Amber Care (East Anglia) Ltd

Stewton House

Inspection report

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11 April 2017
13 April 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 6 and 13 September 2016. Breaches of two legal requirements were found. This was in relation to care plan recording being poor and not up to date and insufficient staff to meet people's needs. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches.

We undertook this focused inspection on 11 and 13 April 2017 to check that they had followed their plan and to confirm they now met the legal requirements. During this inspection on the 11 and 13 April 2017 we found the provider had made improvements in the areas we had identified.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Stewton House on our website at www.cqc.org.uk.

Stewton House provides care for people who require personal and nursing care. It provides accommodation for up to 48 people. At the time of the inspection there were 39 people living at the home.

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

On the day of our inspection we found that the registered provider had begun to audit all care plans to ensure relevant information was available for each person. Staff had evaluated each care plan on at least a monthly basis so that they were aware of people's immediate needs. The provider had calculated staffing levels to see whether sufficient staff were on duty to meet people's needs. People told us their needs were being met, but not necessarily in a timely way.

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

We found that action had been taken to improve the safety of the service.

This meant that the provider was now meeting legal requirements.

Staffing levels were calculated on a regular basis.

However, people and relatives and staff told us that at times there were staff shortages. This meant that people did not have access to staff when they needed them.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Is the service responsive?

Requires Improvement

We found that action had been taken to improve the safety of the service.

This meant that the provider was now meeting legal requirements.

Care plans were evaluated on a regular basis.

Auditing of care plans had begun to ensure staff had recorded people's needs.

However, people and relatives told us that although their needs were being met, this was not always done in a timely manner, suitable to their needs.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Stewton House

Detailed findings

Background to this inspection

We carried out an unannounced focused inspection on 11 and 13 April 2017. This inspection was completed to check that improvements to meet two legal requirements had been met. This was in regard to care plan recording being poor and not up to date.We inspected the service against two of the five key questions we ask about services; is the service safe and is the service responsive. Also there were insufficient staff to meet people's needs and calculations of staffing levels had not taken into consideration people's current dependency levels. The provider told us improvements would be made after our comprehensive inspection on 6 and 13 September 2016.

The inspection was undertaken by a single inspector.

During our inspection we spoke with seven people who use the service, four relatives, three care workers, two registered nurses, the activities co-ordinator, a cook, a member of the domestic staff and the deputy manager. We also spoke to the area manager on the second day. We observed the staff attending to people's needs. We looked at records which included seven care plans, training records, staff rotas and calculation tools of how staffing levels had been decided, audit records and staff personal files.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 6 and 13 September 2016 we identified that there were insufficient staff to meet people's needs. The calculation of staffing levels had not taken into consideration people's current dependency levels. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection the provider wrote to us to say what they would do to meet the legal requirement. At our focused inspection on 11 and 13 April 2017 we found that the provider had followed the majority of the action plan they had written to meet shortfalls in relation to Regulation 18 described above.

The registered manager was now using a calculation tool to determine the required number of staff which would be required to be on duty. They also took into consideration evidence from staff who could tell the registered manager if people had extra high, high, medium or low dependency needs. This was calculated on at least a weekly basis. The provider had told us this calculation would also take into consideration other issues which may affect staffing levels, such as those requiring palliative care or a hospital escort. However, there was no evidence to support when this had taken place. People and relatives told us that staff informed them if they had to wait for their needs to be met and instanced when staff told them this was because of staff attending appointments with other people and because other people were "poorly". We saw on one occasion when there had been a new admission to the home. There were no extra staff put on the rota at that time, despite the provider telling us this is what would happen.

From 5 December 2016 the shift patterns for staff changed. We had mixed views from staff of whether this was working. One staff member told us, "It's ok I prefer a longer day." Another staff member said, "The main problem is we have been told we can change shifts when we want to, but then the skill mix isn't right." Another staff member said, "We tell the management regardless of any calculations being done, the mix and numbers of staff aren't right." Staff told us they all worked hard to ensure people's needs were being met, but this was often to the detriment of becoming behind on their written work. Staff told us they would like more consultation over staffing levels, which they felt was not happening at the moment. One staff member said, "We are the ones that know, ask us."

The registered manager had informed us when over a weekend period on two occasions staffing numbers had been lower than required. They told us what avenues they had explored to find staff and how if this had not been possible what contingency plans they had taken. This involved using staff from other departments within the home to for example help make beds. They had stated that in their opinion no harm had come to anyone within the home during this period. People, relatives and staff could recall those times and made comments such as, "it was a hard shift"; "we tried to help out where we could as relatives" and "they eventually got around to me, but I was alright." The registered manager is in the process of recruiting extra staff to cover any future such events.

People and relatives told us staff often appeared rushed and would tell them if they had to work with less staff on any one day because of sickness or other events. One relative told us, "I don't want [named relative]

worried like that, it's up to management to sort it out, not us." One person said, "I suppose we have to put up with it if there aren't enough staff because of sickness, but on the day it happens life can be difficult for them and us."

