Allambie Enterprises Limited

Allambie House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Allambie House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Allambie House provide accommodation and personal care for up to 30 older people. This can be people who have a learning disability, physical disability, live with dementia or sensory impairment.

At the time of our inspection visit there were 21 people living in the home. The inspection visit took place on 23 and 26 January 2018, both visits were unannounced.

When we last inspected the home on 19, 21 July 2017 and 21 August 2017 we found improvements were required in all key questions. There were four breaches in the regulations and the provider was rated as 'Inadequate' and was placed in Special Measures. We added a condition to the provider's registration so that they were not able to admit further people to the home until improvements were made.

Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions Safe, Effective, Caring, Responsive and Well Led." We also met with the provider who confirmed the actions they planned to take to ensure the home improved.

During this inspection, we found sufficient action had been taken to address three of the previous breaches in the regulations and to improve so that the home was no longer rated inadequate. However, there continued to be areas needing improvement, including person centred care, which we identified as a breach in regulation 9. We also found there were some risks associated with people's care which meant there was a continued breach of regulation 12. Action was ongoing by the provider to areas of improvement we identified.

The registered person (provider) had been in post since June 2016. The manager in post at our previous inspection had since left and a new manager appointed. They had submitted their application to register with us. Following our inspection visit, we were told the application had been approved. 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.

The provider's recruitment system required a series of checks to be made before new staff could work with people at the home. People told us they felt safe living at Allambie House and spoke positively of the staff team that supported them. They told us staff were caring and approachable and we saw enough staff to support people's needs.

We had been notified of reportable accidents and incidents as required. This included incidents related to

safeguarding people from potential risks to their health and safety.

Risks associated with people's care were not always sufficiently detailed in care plans to ensure these were managed safely by staff. Information in care plans was also limited in regards to people's backgrounds and interests to assist staff in providing person centred care. Some people told us they wanted more opportunities to go out of the home and to participate in activities that were of interest to them. Where people had identified healthcare needs, sometimes records didn't support staff to help ensure they effectively addressed them.

Staff who administered medicines had completed the necessary training to do this safely. However, we found medicine records were not consistently completed to show that creams and lotions had been applied as prescribed.

People were positive about the food provided and a daily choice was provided. Staff knew about people's nutritional needs and took advice from health professionals when required. Staff told us they arranged for people to see a doctor when they needed one and people's healthcare records confirmed visits undertaken.

There continued to be gaps in staff training but staff were working through e-learning (computer based) training to update this. The manager had started to hold supervision meetings with staff to talk about their training and development needs. Staff had some understanding of the Mental Capacity Act and knew to ask for people's consent before delivering care. However, records were not clear in determining if people had capacity or not when decisions about their care needed to be made. Deprivation of Liberty Safeguard applications had been made to the local authority for consideration.

Staff had completed training in infection control and wore gloves and aprons when supporting people and carrying out their work to help prevent the spread of infection.

The provider had implemented some quality monitoring processes to assess the quality and safety of the service. There had been no recorded complaints since our last inspection visit and people told us they knew who to raise concerns with if they needed to.

Staff told us they felt valued by the manager and provider and were happy working at the home. They spoke positively of the improvements made at the home since the last inspection visit.

The provider had continued to make improvements to the environment and these were ongoing including the refurbishment of all bathrooms. A maintenance person carried out Health and safety checks of the building to ensure this was safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were enough staff to support people's needs and people told us they felt safe living at the home. Records related to risks associated with people's care were not consistently completed to show these were being safely managed. Staff knew what to do if they suspected abuse and safeguarding procedures were followed by the provider. Staff recruitment procedures ensured staff were safe and suitable to work with people at the home. It was not always clear that some medicines such as creams were applied as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was provided but there continued to be gaps in essential training. Action had been taken to assess people's mental capacity but outcomes conflicted with staff understanding to ensure people were supported with decisions and maintained their independence. Deprivation of Liberty applications had been made to authorise restrictions linked to people's care where this was considered to be in their best interests. People had a choice of food and drink and staff had some knowledge of people's nutritional needs. People had access to health professionals when there was an identified need.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the staff. People were supported by a staff team who were patient and respectful towards them. Overall people's privacy and dignity needs were met and staff treated people with kindness.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive person centred care that met their needs. Staff supported people to make choices about their care and people had access to some social activities although these were not always based on their hobbies and interests. Care plans related to people's health and social care needs required more information to support staff in delivering personalised care. People had some involvement in planning and reviewing their care. There was a complaints process in place. People felt confident to report any concerns and knew who to speak to.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

There was a manager in post and their application to register with us had been approved following our inspection. Staff spoke positively of the provider and new manager and the changes implemented since the last inspection to improve the home. Some quality monitoring processes had been implemented to drive improvement within the home. Statutory notifications about notifiable incidents had been submitted as required.

Allambie House

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.

