

Community Integrated Care

Amberleigh House Care Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 February 2017 and was unannounced.

Amberleigh House is registered to provide accommodation for people who require nursing or personal care, and the treatment of disease, disorder or injury. It is a charity owned care home which provides accommodation for up to 38 adults living with dementia. The service is located in the Fazakerley area of Liverpool and is close to local public transport routes. Accommodation is provided at ground level and all rooms have en-suite facilities. During the inspection, there were 35 people living in the home.

When we last inspected Amberleigh House in January 2016 the service was rated as 'Requires improvement.' This was because the provider was in breach of regulations in relation to medicines management and compliance with the Mental Capacity Act 2005. Following the inspection the provider sent us an action plan to tell us how they would address these concerns and make improvements to meet the regulations. We reviewed this plan as part of this inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last inspected Amberleigh House in January 2016, the provider was in breach of regulations in respect of the safe management of medicines. During this inspection we found that improvements had been made and the provider was no longer in breach of regulations in relation to medicines management. Records relating to medicine administration were completed fully and for people who required their medicines to be administered covertly (hidden in food or drink); appropriate assessments and agreements were in place. A system was in place to record when topical creams had been administered, though this was not utilised for all creams such as moisturisers.

At our last inspection the provider was in breach of regulations because applications to deprive people of their liberty were not applied for in a timely way. During this inspection, we found that DoLS applications had been made appropriately and records showed that consent was gained in line with the principles of the Mental Capacity Act 2005 (MCA). The provider was no longer in breach of this regulation.

Staff told us they were well supported by the management team and were able to raise any issues. We found however, that supervisions and appraisals were not completed with staff regularly. Records also showed that not all staff had completed training considered mandatory. The registered manager had identified this and developed a plan to make improvements in these areas. A number of training courses had been booked and staff were due to attend these.

We found that not all identified care needs were evidenced as provided, such as regular repositioning to

help prevent deterioration of people's skin integrity. Where repositioning support had been recorded, records reflected that people all received the support at the same time. This meant that accurate records of care were not maintained.

At our last inspection, the caring domain was rated as 'Requires improvement.' This was because staff did not always have time to interact with people living in the home in a meaningful way. During this inspection we found that improvements had been made and we observed staff spending time sitting and chatting with people and providing support in a timely way.

The well-led domain was previously rated as 'Requires improvement.' This was because there was no registered manager in place, there was no evidence of staff meetings and quality assurance processes were not always effective. We found at this inspection that improvements had been made.

We looked at four personnel files and found that appropriate checks had been completed prior to staff commencing in post. Not all staff files included a full employment history and the registered manager agreed to request written information from these staff.

The registered manager told us the service was fully staffed and staff told us there were usually sufficient numbers of staff on duty. Feedback regarding staffing levels from people living in the home and relatives was mostly positive.

People told us they felt safe living in Amberleigh House and relatives we spoke with agreed the environment was safe for people. Staff had a good understanding of safeguarding processes and how to raise any concerns.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

People living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing. Relatives we spoke with told us that staff always kept them informed about any changes to their family members health or wellbeing and agreed that advice was sought quickly when needed.

Feedback regarding meals was positive and staff knew people's dietary needs and preferences. A choice of meal was available and we observed people receiving support to eat and drink when required.

Adaptations had been made to the environment to assist people living with dementia with orientation and safety.

Not all people we spoke with were able to talk to us about their experience of living in Amberleigh House, however all relatives we spoke with told us that staff were kind and caring and treated people with respect. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection.

Care plans were written to guide staff to promote people's independence when providing support and relatives we spoke with agreed that people's independence was encouraged. Staff knew the people they were caring for well, including their needs and preferences. This meant that staff could support people in a person centred way.

All relatives told us they were made welcome when they visited and that they could visit their family member in private if they wished to. For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access.

Care plans reflected people's individual needs and were detailed and informative. They reflected people's choice and preferences and included information regarding the person's life history. Pre-admission assessments were completed to people's needs could be met effectively from the day the person moved into the home.

A schedule of planned activities was on display within the home, provided by an activity coordinator and volunteers. People had access to a shared minibus and trips to local attractions were arranged regularly, as well as external entertainers visiting the home.

