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

Date of inspection visit:
30 June 2020

Date of publication:
19 August 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Amberley House Care Home – Stoke-on-Trent is a care home providing personal and nursing care to up to 74 people. At the time of the inspection there were 46 people living there. There are three separate units accommodating people with differing needs. Some of the people living in the home are living with dementia, mental and physical disabilities.

People's experience of using this service and what we found
The provider had consistently failed to make improvements that were effective or sustained. People were exposed to an extended period of poor-quality care and the service had continued to be rated less-than-good. Systems to monitor the safety and quality of care were ineffective and did not always identify areas for improvement.

People were not always being protected from the risk of cross infection. Risks to people's health and well-being were not always adequately assessed and planned for. Care files contained inconsistencies which put people at risk of receiving inconsistent care. Lessons were not always learned when things went wrong. Medicines were not always managed safely. Staff were not always deployed effectively so they did not always have time to spend with people and to keep up to date with people's changing needs.

People were protected from intentional abuse by staff who knew how to recognise and report concerns. The provider worked in partnership with the local safeguarding authority to report and act upon concerns raised. The provider acted upon their duty of candour responsibilities.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 September 2019) and there were three breaches of regulation. The provider was required to send us monthly updates about actions they had taken following the last inspection which we reviewed and was used to help us plan this this inspection. The update was about how they supported people to feedback about their care, medicines checks and action taken in response to medicine error. At this inspection, enough improvement had not been made or sustained and the provider was still in breach of regulations.

This service has been rated requires improvement for the last six consecutive comprehensive inspections. This will be the seventh consecutive time the provider has failed to achieve a good rating in safe and well-led.

Why we inspected
We received concerns in relation to how people were being supported with their nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained requires improvement overall, however the rating for well-led has deteriorated to inadequate. This is based on the findings at this inspection.

Enforcement
We have identified continued breaches in relation to the safe care and treatment of people and the monitoring and sustainability of quality and safety at this home.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Amberley House Care Home - Stoke-on-Trent

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions following concerns being raised by the local authority. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one assistant inspector.

Service and service type
Amberley House Care home – Stoke-on-Trent is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, however they were not present on the day of inspection. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The local authority told us they had concerns with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service. We were unable to speak with relatives as care homes are not accepting visitors due to the pandemic. We spoke with eight members of staff including nurses, senior care workers and care workers. In addition to this, we also spoke with the four members of the provider's management and quality assurance team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional care records, building safety records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks were not always accurately assessed and planned for. Information in care plans and risk assessments did not always match people's needs.

● One person needed a modified diet to reduce their risk of choking. There was guidance from a Speech and Language Therapist (SALT). However, records were unclear as to how thick fluids should be for the person and the consistency of their food as the instructions from SALT were different on different documents. This meant there was a risk they may not have the correct consistency for their needs. We observed the person being supported in the correct position, however we had to explore with the nurse what the correct guidance should be as they were not clear and there was a risk they may be supported inconsistently.

● The same person also needed repositioning to prevent their skin deteriorating. However, the person's care records were inconsistent about how frequently they needed this support. Their mattress was also on the wrong setting based on their weight. The person had wounds on their skin which were slowly improving. However, it meant there was a risk they may not be repositioned frequently enough to maintain their skin integrity and the mattress may not protect them correctly which could hinder their recovery. Another person's records showed they were not always being repositioned frequently enough which could put their skin at risk.

● One person was having their health condition monitored. One care plan stated a check was required four times a day and another stated twice a day; it was being checked twice a day. The plan specified certain extra checks needed to be carried out if there were particular results, but there was no evidence these extra checks were carried out. If the person regularly did not have their condition adequately checked, their long-term health could be at risk of deteriorating.

● Changes to people's mobility were not consistently reflected in their care records. There were two examples where people's mobility had reduced, and a hoist was required. However, other records stated they were more able and made no mention of a hoist. Whilst we observed staff supported them appropriately, there was a risk they may not always be supported in a way that met their needs. There may also be a risk people may not be appropriately supported in an emergency as inconsistent information was available for staff or those who may attend in an emergency.

● We observed one example of poor moving and handling. One person was supported to stand using an underarm lift. This can cause injury to the person or to the staff members and is not safe. We fed this back to a senior member of staff and to the provider and they agreed to follow this up.

Preventing and controlling infection

● People were not always protected from cross contamination. Due to the COVID-19 pandemic, extra measures were in place to keep people safe, however the application of these measures was not always

consistent.
● For example, there were areas, called 'stations', in the home where staff and visitors could wash their hands, put on and take off personal protective equipment (PPE) such as masks, gloves and aprons. However, it was not always clear where the 'stations' were, and they were not always located in convenient locations. Staff were unclear where some of the 'stations' were, and multiple staff told us signage had disappeared. The provider agreed to review this following our feedback.
● In one unit there were items in the corridors and on the walls that would be beneficial to calm or entertain those who have dementia. However, they posed an infection control risk if multiple people were to touch them and they were not cleaned in-between those touches. There was no system in place to ensure this was monitored and no records to show they had been cleaned. We were told by staff that cloth items were washed weekly, and non-cloth items were cleaned daily. However, there were no records to confirm this, and this may not be frequent enough should someone who had an infection or virus were to touch them. The provider agreed to review this following our feedback.
● A hoist was being shared between separate units. This was not decontaminated between being moved between the units. This posed a risk of cross contamination to people.
● Staff were applying the use of PPE differently between units. Some staff would wear gloves whilst supporting people to eat, but others would not which was not in line with guidance. Some staff had their masks below their noses, which did not afford sufficient protection. One staff member took their mask off and hung it from their ear and put it back on again; however, this is not in line with PPE guidance and put people at risk of cross contamination. We fed back our concerns to the provider and they agreed to review practice within the home.