Allambie House is a care home that accommodates up to 30 people in one adapted building. 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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve across all key questions, Safe, Effective, Caring, Responsive and Well Led. This inspection took place on 23 and 26 January 2018 and was unannounced. This was a comprehensive inspection. The first day of the inspection was attended by two inspectors and the second day by one inspector.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care and spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They told us they were working with the provider in regard to some areas that needed improvement.

We analysed information such as statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at five care plan records, medicine records, complaints information, staff training records, health and safety records, accidents and incident records and quality monitoring information.

We spoke with five people who lived at the home, a relative, a health professional and 10 staff (including a domestic worker, the owner (provider) and manager. We also spent time observing how staff interacted with people as some people who lived with dementia were not able to talk with us in detail about their care.

The provider was not asked to submit a Provider Information Return for this visit as this had been provided at the previous inspection. This is information we require providers to send us annually to give some key information about the service, what they do well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 19, 21 July and 21 August 2017, we rated this key question as 'inadequate'. At this inspection we found sufficient improvement had been made to address the one of the two breaches we had previously identified in this key question. Previously we had identified risks associated with people's health were not always managed to ensure people's needs were met and they were protected from harm. There were not enough staff to support people's needs and the correct procedures had not been followed in response to safeguarding incidents. Although the provider told us in an action plan how they would improve, we found their actions had not consistently been completed and improvements had not always been sustained.

We found during this inspection action had been taken to address the safety concerns we had identified at the previous inspection but there remained areas needing improvement.

In response to our last inspection visit, the manager had undertaken a review of people's care plans. Risk assessments had been devised or reviewed as appropriate to ensure the care and support people received followed safe practice. For example, those people at risk of skin damage, as a result of sitting or lying in bed for long periods, had newly developed "Skin" care plans to manage this risk. However, during our inspection visit we found some people with skin damage and wounds had care plans which did not mention their skin conditions to ensure staff knew of them and actions required to monitor or manage them.

One person had a wound to their foot. The wound dressings were being managed by the district nursing team however some staff spoken with were not aware the person had a wound. This was important for staff to know so they could monitor for any concerns such as the need for any dressing changes. We saw the dressing was in need of changing despite being changed earlier that day. When we spoke with a senior care staff member, they told us they planned to ring the district nurses to visit and change the dressing.

A review of creams used by people had been undertaken and we saw they were safely stored. New records had been introduced for staff to record cream application and these were kept in people's rooms. However, similar to last time, we found records of creams and lotions applied had not been completed consistently. For example, the records we requested for one person could not be located. We made the manager aware of the missing records on the first day of our inspection visit. A new form had been placed in the person's room, however, this had not been completed when we checked on the second day we visited. This meant we could not be confident the creams and lotions prescribed for people were applied consistently to treat people's skin care needs. The manager completed medicine audit checks to make sure these were managed safely each day, but as a result of our findings stated they would implement additional checks to ensure it was clear creams were used as prescribed.

In some cases, plans to manage and minimise risks were not sufficiently detailed. For example, we were told about a person who had recently been admitted to hospital as a result of symptoms associated with unstable blood sugar levels related to diabetes. When we spoke with staff, they were not fully aware of those people who had been diagnosed as having diabetes so they knew to monitor any symptoms. Care

plans for people with diabetes contained no information about the symptoms of high or low blood sugar levels people might experience so staff would know how to identify and immediately respond to them to maintain the person's health and wellbeing. However, some staff were able to describe the symptoms associated with high and low blood sugar levels.

Another person had a catheter and was prone to developing urine infections. The care plan stated staff should observe the person for changes of behaviour which might suggest they had an infection but there was no guidance for staff on what other signs they should look out for that usually occurred when people developed a urine infection. This was important so staff would know to respond quickly to prevent an infection developing. There were instructions in the person's care plan to encourage them to drink fluids and we saw records to monitor the input and output of fluids. However these records had either not been consistently completed or did not correspond with one another (ie the amount the person had consumed did not compare realistically to the output recorded) to demonstrate the person was drinking enough to prevent infections.

One person was not independently mobile. It was unclear from their records what equipment staff should use to transfer the person safely, for example, from their bed to their wheelchair. The person's care plan stated they should use one type of equipment, but we saw staff also use a different type which was not stated in their care plan. It was not clear why different equipment was being used in different areas of the home. Although staff knew how to use both pieces of equipment, three staff told us they were concerned about the safety of using the equipment. This was due to recent changes in the person's strength and ability to stand and move safely. One member of staff told us they thought the person needed further assessment because they felt their needs had changed and the equipment they currently used was not providing adequate support. The manager told us the person had only recently been provided with new moving equipment but they would make further contact with an occupational therapist to check the two pieces of equipment in use were appropriate for the person's current needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

The provider used a variety of risk assessment tools to identify risks to people's health and wellbeing. Some people were at risk of falling from their bed and staff were instructed to ensure these people had a "crash mat" and "sensor mat" by the side of their bed in case they fell. We saw these in place.