Records we viewed showed that relative meetings took place regularly, as well as the family forum meetings. People told us they felt listened to and one relative told us, "The home is always asking [your views]; they are interested in what you think."

There was a complaints procedure in place within the home and all people we spoke with knew how to raise any concerns they had.

We looked at the quality monitoring systems in place and found that systems in place were effective in monitoring the quality and safety of the service. Audits identified actions required for improvement and it was recorded when these actions had been completed. The provider maintained oversight of the service through regular clinical governance reports, internal quality assurance team visits and were notified of any significant incidents within the home.

Feedback regarding the management of the home was positive from all people we spoke with. Staff told us they were well supported, enjoyed working in the home and would be happy for their family members to be supported there.

The ratings from our previous inspection were not displayed within the home as required. We discussed this with the registered manager who arranged for the ratings to be displayed in the foyer of the home before the end of the inspection.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications.

You can see the action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Medicines were managed safely within the home.

Most safe recruitment practices were evident within staff files, though some contained small gaps in employment history.

There were sufficient numbers of staff on duty to meet people's needs in a timely way.

People told us they felt safe living in Amberleigh House and that the home was clean and well maintained. Staff had completed and reviewed risk assessments to assess and monitor people's health and safety.

Staff had a good understanding of safeguarding processes and how to raise any concerns.

Is the service effective?

Good 

The service was effective.

At our last inspection the provider was found to be in breach of regulations as applications to deprive people of their liberty were not always applied for in a timely way. During this inspection, we found that DoLS applications had been made appropriately and consent was gained in line with the principles of the MCA. The provider was no longer in breach of this regulation.

Although not all staff had received regular supervision and training, the registered manager had identified this and was taking steps to address this.

Staff received an induction when they commenced in post that was in line with the requirements of the care certificate.

Feedback regarding meals was positive and staff knew people's dietary needs and preferences.

Adaptations had been made to the environment to assist people living with dementia with orientation and safety. Bathroom

doors contained pictorial signs of a toilet to assist people in finding the bathroom independently.

Is the service caring?

Good ●

The service was caring.

At our last inspection, the caring domain was rated as 'Requires improvement.' This was because staff did not always have time to interact with people living in the home in a meaningful way. During this inspection we found that improvements had been made and we observed staff spending time sitting and chatting with people and providing support in a timely way.

Relatives told us that staff were kind and caring and treated people with respect. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection.

Care plans were written to guide staff to promote people's independence when providing support.

There was no restriction on visiting and relatives were welcomed when they visited the home.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Not all identified care needs were evidenced as provided. Where records had been maintained, they were not always completed accurately.

Care plans reflected people's individual needs and were detailed and informative. They reflected people's preferences and included information regarding the person's life history.

A programme of activities was available to people, as well as trips out and external entertainers.

Feedback was gathered from people during resident and family forum meetings. People told us they felt listened to.

There was a complaints procedure in place within the home and all people we spoke with knew how to raise any concerns they had.

Is the service well-led?

Good ●

The service was well-led.

When we last inspected this service, the well-led domain was rated as 'Requires improvement.' We found at this inspection that improvements had been made.

The ratings from our previous inspection were not displayed within the home as required on arrival, but were displayed by the end of the inspection.

Systems in place were effective in monitoring the quality and safety of the service.

Feedback regarding the management of the home was positive from all people we spoke with.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The manager had notified the CQC of events and incidents that occurred in the home.

Amberleigh House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 February 2017 and was unannounced. The inspection team included two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance their experience was in relation to supporting older people living with dementia.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the quality and excellence partner, the deputy manager, the maintenance person, an activity coordinator, five members of the care staff, four people living in the home, 11 relatives and the chef.

We looked at the care files of seven people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection. 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.

Is the service safe?

Our findings

When we last inspected Amberleigh House in January 2016, the provider was in breach of regulations in respect of the safe management of medicines and the safe domain was rated as 'Requires improvement.'

At the last inspection we found that covert medicines (medicines hidden in food or drink) were not administered in line with safe practice. During this inspection, we reviewed how medicines were managed and found that improvements had been made.

