moving into the home. This helps to make sure that the home was able to meet their needs.

One relative told us he wanted to look at a number of homes but in some he had to wait whereas this home invited him to visit "Anytime you like." He then went on to say "I had a very positive first impression. The staff greeted me personally. There were no smells. The entrance foyer looked lovely. Staff looked happy. The manager was good. They were redecorating the home; the Café was a great place to go for a sociable coffee in nice surroundings. They've got a movie room and the residents are active and do things. Mums bedroom is even better than the one she's got at home. I liked this place so much I told the manager 'I'll take it now'."

We saw that each person living at Amelia House Care Home had an assessment and care plan which recorded the way in which their needs should be met. The care plans that we looked at were detailed and described how people should be supported. There was information about people's individual needs and the plans were being reviewed on a monthly basis.

However we found that some sections of the care plan had not been signed or completed. For example, in one care plan we looked at the 'This is me' section was completed but there was no signature or date to say when it had been completed and who had been involved. The DoLS checklist had been completed but was not signed and there was no signature to tell who had completed this. In another care plan, we saw that the needs assessment was blank, as was the monthly dependency score. Staff told us that they knew care plans needed updating but said that staffing numbers and the high use of agency had meant that some had not been reviewed or updated.

We saw input from relatives in some sections of the care plan where people did not have capacity. This included 'This is me 'documents and information about the person's dementia and the impact this had on them. This information is important as it helps staff see the person and not the diagnosis. It also provides information which can enable staff to relate to people, for example, information about things they had done in their past or important information about their family.

We spoke with a relative who told us their relatives care plan was locked in a room and that they could only read it in the presence of a staff member. They told us that they had contributed to it initially but also said it required updating.

We saw very little to demonstrate that people were involved in discussions regarding their care records. For example, staff sat in communal areas when writing their daily updates but they did not sit and chat to people while doing so. We felt they could include people in discussions about what they had done that day.

People spoke highly of the activities co-ordinator and were generally complimentary about the social opportunities available. Comments included "They have days when singers come here but we haven't had one for a while" and "People go out in the minibus. The cinema room is fabulous."

During both days of our visit we observed activities taking place. We observed a bingo session taking place on our first day and saw that it was well attended by people and their relatives. The atmosphere was relaxed and people were engaged. We also saw that the activities co-ordinator spent time on a one to one basis with some people. We saw an individual doing some sewing as this was something they had enjoyed previously.

We later spoke with the activities co-ordinator. They told us they worked full time Monday to Friday. In addition two other staff supported with activities; one full time and one part time. Consideration was also being given to activities hours being allocated during the weekend.

The activities co-ordinator highlighted the importance of both organised small group activity and 1:1 work with people in their own bedrooms. We were shown a grid used to map out the involvement of each person who had participated in either group or individual activities over a month. This helped to identify people who may be vulnerable to social isolation.

We were told that a range of activities were provided. This included visiting choirs and singing, pet therapy, floor based snakes and ladders, chair aerobics, bean bag target

Requires Improvement

Is the service responsive?

shooting, velcro stick on games, and activities that tested and encouraged residents to match three dimensional shapes to particular shaped nets. We were also told that people were involved in baking and in the cinema on the top floor they hired 'sing-along' versions of famous musicals like Carousel.

We asked about outings and trips. We were told that the home owned its own minibus but that the only person able to drive it was the handyman who had limited time to undertake this work.

We also asked about specific activities for people living with dementia; we were told about a battery operated cat which moved in particular ways and whose coat has several different textures. People were encouraged to hold, touch, stroke and talk about the sensations and memories that this reminded them of. We were also told of different herbs being placed into old film reels, so that people could smell a number of different pots each containing different herbs and ingredients and match the same smelling pots together.

The complaints procedure was displayed in the entrance foyer and most people we spoke with confirmed that they would feel confident in raising any issues with the manager or staff.

We saw that only one complaint had been received since Christmas 2014.