Staff knew about most people's needs and told us about the actions they took to manage them. They told us one person had a wound which they needed to clean and apply cream to on a daily basis so this did not further deteriorate. However, they said the person was laid flat when they carried out personal care which resulted in the person "struggling to breathe". They said the person had expressed they didn't like lying flat. It was not evident this had been fully considered when planning their care but we were told the person was positioned this way to ensure personal care could be carried out properly. When we checked this person's records it was clear they had difficulty breathing at times so we discussed this with the manager as it was clear the person was at times in discomfort. Following our visit the manager confirmed action had been taken to ensure the person was supported comfortably at times when personal care was provided and arrangements had been made to review the person's needs in regards to their breathing with a health professional.

People told us they received their medicines when they needed them to support their healthcare needs. One person was able to tell us what medicines they took and what they were for. They said they normally received their medicines at the same time every day.

At our previous inspection we did not have confidence creams were always stored and applied correctly by trained staff. We also questioned whether people had the right medicines at the right time, the accuracy of records and the arrangements for medicine management at night. The manager told us that following our last inspection, staff had completed medicine's training and were able to administer any prescribed medicines, including creams, safely. This included at night. Staff told us they felt they had learned from the training they had completed. A staff member that worked at night told us, "I am fully medication trained," and said they felt confident to administer medicines to people when required. At the time we carried out this inspection, there were no people that had been prescribed medicines for during the night.

People felt safe living at the home. One person told us, "The door is locked and that makes me feel safe." This person told us they could become anxious about their personal possessions and the provider had given them some lockable cabinets where they could store their things safely. They went on to say if they had any concerns they would speak to either the deputy manager or manager. Another person told us they felt safe because, "There are more carers here" and said they felt safe when staff transferred them from their bed to a chair using the specialist equipment prescribed for them to enable this to be done safely.

The provider ensured new staff were safe to work with people at the home. Recruitment procedures required a number of checks to be undertaken before new staff could work with people. Staff recruitment files showed a Disclosure and Barring Service (DBS) check had been obtained for each staff member prior to their employment to check for any criminal convictions. Two written references had been obtained for new staff. A new member of staff told us they had not been able to start work until the DBS check and references had been received by the provider for them to check.

Following our last inspection, the provider had reviewed their safeguarding procedures to ensure incidents that could impact on a person's safety and wellbeing were identified and reported to us and the local authority as required. Staff had a better understanding of how to recognise potential abuse. For example, when describing what could amount to abuse, one staff member told us, "Neglect for a start, anything that involved the resident's wellbeing." Staff had been reminded of their responsibilities to keep people safe and told us they would report any concerns to senior staff and/or the manager.

Staff told us that if they felt managers had not taken appropriate action in response to their safeguarding concerns, they would escalate them further. They told us, "I would tell somebody outside the place like a social worker" and, "I would report it to whoever I thought I had to, probably yourselves." Not all staff were sure whether there was a whistleblowing policy but said they would report poor practice. One staff member told us, "I would tell the senior in charge or the manager because it is about people's safety."

There were systems to manage the control of infection and good hygiene in the home. The provider had made some improvements to the environment since our last inspection visit. For example, there was new washable flooring in communal areas and some bedrooms which was easier to keep clean. We spoke with a member of domestic staff who told us they had received training and guidance on how to keep the home clean and hygienic. They told us they had a schedule of cleaning tasks to ensure all areas of the home were regularly cleaned. They demonstrated a good understanding and working practice of infection control.

Overall the home was clean. However, staff did not respond swiftly to an incident which occurred early in the afternoon that resulted in stains to a bedroom floor, corridor and bathroom. When we checked they had been cleaned later in the day, we saw the floor of the room had been cleaned but the corridor carpet and bathroom floor had not. We discussed this with a member of staff who told us of plans for these to be cleaned the next day. We alerted the manager who advised they would address this with immediate effect. On the second day of our inspection visit we saw the carpet in the corridor had been removed and the floor

prepared for new flooring to be fitted. The manager told us they planned to hold a staff meeting where infection control and other procedures would be reinforced with staff to ensure continued safe practice.

The manager knew how to manage infection to prevent it from spreading. One person had been discharged from hospital with an infection. There were risk management plans in place to ensure the risks of the infection spreading were minimised. Supplies of personal protective equipment such as plastic aprons and gloves were readily available to staff in different areas of the home and we saw staff wearing them. Hand sanitiser was in the entrance hall with a sign encouraging visitors to use it on entering. Staff were required to complete training in relation to infection control so they understood what was required of them. We saw staff meeting notes where the manager reminded staff about keeping all areas of the home clean and their responsibilities to do this.

Staff told us there were enough of them to support people safely with the current level of occupancy in the home. Staff told us, "At the moment staff are coping, but when it is full, it is more difficult" and, "When it is full, it is really busy." They told us there were enough staff to support people to get up when they liked, because some people liked to get up early with the assistance of night staff.