We looked at the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available to guide staff and records showed that staff had completed training in relation to safe medicine administration and had their competency assessed. We checked the stock balance of seven medicines and they were correct. Medicines were stored in trolleys in a locked clinic room and the temperature of storage areas were monitored and recorded daily.

Controlled drugs were stored securely and appropriate records were maintained as well as daily stock balance checks. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We saw evidence of PRN (as required) protocols and records for people who required them. PRN medications are those which are only administered when needed for example for pain relief.

We looked at people's MAR charts and found that they were fully completed and included details of any allergies people had. A system was in place to record when topical creams had been administered, though this was not utilised for all creams such as moisturisers. The registered manager told us they would ensure the system was reviewed and updated to include all creams. Individual medicine care plans were available with people's MAR charts, including guidance on how to administer each person's medicine. For people who required their medicines to be administered covertly, we found that appropriate assessments and agreements were in place. This included input from the GP and pharmacist, who signed the plan to show their input and agreement. The provider was no longer in breach of this regulation.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they are suitable to work with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. Two of the four files we viewed contained small gaps in the staff member's employment history and the registered manager agreed to request written information from these staff members to confirm their full employment history.

A relative we spoke with told us they had taken part in staff interviews and showed prospective staff around the home. They told us they enjoyed doing this as it meant they had some input in the staff that would be caring for their family member.

We looked at how the home was staffed. On the first day of inspection there was a nurse, seven support workers and a team leader on duty, as well as domestic, activity co-ordinator, administration, catering and maintenance staff, to support 35 people living in the home. Staff rotas we viewed showed that this level of staff was regularly maintained. The registered manager told us the service was fully staffed and the organisation has a policy to over recruit to minimise use of agency staff. They also told us staffing levels had increased recently based on feedback from staff and use of a staffing analysis tool. Staff we spoke with were aware extra staff had been recruited as it could be busy in the afternoon and all staff told us there were usually sufficient numbers of staff on duty, though it was difficult when staff phoned in sick.

Feedback regarding staffing levels from people living in the home and relatives was mostly positive. Comments included, "Yes, there is enough staff", "Oh, yes enough staff no problem" and "When I come there is always staff here." Two relatives told us they did not feel there were always enough staff, especially in the communal lounge areas. We discussed this with the registered manager who told us one staff member was allocated daily to supervise each lounge, however they would respond to call bells if other staff were already supporting people. They also told us they had spoken with staff to ensure they were aware of their responsibilities in relation to monitoring lounges as this had already been raised with them.

Our observations during the inspection showed us there were sufficient numbers of staff on duty to meet people's needs in a timely way. For instance, call bells were answered quickly, people were not rushed with their meals and we observed staff sitting and talking with people throughout the inspection. We spent time in both lounges during the two day inspection and found that staff were present most of the time.

Most people we spoke with told us they felt safe living in Amberleigh House. One person told us, "Yes, I feel safe here, thank you" and another person told us, "I feel quite safe here." Relatives we spoke with agreed the environment was safe. Comments included, "Straight away it felt secure, it has push button doors", "I think it is very safe, no problems. There are handrails all the way round for residents to hold onto" and "Its secure and flat, no upstairs to go to and wide corridors."

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were able to explain how they would report any concerns they may have. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made to the Local Authority for investigation. Incidents were recorded electronically and shared with head office.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and skin integrity. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as pressure relieving equipment and diet monitoring.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. External contracts were in place to ensure the building and equipment were safely maintained. We viewed certificates in relation to gas safety, electricity, fire safety and lifting equipment and these were all in date. Regular internal checks were made and recorded in areas such as fire alarms, emergency lighting, wheelchairs, water temperatures, bed rails and beds.

We looked at accident and incident reporting within the home and found that these were reported and recorded appropriately. Incidents were recorded in people's care files as well as electronically. Accidents

and incidents were reviewed each month by the registered manager in order to look for any potential trends to enable risk reduction measures to be implemented. Head office was made aware of all accidents and incidents and records reflected what actions were taken, such as whether hospital admission was required or a referral to the safeguarding team.

