Tamaris (England) Limited

Amelia House Care Home

Inspection report

Coningham Avenue
Manor Lane
Rawcliffe
York
YO30 5NH
Tel: 01904 692265
Website: www.fshc.co.uk

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Ratings

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

Overall summary

The service is registered to provide accommodation and care, including nursing care, for up to 81 older people, some of whom may be living with dementia. The premises are purpose built and bedroom and communal areas are located over three floors. Each floor is managed and staffed as a separate unit. All of the bedrooms are single and have en-suite facilities and the first and second floors are accessed by a passenger lift.

The registered provider is required to have a registered manager in post and on the days of the inspection there was a manager in post who was not yet registered with the Care Quality Commission (CQC). 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. On 21 October 2015 the manager wrote to us to confirm that they had commenced the registration process.

Summary of findings

We saw that staffing levels had increased; more permanent staff had been employed but there was still a reliance on using high numbers of agency staff.

People told us that they felt safe living at Amelia House. We saw that there were appropriate assessments in place to protect people from the risk of harm when staff were assisting them with mobilising and that staff used equipment safely. The premises had been maintained in a safe condition.

We found that people were protected from the risks of harm or abuse because the registered person had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Managers and care staff had attended training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They followed the basic principle that people had capacity unless they had been assessed as not having it. When people lacked the capacity to make decisions, meetings were held to make sure any decisions were made in their best interest. The manager was aware of their responsibilities in relation to DoLS and had made applications to the local authority when someone was considered to be deprived of their liberty.

There were robust recruitment and selection practices in place and we saw that only people considered suitable to work with vulnerable people had been employed. There were systems in place to check each nurse's registration details to ensure they remained fit to practice.

We saw that staffing levels had increased; more permanent staff had been employed but there was still a reliance on using high numbers of agency staff. We made a recommendation about this in the inspection report.

Staff told us that they were happy with the training provided for them. The training records evidenced that staff were provided with induction training when they were new in post and then on-going training to ensure they had the skills needed to carry out their role.

Staff who had responsibility for the administration of medication had completed appropriate training. Medicines were administered safely by staff and the arrangements for storage and recording were robust.

People's nutritional needs had been assessed and people told us that their special diets and likes and dislikes were catered for, and that they were happy with the meals provided at the home. We saw there was a choice available at each mealtime, and that staff ensured people were aware of the choices available.

People told us that staff were caring and we observed that staff had a caring and supportive attitude towards people; this was supported by the relatives and health care professionals who we spoke with.

There were systems in place to seek feedback from people who lived at the home, relatives and friends, staff and health care professionals. Any complaints made to the home had been dealt with in line with the home's complaints procedure and we saw that people were given feedback about the outcome of the complaints investigation.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the manager and senior staff were designed to identify any areas that needed to improve in respect of people's well-being and safety. We saw that some improvements had been made as a result of people's comments and staff told us that any issues were discussed openly so that they could learn from the outcome of investigations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

More permanent staff members had been employed but the home was reliant on agency staff to maintain staffing levels.

Staff had received training on safeguarding adults from abuse and moving and handling, and accidents or incidents were monitored to identify any improvements in practice that might be needed.

People were protected against the risks associated with the use and management of medicines. People received their medicines at the times they needed them and in a safe way.

The premises were being maintained in a safe condition.

Is the service effective?

Good

The service was effective.

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS), and that best interest meetings were used to assist people to make decisions.

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home and their relatives (with the exception of one relative) told us that staff were caring and we observed positive relationships between people who lived at the home and staff on the day of the inspection.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive to people's needs.

Visitors were made welcome at the home.

Summary of findings

People's care plans recorded information about their previous lifestyle and their preferences and wishes for their care were recorded.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager if they had any concerns.

Is the service well-led?

Good

The service was well-led.