During our visit we saw sufficient numbers of staff were available to deliver care to people without rushing and call bells were answered promptly. However, there were times of the day when there were no staff in the main lounge, even though some people in there had been identified as being at high risk of falls. We discussed the staffing arrangements with the manager who gave assurances that staffing numbers were considered in accordance with people's dependency needs. They told us they would continue to consider people's dependency needs when determining staffing levels if the number of people in the home increased.

During our last inspection we had been concerned about people at risk of falls not being closely monitored and supported, particularly those people on the first floor. During this inspection, we found action had been taken to review these risks. Where there were risks associated with people walking independently, appropriate referrals had been made so they could be supported with walking aids. A relative told us their family member had moved from an upstairs room to a downstairs room which meant risks of them falling when using the stairs were minimised. We saw staff prompted people to use their walking aids when needed. For example, one person who was unsteady on their feet, would not always use their walking frame to support themselves. Staff were aware of the fall risks this posed to the person and encouraged the person when walking to use their frame. We saw one staff member walked with the person to remind them how to use their walking frame.

We saw equipment such as specialist beds and hoists had been checked by an external contractor to make sure they were safe to use. During our last inspection we had identified hot pipes around the home that were not protected and also found the hot water in people's rooms was very hot and presented a burn risk. During this inspection we saw the provider had taken action to cover the pipes to ensure people were protected from this risk. We saw the provider had made arrangements to put 'stops' on the hot water dials on the water heaters in people's rooms so that the water temperature was controlled to a safe level. There was a maintenance person at the home who was responsible for checking these. During our visit we identified two of the dials went past the 'stop' point and continued to run hot water at an unsafe level. We were advised this was due to a fault and these were addressed immediately by the maintenance person so that the hot water temperature was controlled.

On the first day of our visit we identified a portable heater was plugged in and was very hot to touch. This was found in the second lounge on one of the upper floors. We told the manager about this and it was

immediately removed. The manager told us they had not been aware this had been in use.

Arrangements were in place to ensure people could evacuate the building safely in an emergency. Each person had a personal evacuation plan which detailed how many staff and what equipment would be needed to support them to evacuate the home. Information about people's abilities and the support they would require was held in the entrance hall in the event the emergency services would need this information.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 19, 21 July and 21 August 2017 this key question was rated as 'requires improvement' and there was a breach in the regulations relating to the need to gain people's consent. We found during this visit, improvements had been made to address this breach, but there remained some areas which required continued improvement.

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 interests 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Following our last inspection, the provider made a commitment for the manager and all staff to complete training in relation to the MCA and DoLS. The manager had completed this and training was ongoing for staff at the time of our visit.

Action had been taken following our last inspection to complete mental capacity assessments for people, but these were not clear. This was because there was a lack of clarity around people's capacity to make their own decisions about their care and treatment because people could sometimes make decisions and at other times could not. When we looked at one person's care plan, they had signed several documents to confirm their involvement in care planning including consenting to the use of their photographs and staff giving them their medicines. However, when we talked with the manager and staff about the person's capacity to understand, there was a lack of consistency in what they thought about the person's capacity and what the records told us. When we asked one member of staff if this person had capacity, they were not sure. They responded, "Yes I would say they did. They can make every day decisions. Sometimes they can get very confused so I'm not sure on that one. Actually I don't think [Person] has." Care plan information did not make it clear how staff could support the person to make their own decisions such as asking at a certain time of day or in a quiet environment etc.

Another person's care plan stated "Can make small day to day decisions but will need wife and daughter to help make more complicated decisions around health and wellbeing." There was a capacity assessment on the file which stated the person did not have capacity but did not indicate exactly what decisions they did not have capacity to make. A family member had signed to consent to some care decisions but there was no evidence they had the legal power to consent on the person's behalf.

Staff had some understanding of the MCA 2005 as we saw staff asked people about every day decisions such as what they wanted to do. For example, they asked "Where do you want to go?" and, "Would you like to sit in the dining room?" When we asked one staff member how they would support a person if they appeared

confused and unable to make their own decision, they told us, "I will repeat myself and see if they understand. If they still do not understand, I will ask the senior for another opinion as to what is in their best interests." Staff told us if people declined care they would report it to their manager and go back later to offer a choice. One staff member told us, "If they were still refusing I would have to document it because we can't force them." This demonstrated staff understood they needed to ensure people consented to their care.

Following our last inspection the manager had completed Deprivation of Liberty Safeguards (DoLS) referrals and had forwarded these to the local authority for authorisation in regards to those people considered not to have capacity to consent. The decisions and outcomes of these referrals were still in progress.

Staff told us when they started work at the home they completed an induction and we saw records confirming this. A new member of staff told us they completed an afternoon of shadowing (working alongside) more experienced staff to make sure they understood their responsibilities and job role. They stated they already had a good idea about the needs of the people living at the home because they had previously worked there so did not need to shadow staff for a longer period of time.

Staff completed on-line (computer) training in areas such as catheter care, infection control and first aid to ensure they could carry out their role and support people safely. The manager told us this training was linked to the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The provider had a system to identify when training was required which included a training matrix which detailed all training staff had completed. However, this showed there were a number of staff who had not completed essential training such as fire training and health and safety training. Some staff had not completed dementia care training to help ensure they could support people in the home living with dementia effectively.