One relative we spoke with said that she had no need to complain as she and her mother spoke with staff or the manager directly if anything needed to be discussed and things were always sorted out.

It was not always evident how the manager demonstrated responsiveness to feedback from relatives and people living at the home. Some relatives told us about not routinely being kept in the communication 'loop' by the home. We were told that only one resident/relative meeting had taken place and some people said that they felt the home failed to respond to issues raised.

It was disappointing to see that the customer survey displayed in the foyer was one from two years previously; it was fairly inaccessible and in print so small people struggled to read it. The manager told us that the new iPad (mini computer) system would help to counteract this as it meant that any relative or person living or visiting the home could leave feedback there and then. However it is still important for the manager to provide relatives and people living at the home with updates and information.

One relative said "Apart from lack of staff in the home my other big issue is the laundry. No matter that we label everything, almost inevitably it falls off. That's the time I see my relative in someone else's clothes." Other comments included "We could raise issues definitely, laundry is a bit of a problem and sometimes the tea trolley can be cold by the time it reaches my relatives room. Otherwise we are pleased Mum is here."

Requires Improvement

Is the service well-led?

Our findings

People provided mixed views about the home; comments included "I'd recommend this home. The staff are very caring, nice people… well 99% of them are. They take an interest. They don't have enough time though and seem pushed for time, it's clean and tidy. The staff work very hard. The only thing is its different staff all the time. Staff I don't recognise. It's a very good home on the whole. I'd like to see more of the manager and I'd wish they'd not play programmes like the Jeremy Kyle show and pop music programmes in the lounge. I don't think it's right for residents to see and hear some of that in the lounge." Another person said "The staff are marvellous. The best thing about this home is the quiet. It's beautifully clean. The foods ok. The lounge and dining rooms are lovely. The staff are very good. Mind you they've not got enough time to listen to your goings on. They listen but they're too busy. Look they're redecorating the home. There are lots of activities. They always ask me to join in but if I'm not in the mood I tell them 'Go away. I'm not in the mood.' Could I recommend this home? Yes I could."

The home had employed a new manager who was not yet registered with the Care Quality Commission. The manager told us that they were in the process of applying for their Disclosure and Barring Service check (DBS) so that their application could be submitted.

The manager and staff told us that the service was going through a substantial change process. The new manager had been in post for approximately six months and they were generally valued by visitors and relatives. A programme of refurbishment and redecoration was well underway. People told us they thought the home was heading in the right direction and that the quality of resident experience was being enhanced. One person told us "(Name) is a remarkable manager; she has a great vision for this place." They added, "She needs to let her staff know how valued they are, the staff also need to know that they're really, really good." Another person said "The manager does listen if you speak to her. She is fantastic, you can approach her. Staff could be involved more in discussion - that would be a good idea."

However, not all of the comments regarding management were so positive. Some staff told us they did not feel valued. Comments included "It's hit and miss, I don't feel we're appreciated, it's not often shown." They then went on to say that they did have 'carer of the month' which was "a token to say thank you when you've been run off your feet all day." Other comments included "The manager is critical rather than supportive, sometimes in front of other staff" and "This floor (the second floor) is very isolated. This is the floor that everyone dreads working on" and "You don't feel you can say what you want to say as there is politics between the management and nurses."

We asked what improvements there had been since the new manager had been in post. One carer said there had been slight improvements, changes to carpets, some decoration, and more equipment. A relative said "It's been a lot better in the last nine months or so. The manager appointment was a big plus; we'd met her before, as she worked here previously." They went on to say that "Staffing seems to be more consistent, they used to swap people around the floors, it's really important that you have consistency in the staff."

We asked people if they received feedback about the service. People made the following comments: "Once every month or couple of months there's a meeting with residents and relatives held in the dining room. I've raised the laundry issue but nothing's happened." Another person said "Survey? They ask you some questions about once a year. I don't think I've ever seen the results." We saw that 'You asked, we did' was displayed in the foyer; however the print was so tiny that it was almost impossible to read.