The manager was not registered with CQC but they have commenced the registration process.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Amelia House Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 19 and 20 October 2015 and was unannounced. The inspection team consisted of two adult social care (ASC) inspectors, a pharmacy inspector and a specialist advisor on dementia care. The full team carried out the inspection on the first day and the second day of the inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection, as they submitted one in preparation for the inspection in April 2015. The PIR is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with six people who lived at the home, five relatives or visitors, eight members of staff, two health care professionals, the manager and the area manager. We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, which included the care records for six people who lived at the home, the recruitment and training records for six members of staff and other records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

At the last inspection of the service on 1 and 7 April 2015 we identified some concerns in respect of the administration and recording of medicines. This was a breach of Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the inspection on 19 and 20 October 2015 we looked at medicines, medication administration records (MARs) and other records for 17 people living within all three units of the home. We spoke with two nurses and a senior care worker about the safe management of medicines, including creams and nutritional supplements within the home.

Medicines were stored safely and securely. The temperature of medicines storage areas was monitored regularly. However in one unit the air conditioning unit was not functioning and the temperature was higher than the maximum recommended for storing medicines safely. We discussed this with the manager and they told us they had not been aware of this, but would take immediate action.

Only nurses or senior care workers supported people living in the home to take their medicines. Most medication records were clear, complete and accurate and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. We found however that care workers did not always record the use of creams, ointments and other external products and it was not possible to see from the records whether these products had been used as prescribed. We discussed this with the manager and they told us they had identified this as an area of concern and had introduced a new system; they were going to be piloting it for a month to test out its success.

Some people were prescribed medicines such as painkillers and laxatives that were to be taken only 'when required'. Whilst some guidance was available for care workers to follow, the information was not always personalised with details of people's individual signs and symptoms. This information is important to ensure that people are given their medicines correctly and consistently, especially if the individual has communication difficulties or is unable to recognise their own needs. Pain assessment tools were available to help staff determine when people who were unable to ask for pain relief needed their medicines.

At the last inspection of the service on 1 and 7 April 2015 we identified some concerns in respect of the safety of the premises; people had not been able to access emergency call bells and there was a lack of clarity in recording people's injuries. This was a breach of Regulation 12 (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the inspection on 19 and 20 October 2015 we observed that there was a keypad entry system to all floors of the home and this meant that only people who had permission to be in the premises could access the home. Two people who we spoke with told us that this made them feel safe. We saw that people who lived at the home had emergency call bells in their bedrooms as well as in toilets and bathrooms; this meant that they could alert staff if they needed assistance. Two visitors who we spoke with told us they felt their relative was safe. One person said, "Yes – they are safe and treated well."

We asked staff how they kept people safe. Their comments included, "Observing people and making sure they are not in danger, and moving and handling training", "Make sure there are no trip hazards and that we transfer people safely" and "We check all equipment and report any repairs that are needed to the handyman and we make sure all care bells are working and accessible."

Care plans included information about each person's needs in respect of moving and handling, such as the type of equipment that was needed and how many staff were required to assist with the transfers. We observed staff using mobility equipment to transfer people to and from chairs and wheelchairs on the day of the inspection; we noted that the correct equipment was used and that these transfers were carried out safely. However, we noted that moving and handling tasks were sometimes carried out by two agency staff who did not know the person well; this meant there was minimal conversation that could have reassured the person whilst transfers were taking place.

On the first floor we saw one person mobilising by using a wheelchair and that there was no foot rest on the wheelchair. We asked the nurse in charge if the person had a footrest and if it was normally used and they were not

Is the service safe?

able to confirm this. The manager told us they would ensure this person was using their wheelchair in a safe way and acknowledged that the member of staff who we spoke with should have been able to answer our query.

We saw that care plans listed the risks associated with each person's care. Risk assessments highlighted any identified risks to the person, and how staff could minimise these risks to keep people safe. The risk assessments we saw included those for nutrition, moving and handling, pressure area care and the risk of falls. We noted that care plans recorded 'clinical hotspots'. These were important areas of risk that had been identified in respect of the person's care to ensure they were considered by staff. A health care professional told us that staff understood people's behaviours and dealt with them effectively to ensure that people remained safe.