When we spoke with staff they told us they had not completed training in end of life care so they would know how to respond to people's needs. However staff knew to seek the advice of health professionals or call emergency services if they felt concerned a person may be at the end of their life. One staff member confirmed they had done this when a person's heart had stopped. They explained the emergency services had talked them through a resuscitation procedure.

The manager told us since they had been in post staff had been working through the required training but acknowledged there was still training staff needed to complete. They told us the 'safe moving and handling people' training was one priority area they were planning for next. They had identified staff sometimes used equipment to move people unnecessarily which did not promote people's independence. They told us, "The staff need a lot of guidance. Nobody has been there to make suggestions about different ways of doing things. The staff are very willing to learn and they take things on board. They need more confidence in themselves because they are very caring." They told us, "It is little things that can make a great difference".

Staff told us they had started to attend supervision meetings with the manager. Records confirmed at least half of the staff had attended a supervision meeting where they could discuss their training and development needs.

People were provided with a choice of meals. One person described the food as 'fabulous' and said they particularly liked the lunches on Sunday. Another person told us they could have drinks whenever they wanted, and demonstrated this when they went to the kitchen and asked for a cup of coffee which was provided. This person also told us they were able to eat their main meal when they preferred and could have

snacks at any time of night. At lunch time one person requested something different to the choices offered and we saw the cook accommodated their choice. The person told us how pleased they were they had been provided with the meal of their choice.

There was a menu on display outside the kitchen to remind people what meals were available to them. There was also a selection of pictures in the dining room to display the meals planned for that day so people had a visual prompt to assist them to choose what they wanted to eat. However, the pictures available on the day of our visit did not reflect the meal options that were provided.

Risks to people's nutritional health were assessed and plans put in place to ensure they had appropriate support so they had enough to eat and drink. Staff knew about people's nutritional needs such as those who needed a thickening agent added to their drinks to reduce the risk of them choking. Some people who needed assistance to eat stayed in their bedrooms and staff took meals to their rooms to assist them. The provider had purchased adapted eating plates and utensils to support people to eat independently, although at the time of our visit, nobody needed to use them. We saw several people were provided with drinks in non-spill drinking cups to help them drink independently.

People were weighed regularly to identify any changes in their health although there was no central record of these so that the manager could swiftly identify any concerns. We saw where one person had lost weight consistently over several months, action had been taken to refer them to the GP so reasons for this could be explored.

Most people were on food and fluid charts, although the manager accepted that some people did not need to be, because there were no concerns regarding their nutrition. The manager wanted to be sure that people were eating and drinking enough before this practice was reviewed. Staff were completing the forms, but in some cases this was done retrospectively so we could not be sure they were always accurate. For example, when we looked at the charts at 5.30pm, no food or drinks had been recorded since 12.00pm. When we spoke with staff, they told us when they provided drinks to people this should be recorded at the time and staff should check later to see how much people had actually consumed and record this. The manager told us they monitored food and fluid the charts daily to make sure people had received sufficient to eat and drink.

People had access to health professionals such as a district nurse, GP and Occupational Therapist, however sometimes the notes were not clear in regards to the advice provided. One person's records had not been maintained sequentially so it was difficult to tell what the most up to date advice was. There were people in the home with a diagnosis of diabetes and it was therefore important for them to access chiropody care. The care plan for one person with diabetes stated the person would like to see a chiropodist but records did not show they had. It was therefore not clear how the person's nail care was being managed. We discussed this with the manager who agreed to follow up this concern and ensure people who needed nail care had access to it.

The premises were on four different levels and some of these had steps to access rooms and bathrooms. There was a lift and chair lifts on stairs to enable those people with limited mobility to move around the home safely. Some bathrooms had been refurbished and made bigger for easier access by people. One person told us they would like to have a shower but had not been able to access it due to their mobility difficulties and the lack of sufficient space for staff to use the equipment they needed to support them safely. This meant they had a 'body wash' each day instead. The provider told us a 'wet' room was almost complete and would soon be accessible to the person.

There was a second communal lounge on the first floor but this was not being used to its full potential and was being used as a storage area for equipment. This meant it was not a relaxing and inviting environment for people. We saw most people chose to sit in the ground floor main lounge.

There were some directional signs around the home but these did not include pictures to help people understand the words. The layout of the building meant it could be difficult for some people to locate their rooms and communal rooms without the assistance of staff. The provider told us that as part of their refurbishment plans they aimed to adapt the building to support people's needs including those who lived with dementia. The garden was not freely accessible to people as the doors to the home were locked and the garden area was not secure to ensure it was safe for everyone to use. This meant people did not have access to an outdoor space without support from staff. However, there were people who told us they had sat in the garden in the summer months demonstrating this was used. The provider told us new garden furniture had been purchased so that when the weather improved people would be able to sit more comfortably in the garden.

Good

Is the service caring?

