Amore Elderly Care Limited

Amberley House Care Home - Stoke-on-Trent

Inspection report

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Date of inspection visit:
11 August 2016

Date of publication:
12 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 August 2016 and was unannounced. At our previous inspection we had judged the service as requiring improvements throughout. The service was not consistently safe, effective, caring responsive and well led. We had issued the provider with requirement actions and asked them to improve. Since our last inspection the service had been placed into Large Scale Investigation (LSI) by the local authority due to the amount of safeguarding concerns they had received. At this inspection we found that no improvements had been made and the provider was now in breach of several Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Amberley House provides nursing care to up to 74 people. At the time of the inspection 71 people were using the service. The service was split into three areas, a nursing care area, an area for people living with dementia and a special care unit.

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

The manager had identified areas that required improvement but had not acted to make the desired improvement in relation to insufficient staff. Systems in place to monitor and improve the service were ineffective.

Relatives and people told us they knew how to complain but were not confident that complaints would be acted on.

People were at risk of unsafe care as there were insufficient suitably trained staff to meet the needs of people who used the service. People had to wait to have their care needs met and staff were unable to spend quality time with people in some areas of the service.

Risks to people were assessed but risk assessments were not always followed to minimise the risks of incidents occurring again.

The provider did not consistently work within the guidelines of The Mental Capacity Act 2005 (MCA) to ensure that where people lacked mental capacity they were supported to make decisions with their legal representative.

Although staff felt supported they had not received all the training they required to keep themselves and other people safe from harm whilst working with people who may become anxious and aggressive.

People's privacy was not always respected and people were not always treated with dignity and respect as

staff did not have the time to spend quality time talking to people.

People did not always receive care that reflected their needs and preferences as there were insufficient staff to ensure that people's emotional needs were met.

People were encouraged to engage in hobbies and interests. Individual and group activities were organised.

People received health care support when they needed it and were supported to maintain a healthy diet.

People's medicines were stored and administered safely by trained staff.

Staff knew what to do if they suspected a person had been abused. The manager reported incidents of suspected abuse to the local authority for further investigation.
Safe recruitment procedures were followed to ensure that new prospective staff were fit work with people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were insufficient staff to meet people's needs in a timely manner.

Risk assessments were completed but not consistently followed in order to keep people safe.

There were systems in place to ensure that concerns about potential abuse were recognised, reported and investigated in line with local procedures.

People's medicines were stored and administered in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always consent to their care, treatment and support.

People's nutritional needs were met and people were supported to maintain a healthy diet.

Staff required more training to be able to fulfil their role effectively.

People received health care support when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff demonstrated a kind and caring manner but not all people were treated with dignity and respect.

People's privacy and right to make choices was not always respected.

Staff were too busy to spend quality time with people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that reflected their individual needs and preferences.

There was a complaints procedure and people knew how and who to complain to however people didn't feel confident that their complaints would be dealt with.

Is the service well-led?

Inadequate

The service was not well led.

Improvements had not been made since our last inspections and there were several breaches of Regulations.

A lack of sufficient staff had been identified but not acted upon and people's needs were not being met in a safe and timely way.

There was no registered manager in post.

Amberley House Care Home - Stoke-on-Trent

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 11 August 2016 and was unannounced. It was undertaken by three 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.

We reviewed information we had received about the service from members of the public and the local authority. We also reviewed notifications we had received from the provider. A notification is information about important events which the provider is required to send us by law.

We spoke with 12 people who used the service and four relatives. We spoke with ten members of staff, the manager and operations manager. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at five people's care records to see if they were accurate and up to date.

We also looked at records relating to the management of the service. These included quality checks, three staff recruitment files, staff rosters and other documents to help us to see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had concerns that staff were not effectively deployed throughout the service to meet people's needs in a timely manner. At that inspection the manager had told us they were going to introduce a twilight shift on the unit where people were living with dementia were due to the needs of people being heightened at this time. At this inspection we saw and the manager told us that they had been unsuccessful in finding new staff to fill this role and they were continuing to advertise for the post. A relative told us: "I had to take my relative to the toilet the other week during lunch time. I rang the bell for assistance but had to wait for 30 minutes and was then told by staff that I shouldn't have taken them at lunch time". The relative told us they felt bad about doing this, but couldn't have left their relative until after lunch had finished. They also told us that another of their relatives had to wait for 30 minutes for staff to support their relative from the toilet. The time people had to wait for support was impacting on their quality of life and causing people distress.

The manager and staff told us there were insufficient staff to meet people's needs specifically in the nursing unit. We saw that people had to wait for long periods of time to have their needs met. Some people were not supported to get up in the morning until it was near to lunchtime. One person asked the staff and told us they wanted to get up mid morning. We saw that this person was not supported until an hour and a half after they had initially asked and it was close to lunchtime. Another person who used the service told us: "They could do with more staff, I have to wait to go to the toilet sometimes and then I have an accident, but they (the staff) can't help it they only have one pair of hands".