There were risk assessments in place to identify any environmental hazards and how these could be managed to protect people from the risk of harm. In addition to this, there was a fire risk assessment in place about each person's bedroom. These documents recorded the assistance a person would need to evacuate the premises, including any equipment that would be required and the number of staff that would be needed to assist with the evacuation.

We saw that there was an emergency plan and 'grab bag' stored in the entrance to the home; this was located to it could be accessed quickly in the event of an emergency. The plan included advice for staff on what action to take in the event of an emergency such as fire, flood or power failure, as well as details of alternative accommodation for people if the premises had to be evacuated, any critical medication required by people who lived at the home and staff contact telephone numbers.

We checked the service certificates for maintenance undertaken by contractors and found that they were all up to date. This included the three passenger lifts, hoists and slings, the gas safety certificate, the electrical wiring certificate, the fire alarm system, fire extinguishers and emergency lighting. We noted that fire extinguishers were protected by a case and fastened to the wall which meant people could not hurt themselves on them. This evidenced that the premises were maintained in a safe condition to protect people from the risk of harm.

The manager carried out a monthly safety tour of the premises that included checks on housekeeping, fire exits, fire extinguishers, fire doors and laundry. The home's maintenance person carried out checks on emergency call bells each day and there was a supply of replacement call bells so that any faulty equipment could be replaced immediately; we saw that call bells were easily accessible in all rooms. We saw that bed rails were checked by the staff on duty. One care plan we checked recorded, "Bed rails checked hourly." These arrangements meant that any repairs identified could be carried out promptly, and that the home was maintained in a safe condition.

We saw that the quality assurance documents included an audit of falls and an analysis of the cause. When people had sustained an injury this was recorded on an incident form, and we saw records were very detailed. Body maps were used to record where on the body the injury had occurred and we saw these records were signed and dated. This information allowed staff to monitor the person's recovery. However, a visitor told us they were unhappy that their relative had developed a sore area and they had complained about this to the manager. The manager explained this situation to us and we were satisfied that appropriate medical advice had been sought.

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse. They were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the manager or a senior member of staff. Staff also told us that they would not hesitate to use the home's whistle blowing policy if they were concerned about any incidents or care practices at the home. They added that they were certain this information would be treated professionally by the manager and their right to confidentiality would be upheld.

We checked the electronic records held in the home about safeguarding incidents or accidents / incidents that had occurred. The manager told us that information about accidents / incidents was printed off and held in the person's care plan when the investigation had been completed. The information about any safeguarding incidents was held centrally. As part of this process, the manager checked if health and social care professionals and family / friends had been informed, and that appropriate body maps and '24 hour falls checks' had been used appropriately.

Requires improvement

Is the service safe?

We looked at the recruitment records for four members of staff. An application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw records that evidenced checks were carried out each month to ensure nurses who were employed by the service and nurses from employment agencies were registered to practice in the UK. We noted that some recruitment checklists had not been fully completed and this would have provided more robust evidence that all safety checks were in place before staff commenced work at the home.

The home used the organisations system for determining staffing levels; this was known as the Care Homes Equation for Safe Staffing (CHESS); this included a monthly check on the dependency levels of people who lived at the home.

The manager told us that staffing levels were five care staff on each floor plus a registered general nurse (RGN) in both nursing units and a senior care worker in the residential unit. The database showed that these staffing levels were being maintained, although permanent staff were being supplemented by the high use of agency staff on some days. On some days as many as seven agency staff were being used during one shift. The manager told us that they tried to 'overstaff' the home because when people went off sick this meant there were still enough staff on duty to meet people's needs.

We asked staff if they felt there were enough people employed at the home. They told us that staffing levels were improving as more permanent staff had been employed. They also said that they used 'regular' agency who always worked on the same unit so they got to know people.

On both inspection days we observed that there were sufficient numbers of staff on duty and we noted that call bells were answered promptly. However, relatives continued to tell us that there were insufficient numbers of staff on duty.

