Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Amberley Nursing Home

Off Cedar Close, Eckington, Sheffield, S21 4BA

Tel: 01246436850

Date of Inspections: 07 May 2014
02 May 2014

Date of Publication: June 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Enable Care & Home Support Limited
Registered Manager	Mrs Mary Woulfe
Overview of the service	Amberley Nursing Home provides nursing or personal care for up to 15 people with learning difficulties and is located in Eckington, Sheffield.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 2 May 2014 and 7 May 2014, talked with people who use the service and talked with carers and / or family members. We talked with staff.

What people told us and what we found

A single inspector carried out this inspection. We spoke with one person who lived at the home and with the relatives of three others.

Below is a summary of what we found. The summary describes what we observed, the records we looked at and what people using the service, their relatives and the staff told us.

If you want to see the evidence that supports our summary please read the full report.

Is the service safe?

All of the relatives we spoke with told us that the provider's staff cared for people in a safe and effective way.

The provider had effective systems to identify and manage risks to people's health, safety and welfare and to make improvements where required.

Effective recruitment procedures were in place to ensure that staff appointed were suitably qualified and experienced and were of good character.

Procedures for dealing with emergencies were in place and staff understood these.

Procedures were in place to ensure people received a diet that was suitable for their individual nutritional requirements.

Is the service effective?

People's care needs were properly assessed before they received care, which was delivered in line with their individual care plan. People's care plans were regularly reviewed to ensure their needs were being met.

People's relatives were happy with the standard of care provided and they told us that care was designed and delivered to meet people's individual needs.

Is the service caring?

Three people's relatives we spoke with were positive about the care provided. Their comments included, "The staff are brilliant". "I have been extremely pleased ever since they were first admitted". "Staff are patient and support my relative very well".

People's relatives also told us that they thought the staff treated people with respect and promoted their dignity.

Staff understood people's needs and we saw they interacted with people in a caring and respectful manner.

Is the service responsive?

The provider informed people about how to complain and people's relatives we spoke with said they knew how to do this. They also told us they were happy with people's care and had not needed to complain. Records we looked at reflected this.

The service had recorded the details of accidents and incidents that had occurred. These had been investigated and the cause of the issues identified. Service improvement actions plans had been put in place. However, the details relating to accidents and incidents had not been collated. This meant that the opportunity to identify emerging trends had been lost.

People's relatives told us that they thought the provider was responsive.

Is the service well-led?

A registered manager was in place.

The provider had an effective system in place to check the quality of care provided. Records showed that regular checks were carried out to identify and manage risks to people's health, safety and welfare. Where improvements were needed, action plans had been put in place to deal with them.

The service worked well with other health and social care professionals to make sure people received the care they needed.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

At the time of our inspection there were twelve people living at the home. We reviewed the care records of five people.

We found that each set of records contained a full personal profile about the person including detailed information about their family and social history. This record also contained information about individual issues that were important to the person and gave an over view about how the person should be supported.

Staff we spoke with told us that when each person came to live at the home a full assessment of their care needs was undertaken. These assessments were then used to compile a detailed plan of care for each person. The staff also told us that they had access to detailed information about people's care needs. One member of staff told us that people's care plans were reviewed and updated every month.

Staff told us that some people were at risk of falling from their wheelchairs. Risk assessments were in place for each person and their care records also showed that the required health care professionals had been consulted for their use.

We spoke with one person who had consented to the use of a lap belt whilst in their wheelchair. They said they were happy with the arrangement because it stopped them from falling from their wheelchair, which was something they had done before the lap belt was used.

We found that each person's care records included an individualised plan of care. This showed staff the level of support each person required and covered all aspects of their daily living needs. The plans also included risk assessments, which covered areas such as falls, moving and handling and continence needs. Each person's care plans and risk assessments were regularly reviewed. This meant that people's needs were assessed and care and treatment was delivered in line with their individual care plan and/or in a way that

was intended to ensure people's safety and welfare.

People's care records also detailed what people liked to do each day. They showed that where people were able, they attended social events outside the home, such as a local friendship group. One person told us; "I like living here; I like being with my friends and I go to the friendship group; I like doing my jigsaws but there is not much entertainment here".