All people we spoke with told us the home was clean and well maintained. Comments included, "It is very clean and tidy here", "Clean without doubt", "They clean every day, when I visit they are always cleaning the passage ways" and "Place has been done up, absolutely lovely now." We found the home to be clean during the inspection and we observed staff wearing personal protective equipment such as gloves and aprons at appropriate times during the inspection. Bathrooms contained liquid soap and paper hand towels and hand gel was available throughout the home in line with infection control guidance.

Is the service effective?

Our findings

When we last inspected Amberleigh House in January 2016, the provider was found to be in breach of regulations and the effective domain was rated as 'Requires improvement.' This was because the principles of the Mental Capacity Act were not always followed as applications to deprive people of their liberty were not always applied for in a timely way.

During this inspection, we looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was fully aware of any conditions that had been placed on the authorisations. We found that DoLS applications had been made appropriately and the provider was no longer in breach of this regulation.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom and when providing support to people at lunch time.

When staff felt that people may be unable to provide informed consent for specific decisions, mental capacity assessments were completed. We reviewed one care file which included a mental capacity assessment to assess whether the person was able to understand the consequences of refusing medicines. The assessment followed the principles of the MCA and concluded that the person lacked capacity regarding this. Staff had liaised with the person's GP, family and pharmacist and made a decision in the person's best interest. Not all care files contained clear evidence that decisions had been made in people's best interest when they were unable to consent to their care and treatment. We found however, that DoLS applications had been made for these people and further discussions would take place as part of that process and decisions would be made in their best interest.

We looked at how staff were supported in their roles. Staff told us and records showed, that staff received an induction when they commenced in post. The induction was in line with the requirements of the care certificate. The care certificate is an identified set of standards that staff must adhere to and been assessed as competent in, by a senior member of staff.

The registered manager told us that staff should receive four one to one sessions per year to provide support, discuss their role, training and development needs and set performance objectives for the upcoming year. All staff we spoke with told us they felt well supported in their role and that they could raise any issues with the registered manager at any time as they had an 'open door' policy. Records we viewed

however showed that not all staff had received formal supervision or appraisals recently. The registered manager told us they had developed a new tool to record formal supervision sessions, as feedback received was that the previous form was not user friendly. They felt this was part of the reason why supervisions had not been completed. We viewed a new schedule for supervisions in 2017 and records showed they had commenced in January and five staff had received supervision. The registered manager told us that completing supervisions and appraisals was a focus for improvement for the coming year.

Staff told us they had attended training in a number of areas, such as moving and handling, first aid, safeguarding and DoLS, medicines management, care planning and fire safety and felt they had sufficient training to enable them to support people safely. Training records we viewed however showed that not all staff had completed all training courses which the provider considered mandatory. For instance, records showed that of the 49 staff employed, 28 had completed fire safety training, 26 had completed MCA and DoLS training and 16 staff had completed infection control training. Only eight staff were recorded to have completed training in dementia care, however all people living in Amberleigh House are living with dementia. The registered manager told us they had already identified the need for further training and that a number of training sessions had been planned to help ensure all staff received appropriate training to enable them to support people effectively. We saw courses booked in areas such as first aid, dementia, diabetes and infection control and staff we spoke with were aware of them.

People living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed that staff made timely referrals to other health professionals for advice, care and treatment for people when required. Records we viewed showed that people received input from a range of other professionals, including the GP, dietician, optician, speech and language therapist and community mental health team.

Relatives we spoke with told us that staff always kept them informed about any changes to their family members health or wellbeing and agreed that advice was sought quickly when needed. One relative described a time when their family member had developed a new medical condition. They told us that staff had noticed immediately, contacted the GP and treatment was commenced quickly.

We observed lunch during the inspection and found that people could choose where they wanted to eat their meal. We found that there was a choice of meal and people were asked each morning what they would like for lunch. People living in the home told us the food was, "Very nice, lots of choices", "Really good" and "I eat everything here, it is really good." Relatives we spoke with agreed and their comments included, "I have tasted the food, so far so good" and "Staff ask what (family member) wants and if they don't like it they swap it." Relatives told us they could join their family members for a meal if they wanted to and that staff always offered them a cup of tea when they visited.