We recommend that staff deployment and the use of agency staff is reconsidered to ensure that staff are always visible within the home.

The rotas we saw evidenced that there were always sufficient numbers of ancillary staff on duty. This consisted of one or two laundry assistants, a chef, two catering assistants and one or two domestic assistants each day, and two or three activities coordinators each day (Monday to Friday). This meant that care and nursing staff were able to concentrate on providing care and support to people who lived at the home.

At the last inspection on 1 and 7 April 2015 we were concerned about the control of infection. On the day of this inspection was found the home to be maintained in a clean and hygienic condition. The home had recently been redecorated and was bright and odour free. We checked the folder that contained information about the control of infection. This included information from the Health Protection Unit about infectious diseases, an annual infection control report, guidance on deep cleaning, information about the colour coding of equipment, cleaning schedules and notices ready for use in the event of an outbreak of infection. We noted that there were ample supplies of gloves, aprons and other personal protective clothing (PPE). The PPE cupboard was locked (with a keypad entry) and only accessible to staff.

The registered manager acknowledged that not everyone had their own sling and that this would be the ideal situation; they were working towards this. However, they confirmed that slings that did not belong to the person were washed after every use. This protected people from the risk of infection.

We checked the facilities in the laundry room and noted that there were clearly defined 'dirty' and 'clean' areas with an entrance door into the 'dirty' area and an exit door in the 'clean' area. Different coloured trolleys were used to transfer clean and dirty laundry to and from the laundry room to reduce the risk of the spread of infection. The floor and walls were easy to keep clean and there were separate hand washing facilities for staff.

We saw the cleaning schedules used by domestic assistants and these evidenced that all areas of the home were cleaned, including deep cleaning, on a regular basis.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the Local Authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The MCA legislation is designed to ensure that when an individual does not have capacity, any decisions are made in the person's best interests. The care plans we reviewed recorded a person's capacity to make decisions, that any decisions made on the person's behalf should be made in their best interest and that people should be involved in the decision making process as far as is possible. For example, one care plan recorded that a best interest decision had been made about the use of bed rails and bumpers. The care plan recorded, "This is deemed to be the least restrictive option to maximise safety for (name) whilst on bedrest."

The manager was aware of the principles of MCA and DoLS, how they impacted on people who used the service and how they were used to keep people safe. We saw evidence that DoLS applications had been submitted to the local authority when needed and that authorisations in people's care plans were valid. We saw copies of capacity assessments and best interest paperwork that had been used to support the decision making process.

At the last inspection on 1 and 7 April 2015 we recommended that staff should undertake training on MCA and DoLS. All of the staff who we spoke with at this inspection told us that they had undertaken training on MCA and DoLS. One member of staff told us that these topics were also discussed by the manager in a recent meeting and this helped them to understand the key principles.

We saw that staff asked for people's permission, or checked for 'implied' consent before they started to assist people. Some care plans advised staff how to check for 'implied' consent, such as looking for particular behaviours or body language. We noted that the word 'compliant' was used when referring to people living with dementia being asked if they required support with care and suggested that the word 'cooperates' should be used instead.

A health care professional told us that staff understood people's behaviours and dealt with them effectively to ensure that people remained safe. We were told that the policy of the home was to use de-escalation techniques rather than restraint to manage a person's behaviour that might challenge the service. The manager told us that she was due to attend 'break away' training the week following the inspection. This is training that focuses on the use of de-escalation techniques.

We saw that redecoration had taken place to make the home more 'dementia friendly'. This included the provision of a dementia café which was used for some activities within the home. The manager planned that the dementia café would eventually be used by people who lived in the local community as well as people who lived at the home. Corridors were themed; this included York Railway Station, Rowntrees chocolate and 'Women's work'. All of the corridors were interactive, with items that could be used by people who lived at the home; these were all items that could not cause people any harm. Bedroom doors were painted different colours to aid identification, and some people had memory boxes or their name on their door to help them recognise their room.