Our findings

At our previous inspection on 19, 21 July 2017 and 21 August 2017 we rated this key question as 'requires improvement'. We found during this visit sufficient improvements had been made to rate the key question as good.

People were supported to maintain relationships with those who were important to them and told us staff were kind to them. One person described staff as "lovely" and another told us, "They are very nice and very caring." We saw some people had developed relationships with each other and supported one another. For example, one person said their tea had gone cold and they wanted another one. The person sat next to them attempted to locate a member of staff to get them one.

Staff told us they developed relationships with people by talking with them. One staff member told us, "I personally do the best I can for any resident and help them as best I can. I like to chat to them. If you get someone who can chat back I talk to them while giving personal care."
We saw one person talking with a member of staff. They clearly knew each other well and enjoyed talking about what the staff member had done the previous day.

The provider displayed the names and photos of all the staff who worked at the home, to support people and visitors to understand staff's responsibilities and to help develop relationships with them. Visitors were welcomed into the home. A relative we spoke with was positive about how staff supported their family member. They told us, "[Person] is very happy here, [person] likes the girls (staff), they are all very good to [person]."

Staff understood people's varying communication needs and how to support them with these. For example, they knew to speak slowly and repeat questions when people needed time to respond. Some information about people's preferences and backgrounds was kept on people's care files to assist staff to support people in ways they preferred. People were provided with portable call bells so they could alert staff when they needed support. At our last inspection these had not been accessible to some people but we saw action had been taken to address this.

Staff spoke positively of working at the home and often volunteered to cover extra shifts because they enjoyed caring for the people who lived there. One staff member told us, "There has to be some compassion and care inside the staff member to do the job." When we asked them if staff at the home had care and compassion, they responded, "Yes, they are very caring." Another staff member told us, "I like it here because the people are very friendly and welcoming and they help a lot."

Most staff respected people's privacy. We saw staff knocked on doors before entering and ensured we were given privacy to talk with people in communal areas. Staff referred to people by their preferred names. For example, staff greeted one person formally because that was how they preferred. However, we saw a staff member asked people with a raised voice if they wanted to go to the toilet as opposed to this being done more discreetly. We saw some people had a hearing impairment hence why staff spoke in a raised voice but

there were other and more respectful ways of communicating with people that could have been used. The manager told us following our visit they had reminded staff to be aware of how they spoke with people in communal areas and to be more discreet when asking personal questions.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 19, 21 July and 21 August 2018 we rated this key question as 'requires improvement'. We found during this visit, there remained areas which required improvement.

The manager told us to ensure people's preferences, interests and hobbies were met more effectively they had needed to review people's care plans and ensure information on people's backgrounds was updated and accurate. They told us this work had now been completed and action was ongoing to provide social activities and support in accordance with people's wishes and preferences. However, when we spoke with staff they had little knowledge about people's backgrounds to support people's social care needs.

One person's care plan indicated they could get depressed and withdrawn because of their lack of mobility and independence. We saw the person showed symptoms of being withdrawn including sitting for periods of time with their head lowered, resting in their hands. There was a care plan that advised staff to provide reassurance when the person became upset, however this lacked detailed information for staff to support them effectively. For example, there was a lack of detailed guidance to staff about what actions they could take to support the person's social care needs to reduce the risk of them becoming withdrawn and reduce the risk of them becoming upset.

An activity organiser was employed at the home and planned and provided some social activities to people. We didn't see these were always based on people's hobbies, interests or preferences. One person told us their day would be improved if they could watch a certain television channel and do some further learning in IT. This information had not been identified during any assessment of their social care needs so that the person could be supported to watch channels of their choice or pursue their interests. This person told us they would like to go out more but didn't have the necessary equipment they needed to support them to do this. We discussed this with the manager who stated they had not been aware of this person's wishes and would look into how the person could be better supported.

Activities for those people who experienced confusion, or who lived with dementia, did not always take into account their emotional and psychological needs. For example, we saw one person undertake two activities, both of which, had a negative outcome on their mental health leaving the person looking anxious and tearful. Although the activity organiser stopped one of the activities on seeing the person become upset, no comfort was provided to the person which may have helped them to feel less anxious. The person's care plan did not contain specific guidance to staff on how the person should be supported when they became anxious to ensure their emotional needs were met.

Whilst people enjoyed some activities, others felt restricted in regards to being able to go out when they wanted and felt their independence was not fully supported. One person told us the activity organiser had supported them on visits outside of the home but others told us they had not had this opportunity. One person commented, "I would like a day out shopping, they have not had anything like that." Another told us they sometimes got "bored" and said they didn't enjoy the company of others so chose not to sit in the lounge.