Learning lessons when things go wrong
● Lessons were not always learned when things had gone wrong. This was the seventh time the provider had failed to make improvements to the area of safe and they had never been rated good or more, in this key question.
● Some incidents had occurred, but it was not always clear what action had been taken to reduce the risk of an incident reoccurring and staff were not always aware of this.
● For example, one person had their arm trapped in a call bell cord and was leaning over their bed rails. Staff made the person safe at the time of the incident. However, their care plan had not been updated and staff were not aware of the incident to know to check this person was safe.

Using medicines safely
At the last inspection there was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always managed safely. At this inspection we found some improvements had been made in relation to medicines management however, there continued to be concerns so the provider remained in breach of the regulation.
● Medicines were not always managed safely. A recent audit had taken place by the provider which had identified areas of concern and acknowledged that not all of the issues found at the last inspection had yet been resolved. We checked stock levels which generally matched compared to the Medicine Administration Records (MARS). However, we found a medicine error which had not been dealt with and there was no clear action taken to ensure another error didn't occur. This meant the provider could not be sure people were always kept safe. Following our feedback, the provider took action to reduce the risk of a reoccurrence.
● In one unit, the fridge temperatures were consistently going above the recommended maximum temperature. This may alter the efficacy of the medicine. There was minimal action noted to resolve the issue. Following the inspector's feedback a staff member sought advice from the pharmacy and the provider agreed to take action to resolve the issues with the fridge.

The above concerns constitute a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who had 'when required' medicines had protocols in place to help staff identify when they may need their medicines.
● Those who had covert medicines had the necessary agreements in place from other health professionals.

Staffing and recruitment
● There were enough staff in the home, however they were not always deployed effectively and people had differing experiences of care within the home.
● There were three units in the home; however, there was differing feedback, and our observations confirmed, about the staffing levels in each unit. One unit was adequately staffed based on our observations, another had more staff than normal based on the feedback from multiple staff members and the third did not always have enough staff, so care was sometimes rushed.
● In Wedgwood unit, there were extra staff working than normal as fewer staff were off work; however, staff commented on normal staffing numbers it was a struggle to support people in a personalised manner. In Maple View unit we observed people did not have to wait for support. In Castle View feedback from staff was there was not always enough staff so people were sometimes rushed.
● People were having their needs met such as being supported to have drinks and food. However, some people told us they had to wait for support and staff felt they were not always able to have quality time with people. One person said, "Staff are very busy, they need more. If I ring the bell, they [staff] take a long time to come" and they went on to say, "Staff are so busy I feel bad when I start chatting to them as I can see they [staff] want to get away. I end up apologising."
● One staff member said, "On normal [staffing] numbers it's like a conveyor belt. If we had more staff then we have time and don't [have to] rush to get people dressed."
● Another staff member commented, "Honest answer, we need more carers. It's impossible to be there to cover the lounges, give drinks and answer the bells. Nurses are counted in the numbers, but they have things to do and have emergencies. We have people to be observed and it is quite a pain [to staff communal areas to observe people]."
● We discussed staffing with the provider, and they felt the number of staff was correct however they agreed to review people's needs. They also acknowledged the amount of empty rooms was potentially impacting on staff being able to be effectively deployed and they would also review this.
● Staff were recruited safely. Checks were made on staff members suitability, such as employment history, references and criminal convictions.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse. However, there had been multiple concerns raised about how safe people were. This had resulted in the local safeguarding authority monitoring the home more closely.
● The provider had reported multiple safeguarding concerns as they recognised some practices and errors in the home had put people at risk. Other health professionals had also reported concerns. The provider was working with the local safeguarding authority to investigate concerns and put measures in place to protect people.
● Staff were aware of different types of abuse, how to recognise it and their responsibility to report their concerns. They felt able to raise this internally but knew they could report to the local safeguarding authority themselves, if needed. One staff member said, "I have had whistle blowing training and happy to report any concerns I may have."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the last inspection, the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were either not in place or robust enough to demonstrate improvements to people's care had been sufficient, implemented and sustained. At this inspection we found not enough improvement had been made and the provider remained in breach of the regulation.