Some of the lounge areas were also 'themed'; these were smaller than the main lounges and provided more intimate areas for people to spend time with family and friends or smaller groups of people so that more person-centred activities could take place. One room was designed to look like a cinema, and it contained a large screen so that people could watch films. In one of the large lounges we noted that the chairs were placed around the edge of the whole room and we felt that repositioning the chairs to make smaller seating areas would have created a more family atmosphere. We saw that there were small areas of seating in corridors just outside lounge areas. These created more intimate areas but were still clearly visible by staff so that people's well-being could be monitored.

All bedrooms had en-suite facilities; these were large enough to allow access for people using mobility equipment, such as wheelchairs and hoists, and assistance from staff.

A new member of staff described their induction training to us. They told us that they carried out e-learning on a variety of topics including infection control, fire safety, food safety, health and safety, data protection, respect, safeguarding vulnerable adults and children, DoLS and moving and

handling. They told us that it was "Quite difficult to carry out training on fourteen topics at the same time" although the training had made them feel confident about carrying out their role. They had also started a National Vocational Qualification award. Staff also confirmed that they had shadowed an experienced care worker as part of their induction training.

There was an e-learning 'hub' in the entrance hall where staff could sit to use the home's laptop to undertake on-line training. The manager told us that staff were able to access this learning at work and at home. They acknowledged that this area was not ideal to promote learning for staff and there were plans for an unused treatment room to become a learning room.

We saw records of training that had been undertaken by staff each month. This included events on moving and handling, fire safety, medication, dementia awareness, end of life care, hydration and nutrition, person-centred care, safeguarding adults from abuse, infection control and first aid. Staff told us that they were satisfied with the training provided for them and that this gave them the skills to carry out their role effectively.

We saw that one nurse who was in charge of a floor spent most of their time in the office. They did not appear to be supervising the shift and readily passed over responsibility to care staff. Formal supervision records were seen in some staff files but not all. However, the staff we spoke with told us that they had one to one meetings with a manager plus an annual appraisal. Staff told us that they were well supported by the manager and more senior staff. One member of staff told us that they had attended a three month review meeting with the manager when they were new in post; they had been able to discuss their progress and their training needs.

Information we saw displayed in the home, staff training records and quality assurance documents evidenced that best practice guidance was shared with staff at the home.

People who lived at the home and relatives told us they were happy with communication between them and staff at the home. A visitor told us that they always received a telephone call from staff if there had been any changes in their relative's health condition, or any other matters concerning their relative.

A senior staff member confirmed that nurses treated some conditions for people who were placed at the home to receive nursing care, and district nursed visited the home to treat people who were in receipt of residential care. People told us that they told a member of staff if they felt they needed to see a GP and that this would be arranged. Visits of any contact with health care professionals were recorded in care plans; this included the outcome of the contact and whether the person's family had been informed.

A health care professional who we spoke with confirmed that staff discussed complex situations with them and every effort was made to meet the needs of the person who was in receipt of care. They told us that staff made appropriate referrals to the surgery and that they asked for advice and listened to that advice.

We saw that each person's health care conditions were recorded in their care plan. A health care professional also told us that staff had a good grasp of how physical health could impact on a person's mental health. They said that the manager and staff asked for advice appropriately and valued their input. They said that, if they were concerned about a person's nutritional intake, they could request that staff weigh the person each week instead of each month, and this request was complied with. We saw that care plans contained nutritional assessments and that when there were any concerns about nutrition, appropriate referrals had been made to dieticians and speech and language therapy (SALT) services. Quality assurance records included a root cause analysis for anyone with an unexpected weight loss.

We also saw examples of food and fluid charts that were used to monitor a person's nutritional intake. Care plans recorded any special diets that people required, such as soft diets, fortified diets or diabetic diets as well as their dietary likes and dislikes. We saw that one person's care plan recorded they needed a soft diet and 'their food chopped up by staff'. This did not happen on the day of the inspection. We discussed this with the manager and they told us that the care plan was incorrect as the person's needs had changed. They said they would ensure it was updated immediately.