People were supported discreetly when required during lunch and we found that people were not rushed. We observed staff encouraging one person to eat their meal and then providing an alternative as they did not eat the original meal.

We spoke with the chef who was knowledgeable about people's dietary preferences and needs. For instance, they told us one person was allergic to one of the ingredients within the lunchtime meal, so they had prepared a separate individual portion of the food without the ingredient in. There was information in the kitchen regarding people's nutritional needs. This meant that all staff had access to this information to help ensure people received appropriate meals and drinks.

We observed the environment of the home and found that the registered manager had made adaptations to

assist people living with dementia with orientation and safety. For instance, corridors were decorated to reflect themes to help people recognise where they were within the home. The themes included the sea side, sports, music, a garden and days gone by. Each area included a small lounge which had been decorated and furnished to match the theme. For example, the sports corridor contained pictures of famous sporting celebrities and a lounge decorated as a pub, including a bar. The pub contained football programmes from local football teams. The music lounge contained a record player with a selection of records that people could listen to and we observed people sitting and relaxing in this lounge.

People's bedroom doors displayed a photograph of the person which the registered manager told us had been selected by the person or their family member as a picture with significance. The doors also contained people's name and a number, enabling people a variety of ways to recognise their room. Bathroom doors contained pictorial signs of a toilet to assist people in finding the bathroom independently when required. We also observed orientation boards on display within both dining rooms, providing people with information such as the day and the date.

Is the service caring?

Our findings

When we last inspected Amberleigh House in January 2016, the caring domain was rated as 'Requires improvement.' This was because staff did not always have time to interact with people living in the home in a meaningful way.

During this inspection we spent time in both the residential and nursing units, observing interactions between staff and people living in the home. We found that interactions were warm and caring and we observed staff spending time sitting and chatting with people and looking through books. We found that staff were regularly in the corridor areas and would stop and chat to people who were walking along the corridors, often stopping what they had been doing to walk with the person to the lounge or to get them a drink.

Not all people we spoke with were able to talk to us about their experience of living in Amberleigh House, however all relatives we spoke with told us that staff were kind and caring and treated people with respect. Comments included, "Staff are great, nothing is a problem, they never get upset", "[Staff] are all lovely, not one that isn't nice", "[The staff] approach is good, they are casual, not formal" and "It is a friendly, relaxed and family atmosphere." One relative described the home and its staff, as, "Amazing." Another relative told us how they particularly liked the décor of the lounge, as chairs and sofas were positioned in small groups, one of which was around the fireplace. They told us it felt like home for their family member as they always sat by the fireplace watching television when they lived at home.

The home utilised picture cards which used simple pictures to help people with communication difficulties express their needs. The cards helped people to express needs such as whether they were in pain, too hot, hungry or needed to use the toilet. This meant that staff could provide appropriate support to people based on their needs.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms, referring to people by their preferred name and providing discreet support with meals at lunchtime. Personal care was carried out in private and people did not have to wait long if they needed support. Staff we spoke with gave us clear examples of how they ensured people's dignity was maintained when they were supporting people with personal care needs. This included ensuring the door and curtains were closed, using a towel to help cover the person and talking to the person, offering choices and providing support in such a way as to promote people's independence.

Care plans were written to guide staff to promote people's independence when providing support. For instance, one person's personal care plan reminded staff to offer prompts and encouragement. It clearly described what the person was able to do for themselves and what they required staff to support them with. We also observed staff encouraging people to be independent during the inspection, such as with their meals, only providing assistance when it was required.

Relatives we spoke with agreed that people's independence was encouraged. One relative told us how their

family member had improved since moving into the home, describing it as, "A light being switched on inside them."

We found that care files were stored securely in order to maintain people's confidentiality. This meant that only people who were required to view the care plans were able to access them.

The registered manager told us that people's religious and cultural needs were always accepted and respected in the home. Care plans we viewed reflected whether people chose to participate in religious practices. One person's care file reflected that they received a visit from a local member of the church each week for holy communion.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained and relatives we spoke with agreed that they could visit their family members at any time. All relatives told us they were made welcome when they visited and that they could visit their family member in private if they wished to. People living in the home had access to skype, which the registered manager told us staff supported people with to enable them to keep in contact with relatives who may be unable to visit the home.