Staff we spoke with told us they needed more staff to help them. One staff member told us: "We just need one more member of staff. We have to stop getting people up to serve breakfast and then we have to stop again to serve the morning drinks. I've only just finished supporting people to get up and it's now lunch time". We saw several people sat for long periods of time in the lounge and dining areas waiting for staff to support them. Some people had fell asleep and other people were distressed and asking to move from the area. The manager told us that they used a dependency tool to assess the level of staff they required to meet people's needs, however they told us that they knew that they needed one more staff member in the nursing unit but had yet to action this.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that risks to people had been assessed and identified and risk assessments had been put in place but these were not always being followed. At this inspection we found that there was no improvement in this area as risk assessments were still not always being followed to keep people safe. We found one person who had been assessed as being at high risk of falls and had fallen several times in a few months was sitting in the lounge with no shoes or slippers on. Staff told us they had to observe this person at all times when they were out of bed and we saw staff did stay with the person. However the person's risk assessment stated they should have suitable, stable footwear on and we saw they had bare feet. The risk assessment also stated that they should have a sensor mat in front of them which

would alert staff to the person moving wherever they sat and this was not present when we saw them. We discussed this with the manager who told us they were not aware that the senor mat should be in situ when in the living area. This meant that this person's risk assessment was not being adhered to and this put them at risk of further falls and injury.

We saw another person had been assessed by a physiotherapist as requiring two members of staff to help them to mobilise with the use of a handling belt, which is placed around the person for staff to hold onto. We observed that one member of staff supported this person using in an unsafe manner which could have resulted in harm to them and the person. The staff member told us: "We've been told to support them like this and I did hurt my back last week". A nurse told us: "We tried the belt but [person's name] didn't like it". Further advice had not been gained to ensure that this person was supported to move safely. This meant that this person and the staff were at risk as the person's risk assessment was not being followed.

Several people were sat in specialised low chairs called 'kirton' chairs. We saw that staff moved people in the chairs from place to place. However there were no foot rests on the chairs and some people's legs were left dangling or dragging on the floor. Foot rests should be in place to ensure that people have a base of support and only used without foot rests if prescribed by an occupational therapist. There were no records to confrim that occupational therapists had prescribed the used of 'kirton' chairs without foot rests and the manager was unable to confirm that this was the case. This put these people at risk of harm if their feet became trapped whilst moving.

Several people who used the service had dementia and became anxious and agitated at times. This often resulted in them becoming aggressive towards other people or staff. We saw records and staff confirmed that they were often assaulted by people when trying to support them. Staff told us they had not received any training in how to support people with challenging behaviour and although the nurses and manager offered support they would benefit from training to help them care for people safely and reduce the amount of reportable incidents. One staff member told us: "Sometimes we don't know what to do for the best, some staff say one thing and some say another". This put staff and people who used the service at risk as staff were not equipped with the knowledge to be able to support people with their anxiety safely.

We saw one member of staff had a medical condition that put them at risk working with people with challenging behaviour. There was no risk assessment for this staff member and we saw on at least one occasion they were left alone in the unit whilst other staff left the unit. This put this staff member at risk of harm from assaults.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were safeguarded from the risk of abuse. Incidents of abuse and suspected abuse were reported to the local safeguarding authority for further investigation. Staff we spoke with demonstrated an understanding of how to keep people safe and who they needed to report any suspected abuse to. They all told us that they felt that if they reported any incidents of suspected abuse that the manager would take it seriously and respond accordingly.

Staff were recruited using safe recruitment procedures. Staff told us and we saw that that safe recruitment practices were followed. This included references from previous employers and Disclosure and Barring Service (DBS) checks to make sure that staff were safe and suitable to work at the home. The DBS is a national agency that keeps records of criminal convictions.

People's medicines were stored and administered safely by the trained nurses. We saw there were clinical rooms where people's medicines were stored in a locked trolley. We observed the medication being administered throughout the service by the nurses. We saw it was administered dependent on people's individual needs. We saw people's medication care plans were followed, for example, one person required their blood sugar levels monitoring prior to having their medicine. We saw that the nurse took the reading and then delayed the administration of the medicine as the reading was too high. We saw this was recorded in their care plan as the appropriate action to take at this time. Topical creams were applied by the care staff. We saw care staff asking the nurses for the creams when they were supporting people with personal care. After application the care staff signed a Topical medication administration record (TMAR) to say it had been applied. We found that where medicines needed to be crushed to be disguised in food there had been contact made with the pharmacy to make sure that by administering the medicines this way, it did not change the effectiveness of the individual medicines.