We observed the serving of lunch on all three floors of the home and noted that the dining rooms were bright, clean and welcoming. Tables were laid with appropriate crockery, cutlery and table linen and some people were provided with a clothes protector. Adapted cutlery or crockery was provided for people who required it. There was a menu on

Good

Is the service effective?

display outside of each dining room and this recorded the choices on offer for that day in both written and pictorial format. The service of lunch was carried out efficiently and calmly by staff.

We saw that people were encouraged to eat independently if they were able to do so. People were asked if they required assistance with eating their meal and if assistance was required, a member of staff sat beside the person to support them. The service had 'protected mealtimes'; this is when visitors are asked not to visit over mealtimes so that people can take their time to eat their meals and have a positive mealtime experience. People told us that they enjoyed their meals and they confirmed that there was always a choice on offer. We saw that one person asked for soup and a sandwich instead of one of the meal choices on the menu and this was provided.

The manager told us that no finger foods were currently being provided but our discussion indicated they had a clear understanding of the types of foods that should be provided when people had difficulty eating using cutlery or were reluctant to sit down to eat.

Good

Is the service caring?

Our findings

We asked people who lived at the home if they felt staff really cared about them and comments included, "Fantastic", "They can't do enough for you" and "If there is every anything wrong they sort it." We observed that a member of staff clearly had a good relationship with one person who lived at the home. We could see this by the expression on the person's face when the staff member entered the room.

The interactions seen by members of the inspection team between people who lived at the home and staff were positive, with the staff approach being calm, gentle and supportive. However, we saw one example of staff behaving in an disrespectful manner; the member of staff was 'waving' a plastic flower pot around a person's head for no apparent reason. This led us to believe that this member of staff may have required closer supervision to ensure that their behaviour was always respectful towards people. We discussed this with the manager who assured us that this issue would be addressed.

One service user told us they were not very happy at the home. However, they told us that this was not because staff had been unkind, but that they wanted to live in another area of the city close to where they used to live. We fed back this information to the manager and asked them to make sure that the appropriate professionals were aware of this person's wishes.

Staff told us that they felt staff genuinely cared about people who lived at the home. One member of staff told us, "Yes, staff genuinely care" and a new member of staff said, "I haven't met anyone yet who doesn't care." Staff also told us that the increase in staffing levels had led to people receiving better care.

We spoke with two health care professionals on the day of the inspection. One of them told us that, in the past, staff at the home "Didn't always know what was going on." They said that this had improved and that staff now had a "Good grasp of patient's needs and their 'stories'." Another health care professional told us that they would not hesitate to recommend Amelia House to their relatives.

Care plans included information about people's preferences for care, and information about their previous lifestyle, likes and dislikes and daily routines. One care plan we saw stated, "To have hair done weekly and cut monthly. Likes to wear nail polish, jewellery and perfume – staff to prompt and encourage them to still do this." This type of information helped staff to provide care to people that was centred on their individual preferences.

People who lived at the home and relatives told us they were happy with communication between themselves and staff at the home. A visitor told us that they had been invited to attend a multi-disciplinary team meeting to discuss the future care needs of their relative. This showed that relatives were involved in a person's care when this was appropriate.

A member of staff told us that the topics of privacy and dignity were included in the home's induction programme. We observed staff knocking on doors before entering, even when the door was open. Staff told us that they protected a person's dignity by assisting people in their own bathroom and told us, "We keep asking if they are OK with what we are doing" and "We make sure doors and the curtains are closed. We cover them with a towel to protect their modesty." People who lived at the home told us they were happy with the way they were supported by staff, and that staff respected their need for privacy and dignity.

We saw that there was information in the home about available advocacy services. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. This meant that people had access to this information without having to ask, maintaining their independence and confidentiality.

We saw that people were encouraged to be as independent as possible. For example, we saw that one person laid the table ready for lunch. A member of staff told us that they asked people if they would like to wash themselves before assisting them to do this, and another member of staff said they encouraged people to wash their face and clean their teeth if they were able to do so.