During our visit we observed staff members supporting some people to engage in activities, such as making jigsaw's or knitting. Other people were out at the time of our visit. One person was out shopping and two others were visiting the day centre.

A relative told us that staff were making arrangements to organise and support one person to go on a holiday. They also said that the person had been previously supported by staff at the home to take holidays to Blackpool.

At lunchtime we observed that staff communicated well with people and that they encouraged and supported them in a respectful manner.

Three people's relatives we spoke with told us how pleased they were with the standard of care provided at Amberley Nursing Home. One relative said; "The team at Amberley provide outstanding care, I attend regular meetings about my relatives care." Another relative told us; "The staff are brilliant; I have been extremely pleased ever since they were first admitted. Staff are patient and support my relative very well."

We looked at the provider's written procedures for staff to follow in the event of an emergency, such as loss of utility supply. These included contact details for staff to use out of hours for additional advice and support from the provider. We found that each person had a recorded personal emergency evacuation plan in place. These were accessible to staff to follow in the event of any emergency requiring people's evacuation from the home, such as a fire. Staff we spoke with knew and understood these. This meant there were arrangements in place to deal with foreseeable emergencies.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We found that people were provided with a choice of suitable and nutritious food and drink and they were supported to eat and drink sufficient amounts to meet their needs.

We spoke with two cooks employed at the home and found that meals were planned by use of a three week rolling menu, devised by a dietician. They said this was reviewed annually. The menu provided a healthy, balanced diet for people living at the home.

Both cooks were able to tell us, which people needed special diets. For example, where people required soft or liquidised meals because of chewing or swallowing difficulties which meant they were at increased risk from choking. The cooks also knew how to check to ensure they were eating sufficient amounts of the right food.

One person was assessed as needing a low fat diet. The cook was provided with information about the type of foods required for this person. Information was also provided for catering staff about other people's dietary requirements, such as their favourite meals.

We looked at five people's care records and found that they reflected what the cooks had told us about people's dietary needs.

Some people's recorded needs assessments showed they were at risk of malnutrition. The provider had used a recognised screening tool to check the risk for each person living at Amberley Nursing Home. Where risks were identified, care plans were in place for each person which provided clear information about the care and support they required to ensure they received adequate nutrition. This also included regular monitoring of their body weights and ensuring their access to relevant outside health care professionals where required. For example, for specialist assessment and dietary advice when people had swallowing difficulties.

We spoke with two care staff about nutritional needs. They were both able to tell us which people required special diets. They also told us that some people's food intake was being monitored. However, our review of people's care records showed that their food diaries were not always properly completed by staff. We found that one some days no diary entries had been made, and on other days staff had not entered enough detail about people's dietary intake.

During our inspection three people's relatives told us that the standard of the food at the home was good. One of them said, "They (the person using the service) can sometimes be very slow to eat their meal and sometimes they may refuse to eat at all". "The staff are always very patient and spend a long time persuading them to eat, or will ask the kitchen staff to cook an alternative meal". This relative also told us that if the person refused to eat their meal, that the staff always encouraged them to eat nutritious snacks, or offered them a meal again a little later.

We observed staff supporting people at lunchtime. People were provided with their dietary requirements and we saw that staff assisted people to eat at a pace that suited them. Staff chatted with people throughout the meal and people appeared to be enjoying what they were eating.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

People's medicines were safely stored within a dedicated room.

We reviewed the cupboards where the provider stored the stock medications. These cupboards were kept locked and the medications within them were stored in an orderly fashion. All the medication we reviewed was within its use by date. We also reviewed the storage of medications that were in use. We found that all medication was being stored in an ordered fashion within locked cupboards or a locked medications trolley which was kept secured to a wall. Any bottles of liquid medication contained the date the bottle had been opened. This ensured that medicines were not being used when they had been opened beyond their safe to use by date.

Where required, some medicines were stored in a suitable medicines refrigerator, which was kept locked. We looked at the provider's records of the refrigerator temperatures and saw they were checked daily. We found that where required, the necessary adjustments had been made by staff, to ensure the refrigerator operated within the correct temperature range required for the safe storage of people's medicines. However, the provider should note, that there was no written guidance for staff about the action they should take for any medicines to requiring storage in the refrigerator, where the temperature remains outside the required range.