Staff felt more could be done to give people something meaningful to do to keep them stimulated and occupied. One staff member told us, "I think the residents need more stimulation and activities. We could take them out a bit more." The provision of person centred care and activities was an issue we raised at the last inspection and continued to be an area where improvements were required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

Staff told us they relied on care plans for information about people. One staff member told us, "We've got the care plans we can look at. We didn't use to have access to the care plans but we have access to them now so we know more about people. They (backgrounds) are in the care plans so if we need to know anything we can look at the care plans." People's care plans contained some information about people's likes and dislikes such as the type of clothing they preferred to wear and what time they preferred to go to bed and get up in the morning. Night staff told us there were some people who were supported early with their personal care because they were awake. However, during out visit we saw a person asleep in bed at 8.30am with the television on and volume turned up and window open. It was not clear why this was as the person was fast asleep. We told the manager about this person who said they would speak with staff about this. They told us they had gone into the room to check the person and closed the window.
People were assisted to bed during the evenings at times of their choice with some choosing to be in bed by 5pm.

During our inspection, some people participated in activities in the main lounge. For example, one person wanted to colour pictures in a book, another was happy to read a newspaper and another completed word searches with the activity organiser supporting them. Some people played bingo which the activity organiser helped people to play. Most people were smiling and engaging with the activity organiser which showed they enjoyed it. Music was played in the lounge when activities were taking place and some chose to singalong suggesting they liked the choice of music played although they had not been asked.

The manager had established a link with a local school to come into the home and provide entertainment for people. They told us pupils from the school entertained people with musical instruments and it was hoped this would become a regular event. One staff member told us, "She is trying to arrange things so it is a better place for them (people) to be."

People told us they were satisfied living at Allambie House. One person told us, "It's reasonable." Another told us, "I think it's good." A relative told us, "They (staff) look after us. They are always here to help you. We had to ask one of them to help [Person] back into bed. [Person] felt disorientated to move backwards. We called for one carer and two of them came and got [Person] back to bed and tucked them in."

Where people had communication difficulties, there was guidance for staff which explained how they should support the person to understand information. For example, one person's care plan stated that they spoke softly and staff had to listen carefully to what they said. Another person's plan advised staff, "Talk in a calm manner and give information in a quiet distraction free environment." We asked staff how they took into consideration people's sensory needs, one staff member told us how one person had very poor eyesight and sometimes wore their glasses. They explained, "We make sure they have their spectacles on for meals so they can see what they are eating."

At our last inspection visit we found people's cultural needs were not always met. One person had told us their religion was important to them but they had not been supported with this. Since this time, the

manager had made enquiries to see how this person could be supported with the possibility of a representative of the person's faith visiting the home. Staff told us some people's spiritual needs were met by visits from ministers of the Catholic church and Church of England. During our visit, a minister from a local church visited the home to see people as they had requested. A staff member told us how important it was to "Respect everyone's culture and beliefs." We saw care plans detailed people's religious needs and the manager told us how they aimed to ensure people's needs were sufficiently supported.

We asked staff how people's sexuality was recognised and supported. Staff were not aware of anyone in the home with specific needs and we did not see records that showed people's needs had been fully explored. The brochure in the home contained very basic information and did not reflect the diverse culture of people the service could support. The provider told us the brochure was in need of updating.

People told us they would speak to the staff or the manager if they were unhappy. When we asked people if they had any concerns or if their requests were acted upon, we received mixed responses. One person told us they had asked for a lock on their door but this had not been provided. We discussed this with the manager who told us they had found it difficult to source a suitable lock but would look into this. Following our visit, they had agreed to lock the person's door when they were not in their room which the person was happier about.

There was a complaints procedure displayed in the entrance hall to the home and also in some people's bedrooms. Staff told us they would support people to raise a concern if needed. One staff member told us, "We have a complaints procedure and I would tell my manager somebody was not happy and wanted to make a complaint." The manager told us there had been no recent complaints received but there were records available for staff to record these if concerns were raised.

People's preferences and choices at the end of their life had not been fully explored. Although there was a care plan for completion, in some cases this was blank. The manager told us that 'ReSPECT' forms were in place for people which contained information to assist health and care professionals when responding to an emergency and potential end of life situations. ReSPECT forms contain information to help professionals make immediate decisions about that person's care and treatment.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection visit on 19, 21 July and 21 August 2017 we rated this key question as 'inadequate'. The provider was in breach of four of the regulations; as a result the home was placed into special measures. There had been no registered manager at the home from when the new directors had taken over in June 2016 which had impacted on the effective management of the home. There had been minimal management oversight to ensure people's needs were responded to and insufficient action to assess and monitor the quality and safety of people.

At this inspection, we found sufficient action had been taken to improve from the inadequate rating but there remained areas that required improvement. We identified two breaches of the regulations (one of these being a new breach).

A new manager had been appointed and had been working at the home since 30 October 2017. The provider had ensured the new manager submitted an application to register with us and following this inspection visit, their registration was confirmed.

The manager told us when they started at the home, their first priority had been to review people's care plans and this had been completed. Staff had previously not had access to care plans for people so had not always been aware of people's needs. We saw this had changed and staff had access to the care plans in their own office. Staff were still adapting to using the care plans and the new ways of working introduced by the provider and manager to improve the service. They told us the way they recorded information had changed for the better so it was clear to them what care and support people had received. However, we found some care records needed further improvement to ensure they were clear enough and provided staff with the information they needed to support people safely and effectively. People's choices and preferences were not always identified in their care records. This meant staff might not be aware of them and they were not always followed to ensure people received person centred care that met their needs.