Good

Is the service responsive?

Our findings

We checked the care records for six people who lived at the home. We saw that they included care needs assessments, risk assessments and care plans. Assessments covered the areas of nutrition, skin integrity and mobility. Risk assessments had been completed for falls, nutrition and choking. We saw that five of the care plans included comprehensive information about how the person's needs should be met. However, for one person information in care records lacked direction. One entry stated "Needs to interact meaningfully" but there was no description of what this meant for the person and how this would be achieved. We raised this with the manager who acknowledged that staff on some units had updated care plans more effectively than on others, and that this issue would be addressed.

Two of the people we spoke with told us they had not been involved in formulating their care plan, but their relatives had been. We saw that care plans were reviewed and updated each month. More formal reviews had been held for some people that had been organised by the local authority. We saw that the person concerned attended the meetings when they were able to do so and that people involved in the person's care were invited. This meant that staff had up to date information to follow.

We saw that two care plans did not include photographs of the person concerned; this would help new staff to identify people. Although a person's allergies were recorded, this information would have been more easily identified if the entries had been written in red ink.

The SOFI inspection indicated to us that, although most people received appropriate support from staff, much of the contact was task based. We saw that two people who were not sitting in the lounge area received minimal support and that there were times when there were no staff in communal areas of the home. This was a concern, as many people were not able to summon assistance.

The manager told us that they had a 'handover' meeting on each floor and another for the whole service at each shift change. Staff discussed medication, diet, personal care and general well-being for each person who lived at the home. This meant that staff were kept up to date with people's individual care and support needs. There was also a system on the database to record messages for staff; staff had to click to acknowledge they had read the messages.

We saw that each person had a document in their room called 'My journal'. This included a comments book where relatives and friends were able to record notes for staff and vice versa; activities were also recorded in this document. Topical MAR charts, food and fluid charts and repositioning charts were saved in the same folder. This meant that people and their relatives had easy access to this information, and that the information was also accessible to health and social care professionals. A member of staff told us that the journal helped them to get to know the person so they could provide more individualised care.

There were three activity coordinators employed at the home and this meant that two activities coordinators could be on duty each day, Monday to Friday. We saw the activities programme for one week and noted that this included activities for all three units; each unit had four or five activities planned for the week. The programme also included space for one to one time to be spent with people, and for people to be accompanied to go out for a walk. On the day of the inspection we saw the activities coordinator spend time with a small group of people, a larger group of people on another floor and with one person 'one to one'.

A relative told us that the activities taking part at the home were inappropriate for the people who lived there and that they did not take place often enough. However, most people who we spoke with were complimentary about the activities and outings that were provided. On the day of the inspection we saw that activities were taking place and the records we saw indicated that people had regular opportunities to take part in social activities, both individually and in groups. We saw the hairdressing room and the manager told us that the hairdresser visited the home twice a week.

Staff told us that people who lived at the home had access to a telephone if they wanted to contact their family and friends, or if their relatives telephoned them. We saw that people's family and friends were made welcome at the home. There was a 'servery' where visitors could make drinks for themselves and their relative. The manager told

Good

Is the service responsive?

us that there were plans in place to create a café for relatives to replace the servery. It was thought that this would make visitors feel 'part of the home' and more involved in their relatives care.

Staff told us that they supported people to make decisions and express choices. They told us they asked people what they would like to wear, where they would like to sit and what activities they would like to take part in. At lunchtime we saw that staff asked people if they wanted clothes protectors, they offered them a choice of drink and they offered them two choices of meal. If people needed assistance with making a choice, they were shown the two choices on offer to help them decide. We saw that people were invited to take part in activities and that if they declined, this was accepted by staff.

We saw that the complaints procedure was displayed in the home, and also that each person had a copy of the home's service user guide in their bedroom; this included a copy of the complaints procedure. We also noted that feedback received from relatives in July 2015 was displayed on the 'comments, questions and suggestions' board in the entrance to the home.