For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access and the registered manager told us people would be supported to access these services should they be required. One person was receiving support from an independent mental capacity advocate (IMCA). An IMCA is a person allocated to represent a person who lacks mental capacity to make specific decisions and who has nobody to act on their behalf.

Is the service responsive?

Our findings

When we last inspected Amberleigh House in January 2016, the provider was meeting regulations and the responsive domain was rated as 'Good.'

During this inspection, we looked at people's plans of care. We viewed care plans in areas such as personal care, eating and drinking, elimination, maintaining a safe environment, communication and medicines. We found that not all planned care was evidenced as provided. For instance, one person's care plan reflected that they required support to reposition every two hours as they were at risk of developing a pressure ulcer. When we looked at records to evidence that this support had been provided, we found that no records had been completed for five days. Another person who required support to reposition did not have any records completed for eight days, although staff confirmed that the support had been provided. This meant that accurate records of care were not maintained.

We looked at repositioning records for another four people. All of the records showed that people had been supported to reposition at the same time, by the same staff, each day. This meant that the records did not accurately reflect the support that was provided to people, as the times recorded were not correct. We also found that not all staff were using the recording tool correctly as codes to explain what position the person was assisted into, were not used correctly. For instance, some staff used the letter B to show the person was on their back, whilst others used the letter B to reflect that the person was in bed. We discussed this with the registered manager who told us they speak with all staff on the day of the inspection to ensure they understood who required records to be maintained and how they should be completed. On the second day of inspection, we found that a new tool had been devised and those we viewed had been completed accurately.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. Care plans included information regarding people's preferences in areas such as meals, clothing, social activities and personal care. Care files included a care plan summary which included details regarding people's preferred daily routines, such as when they like to get up in the morning, when they like to go to bed, where they like to eat their meals and spend time during the day. If people had a preference as to the gender of the staff member who supported them with their personal care needs, this was recorded within their care file. One person's social activity care plan described how they particularly enjoyed singing, however staff had to initiate the singing and the person would then join in.

Care plans reflected people's individual needs and were detailed and informative. They reflected people's preferences and included information regarding the person's life history. This meant that all staff had access to information to help them provide support to people based on their preferences and people were supported by staff who knew them well.

Care plans we viewed had been reviewed regularly and most relatives we spoke with told us they were aware of the care plan in place, though not all had been involved in a review recently. All relatives told us they were made aware if there were any changes to their family members care and treatment. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff and through viewing people's care files.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from the day the person moved into the home.

We saw that people had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges, whether to join in activities or spend time in their rooms. Care files reflected people choice's with regards to their daily support. For instance, one person's file stated that they liked to spend time alone and eat meals in their room, whilst another person's care plan showed they preferred to sit with other people. Care plans promoted choice and staff were guided as to how this could be maximized. For instance, one care file showed that the person could get easily confused, causing distress, so staff were advised to limit the choices to two options. This helped to ensure that the person could make choices, without it impacting on their wellbeing. Relatives we spoke with agreed that people were encouraged to make their own choices. One relative told us, "Staff let [relative] pick out their wardrobe, what to wear, and ask them to pick their jewellery."

We looked at the social activities available within the home. An activity coordinator was employed, as well as two volunteers who assisted with activities three times per week. A schedule of planned activities was on display within the home. Activities included arts and craft, reminiscence, board games, exercises, cards, bingo pamper mornings and an afternoon in the lounge decorated as a pub. Staff and relatives told us that people enjoyed sitting in this area and taking part in the activities provided there. People living in Amberleigh House had access to a shared minibus and trips to local attractions were arranged regularly, as well as external entertainers visiting the home. Relatives told us about a recent pantomime that took place in the home that everybody appeared to enjoy. One relative told us, "[Staff] are really good here at engaging people", whilst another relative told us the home, "Caters for all."

The registered manager told us about the family forum. This included a group of relatives who met together regularly to plan fundraising events in order to fund meaningful activities for people living in the home. The registered manager told us this encouraged staff and relatives to work together. Relatives had been consulted during the recent refurbishment of the home, which helped to ensure people's preferences were reflected in the décor of their home. For instance, the development of the pub theme and the pictures of sporting legends were chosen as they were significant to people living in the home.