Meetings had taken place with all staff where the new manager had introduced themselves and discussed plans to improve the service. This included meetings with senior staff so they were fully aware of what was expected of them. The manager told us more meetings were planned with all staff so they would have opportunities to share their views and opinions about issues related to the running of the home. One staff member spoke positively of having staff meetings. They told us, "It makes everything better for people and staff."

The provider's processes for delivering staff training had not been effective in ensuring all staff completed all of their essential training in a timely manner. This had the potential to place people at risk. Staff told us they did not always have allocated time to complete their training when working as part of the shift. The manager told us some staff preferred to do their training in their own time, away from the home. A laptop was provided at the home for staff who preferred to complete their training in the home.

The manager said they planned to spend more time with staff 'on the floor' so they could observe and

support them in developing their skills and approach. The manager told us they carried out some observations as they walked around of the home on a weekly basis but planned to do this more often.

Work had been undertaken and was ongoing to improve the environment so that it better supported people with limited mobility and people who lived with dementia. Health and safety checks were regularly carried out and the provider had employed a maintenance person to ensure checks were completed in a timely manner and any concerns acted upon to keep the home safe.

Quality monitoring systems were in the process of being fully implemented to assess, monitor and mitigate risks. Although the manager had introduced new documentation to help manage risks associated with people's care, staff had not completed this consistently to confirm care provided. For example, one person had a sore skin and staff were required to apply prescribed creams to treat it. Records the manager had implemented to record cream applications had not always been completed to show this was done when required. We saw another person had a wound on their foot but this was not reflected in their skin care plan and some staff were not aware of the person's wound which meant there was a risk the treatment required may not be provided. Staff had told us this wound had been caused by an accident but no accident record had been completed in line with the provider's accident reporting procedures. The manager told us this would be addressed immediately and told us of plans to spend more time with staff to monitor their practice and ensure they followed the provider's reporting processes.

Following a review of accident records, we found action had been taken to notify us and other agencies of those accidents and incidents that were reportable as required. Staff told us they completed accident and incident forms if something unexpected happened in the home, such as people falling or sustaining an injury. They told us this information was also shared at handover meetings with staff including management staff prior to the start of staff shifts. The manager had not undertaken an analysis of accidents and incidents to identify any emerging trends at service level. For example, whether the number of falls increased at certain times of the day or in specific areas of the home. They told us this was something they planned to do.

Staff felt supported by the management team which included the manager, senior supervisor and owner. The owner was available in the home most days to provide support as required. We saw the owner supported the manager in regards to any decisions related to the running of the home. We also noted that as we fed back issues needing attention during the day, the owner took immediate action to ensure they were addressed. For example, where two hot taps did not work properly due to a fault, this was reported to the maintenance person who took the necessary action to repair them. Staff told us, "We are able to talk to the management about any concerns we have got now. They are very easy to talk to if you have got any concerns." One staff member described the new manager as "brilliant" and said, "I really like her. I think she is firm but fair and she does listen."

People knew the owner (provider) by name which demonstrated they knew them well and felt confident to approach them directly. Some people knew who the manager and senior supervisor were and described them as "Very nice" and "Very kind".

Staff spoke positively about working at the home and the improvements that had been made. One staff member told us, "The staff are nice and I see the owners do their best to make everyone happy. It is not perfect, but we are doing our best. Some improvements did need to be made but I think they have done really well and I can say I am proud to work here." They went on to tell us how the décor of the home had improved including there being "better showers" which they said made their job "easier and safer".

Some staff told us they felt listened to because they had opportunities to discuss how they felt at supervision meetings with the manager. We saw around half of the staff were still to attend one of these meetings at the time of our visit. Staff told us they felt valued because they were thanked. For example, one staff member told us, "At the end of the shift the senior will say thank you. If you cover a shift, they will say thank you."

The provider had forwarded quality satisfaction questionnaires to people to assess their views of the home. Questions included views of the accommodation, food, activities and staff. Nine had been returned and the results analysed. Responses received had mostly been positive. Two people had felt there could be improved links with the community to improve their social care and this was something we had identified during our inspection visit. The service worked with key organisations such as the local authority, GP's, dentists and other health professionals to support care provision.

There was a "You said, we did" board in the entrance hall of the home. Some of the suggestions were for different activities such as gardening and cooking. The board stated that action had been taken in response to suggestions. Gardening and cooking equipment had been ordered and obtained so people could engage in these activities. This showed the provider's commitment to listen to people's views and act upon them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care that always met their needs. Care records were not always sufficiently detailed to support staff in delivering care and support in accordance with people's preferences, wishes and needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with their health, safety and welfare because risks were not fully assessed to ensure care and treatment was always provided in a safe way. Regulation 12 (1)