We were told that some meetings had taken place; however minutes for these meetings were not always available. This included a relatives meeting held on 11/12/14 (minutes unavailable), a night staff meeting held in February 2015 (minutes seen) and clinical governance meetings which had taken place in November 2014 and February 2015 (minutes seen). We were also told that staff meetings did take place but no minutes of these meetings were available.

One relative said the only time they could recall there being a meeting of relatives/residents was the previous October. They said that the meeting had taken place as relatives specially requested it and added "Even then reportedly the homes manager asked a manager from 'head office' to chair the meeting." We asked what issues were raised at the meeting and what actions had been taken by the manager

Requires Improvement

Is the service well-led?

as a consequence. They said "They promised to sort out the gardens, but nothing had happened. There should also be more things like coffee mornings." Another relative said "(Name) is fairly visible; we speak with her straight away."

The manager told us that senior management visited the home approximately every 6 weeks. We were told that an audit had been completed during the last management visit; however despite asking for a copy of this audit on both days of our visit, it was not provided.

We were told that surveys were sent out from head office. We asked for a copy of the summary of the results of this survey. However this was also not received.

We were told that a number of audits were completed by the manager. We were shown copies of all of the audits which had been completed in January 2014. This included weekly mattress audits, cleaning schedules, audits on bedrails, hoists and wheelchairs, resident admissions, environmental audits, nutrition and falls. In February 2015 we saw that audits had been completed on care plans. Where areas for improvement had been identified action plans were put in place. In March audits had been completed on medication, the environment, food safety and mattresses.

People provided mixed views regarding their involvement in the service. We were shown some evidence of quality monitoring systems. However these were in the early stages of development and it was difficult to measure what actions had been taken in response.

The managers told us that a new 'iPad' system was being introduced where anyone visiting or working at the home could leave a comment. This would then be looked at by senior management so that any required action could be recorded.

We asked the manager if they followed any best practice models and they told us they were going to implement the provider's accreditation scheme 'Positively Enriching And enhancing Residents Lives' (PEARL) to improve the lives of people living with dementia.

We asked one relative if they would recommend the home. They responded by saying "Well it would depend on which floor you were talking about. When Mum came in here she was on the top floor. She came in walking and talking but she deteriorated rapidly up there. They didn't take her teeth out at first and when they did they lost them. However since she's been put on the ground floor she's back to her old self - smiling, lovely self. And she's not distressed anymore. She's more content in herself. Both she and things generally have improved here over the last six months. The manager is nice with residents. The staff know her and the manager is nice to her. My only complaints are that when I visit after a long journey here they never offer me a cup of tea or anything. They also don't communicate with us very well. We ring up and they just say "She's fine". That's not good enough for me. I need to know the detail."

Another relative said, "Overall the best things about this home are firstly the staff who are generally young and friendly and mums bedroom which is bright and has nice views out of the window. The main issues are that there is not always staff around. The buzzers are going off and it can take ages to sort it. Things are changing in the home though. There's more communication now since the new manager's here."

Some people told us they would recommend the home. Comments included "Yes I'd recommend it, the carers are lovely. The meals are nice and my rooms lovely." The relative of this individual then added "Help's on hand if they need it and the staff are cheerful. My relative is well looked after here. She had her hair done yesterday, has regular manicures and also has a pedicure. She also had new glasses when she needed them and if she needs the doctor that's all organised too." And "Yes I could recommend this home. This is a nice place. It's very good. The foods fine. Meals are regular. Mum's day passes quickly. She gets her hair and nails done weekly. There's is a lack of reading material and she could do with more stimulation, maybe an arty activity. She is routinely cared for if she's ill and has her tablets." However others were less complimentary and said that they would not recommend the home to their family or friends.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **(a)(b)(c)** **People must not be given unsafe care or treatment or be put at risk of harm that could be avoided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **(f) and (g)** **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely.**

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.