Requires Improvement

Is the service effective?

Our findings

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. We saw records and staff confirmed that two people who lacked mental capacity had relatives that were making decisions about their relative's health and welfare. We asked the manager if these relatives had lasting power of attorney for health and welfare and we were told they were not. This meant that the principles of the MCA were not being followed as the people making decisions about their relatives welfare did not have the legal power to do so.

We saw that several people who lacked mental capaity had a Do Not Attempt Resuscitation order (DNAR) in place. A DNAR form is an outcome from a process of discussion and consent taking place either directly with the patient, or with their representatives and carers if they lack capacity. We could not see that this order had been discussed and agreed with the person themselves or their legal representative. This meant that these people were not being supported to consent to their care, treatment and support and this put them at risk of not having their wishes respected.

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). We checked whether the service was working within the principles of the MCA. We found that there were several DoLS authorisation in place and referrals for DoLS authorisations had been made when required to ensure that any restrictions upon people were legally authorised. However several people were using 'Kirton' chairs which restricted their ability to mobilise. We could not see that the principles of the MCA had been followed to ensure that this was the least restrictive practice and in their best interests.

These issues constitute a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff we spoke with knew the principles of the MCA and we saw they had received training about it. One staff member said: "The MCA is where when a person can't make a decision for themselves and a decision has to be made in their best interests". We saw training records that confirmed that the staff had received training in some areas of their roles; however staff told us they had not received training in supporting people with challenging behaviour and that this would have been beneficial to them. Staff attended regular meetings and support, supervision and appraisal was on going from the management team.

People's nutritional needs were met, however people gave us mixed views on the quality of the food. One person said: "I can't eat half the food they bring me. Some food I can't chew as the meat is hard". Yet another person said: "The food is very good, I could recommend the gravy to anyone, they could give it to me on its own with bread. I've no complaints at all". We saw that when people had lost weight action was taken to refer them to their GP who referred them to a dietician or speech and language therapist. We saw one person had lost weight and after several health care interventions they had been assessed as requiring a

soft diet and thickened fluids. Since being on this diet the person had steadily gained weight. We saw that when people needed support to eat and drink using specialist equipment it was available to them such as lidded cups, special spoons and straws to drink out of.

One person who used the service told us: "The staff get the doctor if I need him". We saw people received health care support from other health professionals when required. We saw records and staff confirmed there was input from community nurses and tissue viability nurses when it had been identified there was a need for extra support to meet the person's health care needs.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that staff were kind and caring. One person said: "The staff are nice, but they don't get a lot of time to talk to you", another person said: "The nurses are very kind to me". We observed some nice respectful care being delivered and staff we spoke with demonstrated a kind value base and they interacted with people in a gentle manner. For example, we saw a member of staff wake up a person gently by speaking to them quietly and patiently before serving them breakfast.

However we did observe times when people's privacy and dignity was compromised. One person was being cared for in bed with and we saw they were dressed just in their underwear. We saw another person of the opposite sex was sitting directly outside their room and had a clear view of the person. We brought this to the attention of a member of staff who told us: "I don't usually work up here so I don't know people". We saw on another occasion a nurse having a telephone conversation with a health professional about a person's health care needs. This conversation took place in the dining room where other people who used the service were eating their breakfast. We discussed this with the manager who told us that staff had been asked not to do this and they should use the clinical room for private conversations. This meant that staff did not always respect people's privacy and right to confidentiality.

We saw some people were offered certain choices as to what to eat and drink and what they wished to do. One person told us: "Oh yes, I have a choice, I have bacon if I want it. Usually sandwiches or soup for lunch or bubble and squeak or liver and onions, sometimes I eat in my room and sometimes in the dining room". However we saw other people were not always offered choices. Several people were taken to the dining room in chairs that were too low to reach the table. Several people had to sit with their lunch on their lap and their soup on the table which they couldn't reach. One person told us: "I would like to sit at the table but you have to do as the staff tell you". This meant that not everyone was offered choices about how they wished to eat their meals. We saw one person slept throughout the meal time and had nothing to eat. We observed staff were too busy to take the time to spend with people to make it a pleasant dining experience.

Relatives we spoke with told us they were able to visit when they liked and they were kept informed of their relative's welfare. One relative told us: "The nurses are very good; they just seem to have too much paperwork to do to spend quality time with people". The relative also said: "The staff will always make a big effort for my relative's birthday".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had concerns that people did not always receive care that reflected their individual needs and preferences. At this inspection we found that in two of the three units of the service there were still concerns. Some people had to wait long periods of time to get up in the morning or use toilet facilities due to a lack of available staff. We observed in one unit that one female person was in need of their continence needs being met and a change of clothes. We saw two male members of staff attempting to persuade them to change their clothes. The person's first language was not English and neither member of staff could make themselves understood. The person became more anxious and it resulted in them lashing out at one member of staff. We asked the person if they preferred a female member of staff to support them and they nodded. Eventually a female member of staff came and was able to calmly support them to change. We discussed this with the manager and operations manager who agreed that this person was reacting to the lack of female support at a time they required personal care intervention. This meant that the staff had not considered this person preference in relation to the sex of the staff they would like to support them.