We looked at processes in place to gather feedback from people and listen to their views. Records we viewed showed that relative meetings took place regularly and included discussions regarding meals, activities, staffing and the refurbishment of the home. Most relatives we spoke with told us they were aware of relative meetings, as well as the family forum meetings. None of the people we spoke with who lived in the home, or their relatives, were aware of quality assurance questionnaires and the registered manager confirmed that these were not used as a means to gather feedback as people could share their views in regular meetings. One relative told us, "The home is always asking [your views]; they are interested in what you think."

There was a complaints procedure in place within the home and all people we spoke with knew how to raise any concerns they had. Information regarding complaints was provided to people when they first moved

into the home, although the complaints policy was not on display. The registered manager told us they would ensure the policy was displayed so that people had access to this information at all times. A log of any complaints received was maintained and we found that these were responded to appropriately in line with the providers policy.

Is the service well-led?

Our findings

When we last inspected Amberleigh House in January 2016, the well-led domain was rated as 'Requires improvement.' This was because there was no registered manager in place, there was no evidence of staff meetings and quality assurance processes were not always effective.

During this inspection we looked to see how the registered manager and provider ensured the quality and safety of the service provided to people living in the home. We viewed completed audits in areas such as medicines management, infection control, catering and care plans. We found that the audits identified actions required for improvement and it was recorded when these actions had been completed. Most of the issues we identified during the inspection, had been highlighted through the provider's internal quality monitoring systems, such as those relating to training, supervision and appraisals. The issue regarding repositioning records had not been identified but the registered manager told us at the end of the inspection that these records would now be audited daily.

The registered manager completed a medicine audit each week which looked at receipt, storage, administration and recording of medicines. The last audit completed in January 2017 identified that staff were not always providing an explanation as to why PRN (as and when required) medicines, were given or not given. When we viewed MAR charts we found that this had improved and explanations were clearly recorded on the back of MAR charts. This showed that the audit had been effective in identifying issues and driving forward improvements. A care file audit we viewed showed that the person's file needed to be updated to include a life history and record of GP visits. We viewed the care file and these actions had been addressed.

The registered manager provided head office with a monthly clinical governance report, which provided information on all areas of the service, such as whether bed rails were in use, whether anybody had any pressure sores, any safeguarding referrals and any admissions to hospital. Head office were also informed of any accident or incidents and any complaints received. The provider's internal quality assurance team last completed an audit in November 2016. It identified a number of areas for improvement, many of which had already been addressed and some of which were on going. An action plan had been developed and records showed that this was being reviewed regularly. This meant that systems in place to monitor the quality and safety of the service were effective and the provider was able to maintain oversight of the service.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. Relatives we spoke with described the registered manager as, "Wonderful", "Approachable", "Great", "A breath of fresh air" and "Fabulous, a special kind of person." One relative told us that the home had, "Very good leadership, so well organised and so are the staff." Another relative said, "The staff are the same quality as the manager, it is more than just a job for them."

Staff we spoke with told us that there had been a number of positive changes since the registered manager had been employed. Comments from staff included, "It is nice to come to work", "It is a happy place, we try to make it homely" and "This is the best of all of the homes I have worked in." A staff member told us they

had recommended the home to a number of friends and all staff we spoke with told us they would be happy for their family members to be cared for at Amberleigh House. Staff told us they were supported by the registered manager and could go to them at any time if they had concerns and that the registered manager encouraged this.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home.

Records we viewed showed that staff meetings took place and covered areas such as medicines management, care planning, infection control, equipment, health and safety and safeguarding. The minutes from these meetings showed that the registered manager reminded staff of key processes, such as safeguarding and asked staff their views on what was working well within the home and what was not working. An action plan was then developed with agreed actions to help improve the service. We found that actions recorded had been completed.

When we arrived at the service, the ratings from our previous inspection were not displayed within the home as required. We discussed this with the registered manager who arranged for the ratings to be displayed in the foyer of the home before the end of the inspection.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Amberleigh House.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Planned care was not always evidenced as provided and records were not always maintained accurately.