We checked the complaint log and saw that this included a monthly summary and a three monthly summary of complaints received. We saw that initial response letters were sent to complainants to inform them that their information had been received and would be investigated, and that a final response letter with the outcome was then sent.

One relative told us that they had on-going concerns about the home. We checked the complaints log and saw that a recent complaint had been recorded. There was a record of the investigation that had been carried out; this included taking statements from staff and contacting health care professionals who were involved in the person's care. A response letter was being sent out on the day of the inspection.

Staff told us they would support people to make a complaint if something inappropriate had happened and the person was reluctant to complain themselves. They told us that people's complaints were listened to and appropriate action was taken to respond to complaints.

Good

Is the service well-led?

Our findings

The service had a manager in post who was not yet registered with the Care Quality Commission. On 21October 2015 the manager wrote to us to confirm that they had commenced the registration process.

We spoke with staff about how the home was managed. Staff told us that the manager had implemented a number of changes and that these had benefitted both the people who lived at the home and staff. They described the manager as "Approachable" and "Hands on" with the day to day running of the home. They said that a number of new staff had been employed and that staff were now working towards a common goal. One member of staff told us that the manager led by example, and that they "Looked up to them." The health care professionals who we spoke with told us that the home was well managed.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

The service did not have any written visions and values in respect of the culture of the home, but there was a mission statement that was given to new staff during their induction period. This explained the aims and objectives of the service. The manager described the culture of the home as relaxed and person-centred with a "Community spirit and family feel." A member of staff described the culture as "One big family"; they said the staff were friendly and the manager was very supportive. Another member of staff described the culture as, "A happy unit and good team work. Good relationship with relatives."

The home had introduced a scheme that invited family and friends to nominate a member of staff for an award to recognise good practice. The manager told us that this was working well and that staff appreciated it when they were nominated.

The organisation employed four Care Quality Facilitators and we spoke with one on the day of the inspection. They told us that they assisted managers to monitor quality standards within the care home.

Paper surveys were not distributed to people as there was an electronic system in place within the reception area of the home. This allowed staff, people who lived at the home, visitors and health care professionals to leave comments whenever they wished. This information was analysed by the organisation and a 'You Said, We Did' document was produced to record people's comments. We saw the quarterly report dated July 2015. This recorded that 100% of respondents said they would recommend the home, felt their relative was happy at the home, that privacy was respected and that people were safe. The scores in respect of activities, menus and decision making were lower. This information was displayed on the notice board in the entrance hall, along with information about how any shortfalls would be addressed.

We saw the minutes of two meetings that had been held for people who lived at the home and these evidenced that people were invited to express their views. The topics on the agenda included were menu choices, activities, involvement in care plan development, re-decoration and emergency call bells. We did not see any minutes of relatives meetings.

Records evidenced that various staff meetings were held; these included meetings for all staff, ancillary staff, care staff and trained / senior staff. In addition to this, health and safety meetings and clinical governance meetings were held. Staff told us that these meetings were a two-way process; they were given information but they could also ask questions and make suggestions. They felt that they were listened to. Staff said that if there had been an incident or complaint, this was discussed at both staff meetings and handover meetings to identify if there was any learning to improve future practice.

Each month the manager and other staff carried out a number of quality audits that measured whether systems in place at the home were meeting people's needs in a safe way. These included weekly checks on the cleanliness and safety of walking frames, wheelchairs and cushions, bedrails, commodes, emergency call bells, bedrooms, hoists and mattresses. Some audits were carried out less frequently; these included kitchen audits, the control of infection and 'quality dining'. Audits included a record of

Good

Is the service well-led?

remedial action that needed to be taken. For example, the 'quality dining' audit stated, "Staff to continue training on positive dining experience and person-centred care. To work with head chef re: presentation." We saw that a completion date had been recorded.

The regional manager checked quality assurance information each week, even when the issue had been recorded as 'resolved'. This meant that there was an additional check to ensure that any issues that had been identified as requiring improvement had been actioned.