However we saw in the 'special care unit' where only six people resided a personalised service was being delivered as there were sufficient staff to meet their needs. People got up when they liked and went to bed when they liked. Staff in this unit knew people well and knew their preferences and supported them throughout the day to engage in hobbies and activities of their choice.

There were some activities on offer throughout the week and weekends. One of two available activity coordinators told us how they spent time with people in their rooms when they were being cared for in bed. One person was enjoying a sensory session in their room. We saw that entertainment and games were available and there was a planned summer fete. One person told us: "if there are any activities I like to join in", and another person told us: "I like to just sit and watch". One staff member told us: "We have two activity coordinators now, it's better as there's more for people to do which is good". However we saw a large proportion of people had little or no interaction from staff and they sat for long periods of time, only moving to the dining room for their meals.

The provider had a complaints procedure and people and their relatives knew how to use it. We saw that formal complaints were investigated by the manager through the use of the procedure. However some people did not feel their complaints were taken seriously. A relative told us: "I've told the manager that there is not enough staff, and they said there's nothing they can do as it's up to the bosses, I've never had to complain about anything else though, the staff do their best". Yet we saw and we were told that there were insufficient staff to meet people's needs. This meant that not all complaints were listened to and acted upon.

Inadequate

Is the service well-led?

Our findings

At our two previous inspections we had raised concerns with the provider and asked them to improve in all areas. We had judged the service as requiring improvement. Since the last inspection the local authority had placed the service into a large scale investigation as they had received several safeguarding concerns. At this inspection we found that the service had not improved and there were several breaches of The Health and Social Care Act 2008 and associated Regulations.

Since our last inspection the registered manager had left and there was a new manager in post, who was in the process or registering with us. They had recently recruited a new deputy manager. They told us they had been trying to recruit to a twilight shift which had been noted as being required at our previous inspection. People with dementia often require more support during the twilight hours; this is called 'sundowning' where confusion and agitation worsen in the late afternoon and evening, or as the sun goes down. The manager told us they had so far been unsuccessful at recruiting to these posts and the staff hours remained unfilled. No consideration to the use of agency staff had been given to ensure safe staffing levels whilst trying to recruit to these posts.

The manager and operations manager told us that the provider had a dependency tool to assess the level of staff required to meet people's needs and they were currently using the amount of staff deemed as the tool had assessed as necessary. However the manager told us that they felt that they needed one more member of staff on the nursing unit but they were unable to tell us what they had done about this. Staff told us and we confirmed through observations that there were insufficient staff to meet people's needs in a safe and timely manner within the nursing unit. Consideration to the use of agency staff to cover these deficiencies in the rota had not been made. This meant that people were receiving care that was unsafe due to a lack of staff which had been identified but not actioned by the manager.

Most people spoke highly of the new manager and told us they were approachable. However one relative told us: "There was a special residents meeting the other day, but when relatives said that they wanted to talk about staffing levels, the manager didn't want to." The relative added: "Management insist that the four carers and two nurses on duty are adequate. The Manager doesn't seem to take responsibility; I don't feel that anything will change". Another relative said: "They have residents meetings, but does the Manager have the power to solve the problems of having more staff". The information given to the relatives was contrary to the information and admission that there was a lack of staff shared at the inspection.

Staff told us they liked the manager and felt supported. However we found that risks to staff were not always assessed and minimised through effective support and training. Staff had not received training to support people whose behaviour challenged and they were being regularly assaulted which we observed on the day of the inspection. A member of staff who had a medical condition which put them at higher risk of harm was observed working alone in an area where people may have become anxious and assaulted them.

Systems were in place to monitor the quality of the service and the management team had implemented an action plan following the local authorities concerns being raised with them. However the systems and action

plan had not been effective in identifying the issues raised at this inspection. The new manager and operations manager told us that problems had arisen when the manager had took a short period of absence. However some of the issues and concerns we found had been identified at our previous inspections and it appeared that the concerns we had raised had not been taken seriously and acted upon.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the operations manager informed us that they had increased the staffing on the nursing unit and would be arranging training for staff in the management of people with challenging behaviour.

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 11 HSCA RA Regulations 2014 Need for consent People were not always supported to consent to their care, treatment and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care that was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place did not always drive improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs in a timely manner.