- The provider had failed to improve to ensure people consistently received safe, effective, good quality care for the last seven consecutive inspections. People had been exposed to less-than-good care for a significant period of time.
- The provider had procedures to support staff to follow best practice guidance in relation to infection control, however the provider had failed to ensure these were being effectively used and embedded into staff practice which put people and staff at risk. Following our feedback, the provider said they would do a monthly competency check to ensure staff were following best practice infection control guidance, so these were not being completed prior to our inspection.
- Systems were not fully effective at identifying improvements needed or if people's care needs had changed. In response to our feedback, the provider said, "One of the things we know we have to do is review, as there are inconsistencies [in people's care files]."
- There was a 'resident of the day' system in place, so everyone had a review at least once a month. The reviews were supposed to encompass all aspects of their support such as care, maintenance, finances, housekeeping; however, this was not always the case. Some areas of the reviews were not always completed, and omissions noted were not always acted upon or explained.
- Monthly reviews of people's care plans did not always identify changes in people's needs so they could be updated and did not always pick up inconsistencies within files. For example, there was differing information about people's mobility, consistency of diet, health condition monitoring, what sort of bed a person should use and whether someone had a Do Not Attempt Resuscitation in place or not. These inconsistencies could lead to people not having care in line with their needs or preferences.
- The registered manager completed 'walk arounds' on the home however these had been ineffective as they had not always identified areas for improvement. The walk-around form would be ticked that something was checked, but it did not always provide the outcome of the check. The checks had not identified that fridge temperatures in one unit were going above the recommended maximum and that action was not always taken.
- Some care plan 'audits' were carried out, but they only checked whether a particular form or plan was

present, but it did not check the content or quality of those forms. Therefore, areas for improvement were not identified.

● There was a lack of accountability and clear job responsibilities which meant aspects of people's care were not always clearly monitored. For example, whilst we found no one had come to harm, there was not always clear process for bowel monitoring.

● The monitoring of a person's health condition was inconsistent. Recordings were made in two separate places, there was no evidence this was being checked and no evidence that action had been taken when the results of the checks were outside of the safe range stated in their care plan. This meant the system was not effective at monitoring this and had not ensured risks to this person were mitigated.

● Records contained inconsistencies between plans and records of people's care were not always fully completed. This meant there was a risk people may not always be supported in the way they needed, and we could not be sure people were appropriately supported.

● The system used to check safe medicine practice, was not effective. A medicine error had occurred, and this had not been identified and action had failed to be taken to ensure the person was safe at the time of the incident.

Continuous learning and improving care

● The provider had failed to continuously learn and improve. The service was consistently poorly rated and had failed to embed and sustain previous attempts to improve the quality of care people received.

● The provider shared an action plan they put into place following our feedback and feedback from the local authority. However, there had been a consistent failure to make and sustain improvements after previous concerns so we could not be sure this would be effective.

● There was a central review of accidents and incidents, however it was not always possible to determine what action had been taken to continuously protect people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were supported to try and give their feedback about their care. Regular checks were made on people's opinions such as about the environment and how they felt about their care. The outcomes of these checks were displayed on a 'You said, we did' to show how they had acted on the feedback.

● Staff were engaged in the service and team meetings were held. However, there was mixed feedback about how they were supported to be kept up to date about people's needs. One staff member said, "Communication is good, [there is a] daily handover from care staff and nurses, this is verbal from care staff but written from the nurse." However, updates to people's plans when something changed was not effective and staff did not always have time to read these.

● There were regular 'huddles' to share information about people, however some staff did not always have the opportunity to read care plans. This meant if staff were not present for the huddle or had not worked for a while (for example due to annual leave, sickness or non-working days), they relied on information being passed word-of-mouth. One staff member said, "I've read a few [care plans] over time, but we don't get time to read them. It's about a year since I read a care plan." Another staff member said, "I have not read all the care plans which makes it difficult. I know what the residents needs by listening to other staff."

● However, care plans were not always up to date and consistent throughout, so had staff had time to read them, they may not have always had the most accurate information.

● We asked another staff member about the reason or outcome of a person's admission to hospital and they were unaware as they 'had not been on [working]' that day. Another staff member said, "I have not heard anything about what the hospital said, I don't know if we should be doing anything different, I suppose someone would have told me." Therefore, changes were not always effectively communicated.

● There had been some changes to processes since the local authority had fed back some of their concerns. The provider acknowledged, "It feels like we implement a process but don't always explain it to them [staff]."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was mixed feedback about management of the home. One staff member said, "We give our all for our residents and don't really feel appreciated." Another member of staff said, "The senior managers have told us to 'do this, do that' but we don't have the time and are not being given time to update all the records and care plans."

● One member of staff commented, "I've always got on with [registered manager] but their door seems to be closed a lot."

● This meant we could not always be sure there was a positive, open culture that ensure people and staff were fully supported.

The above constitutes a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● When things had gone wrong or incidents had occurred, the provider had followed their duty of candour and informed people and relatives when necessary.

Working in partnership with others

● The provider worked in partnership with other organisations. The local safeguarding authority was supporting the service due to concerns raised and the provider was engaging in joint meetings.

● Health professionals were able to visit the service when needed and a multi-disciplinary team were able to support the service to ensure people received appropriate care.