People's medicines that were supplied in tablet form were dispensed by the supplying pharmacy in a pre-measured, sealed fashion so that each person's medications were only available for staff to administer at the time that they were due. This reduced the risk of staff making an error when administering people's medicines.

We found that people's medicines were safely administered and recorded. We looked at every person's medication administration records (MARs) and checked these against their blister packed medicines supplied. We found that all of the medicines had been given to people as prescribed.

We saw that oxygen cylinders prescribed for people were safely stored. They were securely fastened to the wall in the medicines room and that the oxygen levels within the

cylinder had been checked each week. We also found that hazard notices were displayed where required for the danger associated with the storage and use of oxygen

We found that the provider carried out regular checks of their medicines systems in the home. This included monthly checks of their medicines stocks. We reviewed some of their recent checks and found these were being accurately recorded.

The provider was storing one person's controlled medicine in the required type of cupboard for this. Controlled drugs are medications which are controlled under the Misuse of Drugs Act 1971. The act sets out clear guidance to be followed for their management, including their storage.

We saw that the required records were being kept for the receipt, administration and disposal of one person's controlled medicine. The records showed that the medicine was being given as prescribed.

We discussed administering medicines with a member of staff. They told us that the way they administered medications had recently changed. They told us that they had been taking the medication trolley into the lounge area and administering people's individual medication from the trolley. As the lounge could be a noisy environment staff told us that they had found that they had been constantly distracted whilst they were administering medication. In order to minimise distraction they had altered their procedures so that medications were dispensed on an individual basis from the medication storage room and taken directly to each person. Staff told us that this had reduced the level of distraction and enabled them to concentrate fully on the correct administration of medication. This meant that the provider had identified the risk of staff being distracted during the administration of medication and had altered processes to reduce the risk.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

As part of our inspection we reviewed six sets of staff files. Three sets of staff records were for staff who had been working for another provider when the current provider had taken over the running of the home. The other three sets of records related to staff who had been recruited by the provider.

We found that all sets of records contained photographic identification of the member of staff and evidence of a clear criminal records bureau or disclosure and barring scheme check that had been undertaken before staff had started to work. This meant that the provider had taken adequate steps to ensure that staff they employed were suitable to provide care for people.

All records also showed that the provider had information about each staff member's employment history and that any breaks in service had been explained. Two satisfactory references had been sought for each member of staff and all but one file contained a reference from the staff member's most recent employer. This meant that the provider had taken steps to ensure they had obtained up to date information about people's employment history to verify their previous job performance and also the statements made within their application.

Records showed that the professional registration status of nurses working in the home, were periodically checked when required with the Nursing and Midwifery Council, to ensure their fitness to practice. Records also showed that before they were employed, staff, were required to provide evidence of their previous training and qualifications where appropriate, for example, by providing their training certificates. This meant that people were cared for by staff who held appropriate professional qualifications

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

At our last inspection in November 2013 we looked at the results of the provider's most recent annual satisfaction survey of people's care experiences at Amberley Nursing Home from June 2013. The results from this were positive and showed that people were satisfied with their care.

We found the provider had maintained their systems for checking the quality and safety of people's care. We looked at their records of some of the checks that they regularly carried out. These included, hot and cold water systems, fire safety, the environment and staff training. Where improvements were identified from these, records showed that actions had been taken where required.

We reviewed the records of accidents that had occurred since the start of 2014. We found that seven accidents had occurred, five of which had involved people who used the service. The provider had recorded the details and investigated the cause of the accidents. If any changes had been required following the investigation these had been put in place.

However, we found the provider did not routinely analyse accidents and incidents to look for patterns and trends. This is important as it can help to target any action that may be required to reduce or prevent their reoccurrence.

The provider's complaints policy contained clear information about how people could make a complaint. It was also available in a pictorial version to make it easier for people who used the service to understand. We asked to look at the provider's complaints' records. These showed there had there had not been any complaints made at the home.

We spoke with three people's relatives. They all told us that they knew how to complain if they needed to. They confirmed that they had seen a copy of the provider's complaints' procedure and all said that they were very happy with the service provided for people and had not needed to raise any complaints or concerns.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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