Most staff liked the new system of more staff being on duty at a handover time after lunch each day. They told us they did not need to be rushed informing staff about events which had happened. Staff in departments, other than directly involved in giving care and treatment, told us there were sufficient staff in post to enable them to fulfil their roles. The activities co-ordinator was no longer taken off their role to assist with care duties.

Since our last inspection a number of staff had left the employment of the company for a variety of reasons. Some new staff had been employed and others were waiting to commence employment after safety checks had been completed to ensure they were safe to work with vulnerable people. We looked at the personal files of three new staff. Safety checks had been undertaken and two references taken except for one staff member who only had one reference in their file. The deputy manager was going to follow this up and ensure all records were in place.

A call bell audit had been undertaken on at least a monthly basis since our last inspection. The results were placed on a staff notice board so staff could read them and the additional comments. This gave staff an indication of the shortest and longest times staff took to answer call bells. However, people and relatives told us they had witnessed staff answering people's call bells and if they could not immediately attend to a person's needs switching it off completely and not to a waiting mode. Therefore, it was difficult for us to ascertain whether the audits were a true reflection on people's waiting times.

At our last inspection there were insufficient quantities of call bells in communal areas or for individuals to use and carry with them. We saw there were call bells in each of the communal areas and in the rooms we selected to visit. Where people had difficulty walking those people wore call bells around their necks to be able to call staff from where-ever they chose to sit.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 6 and 13 September 2016 we identified care plan recording was poor and not up to date. Chart recording for such as weight and food and fluid charts, did not reflect actions on care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection the provider wrote to us to say what they would do to meet the legal requirement. At our focused inspection on 11 and 13 April 2017 we found that the provider had followed the action plan they had written to meet shortfalls in relation to Regulation 9 described above.

The provider told us in their action plan that staff would be receiving more training in record keeping. This had not yet commenced but a training provider had now been found

Since our last inspection a new admissions protocol had been implemented. This gave time scales to staff of when certain sections were required to be completed. This would capture people's immediate needs until such time as a full care plan could be implemented. We saw this had worked for a new admission.

There were mixed views of people and relatives about their involvement in the care planning process. People told us they knew records were in place which told staff about the levels of care each person needed. Some people told us they preferred their family members to review their care plans, whilst other preferred staff to read them to them. However, people told us this was not a regular occurrence. They said they were asked for example about their nutritional needs or social needs. Few people told us they had received a full review of their needs in one sitting. Relatives told us they rarely were offered a care plan to look at, but thought they could see them if they wished. People and relatives told us the communication between staff and themselves was poor at the moment. This meant staff could not be sure if the care and treatment people received was responding to their needs.

The care plans were still being audited by the registered manager, which had commenced at our last inspection. Only 18 out of 39 had received a full audit under the newly implemented system. It was explained to us that this was a lengthy process as alongside the views of people and relatives many agencies had to be consulted to ensure the plan of care was workable for each individual. Where there needed to be a review of some sections the registered manager had placed a feedback form at the front of the care plans so staff could see what needed to be amended. Staff were supposed to sign this when completed, but very few had signatures of completion. Staff told us this was because they had forgotten to do this or had not yet had time to review the evidence required.

Of the care plans we looked at each one had been evaluated by the person's named registered nurse or senior care worker. If a person's needs had changed, this was added to an existing care plan. Staff told us this was not ideal, as a new care plan would be required, but the method captured people's immediate needs for care and treatment. Staff had recorded in daily report sheets what care and treatment people had received. More senior staff told us they were instructing more junior staff how to write events in a more

person centred way.

Staff told us they had every intention of reviewing each section of everyone's care plan, but time was often against them. They were aware that some sections were not person centred and had been generically produced, such as those regarding people wishing not to be disturbed at night. We did see evidence in care plans where people were being treated for pressure ulcers and the wound management care plans and treatment plans being person centred and reviewed on a regular basis.

We saw evidence in the care plans that the nutritional needs of people had been more regularly assessed by staff. However, where staff were required to complete charts for weights or to record what people ate or drank each day in some cases these had only been spasmodically completed. One relative told us, "I always question staff if there are gaps in the recording as I like to know how [named relative] is eating. Although they haven't lost weight." We saw in one care plan where a person had lost a significant amount of weight over a three month period. The person had been weighed until recently, but staff told us the person was now difficult to weigh, but had not sourced alternative methods for assessing the person's weight. Staff were recording what the person eat and drank each day. This means staff had no true record of whether the person had lost or gained weight recently, which could be detrimental to their health.

Since our last inspection the staff had asked medical practitioners to review each Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms. We saw the documentation in three care plans which followed latest guidance. The registered manager was liaising with local GPs' to ensure each one which required review was completed.

The provider told us that the long term plan was that a minimum of a yearly full review would take place at the same time as commissioners of services completed their reviews. The review process was not at this stage yet.

People and relatives told us their needs were being met, but not always in a timely manner when staff were asked to respond to them. For example people said they had to wait sometimes to obtain assistance to go to the toilet, to be able to go to bed or leave the dining room. One person said, "Staff look after me, but the organisation isn't there at times. I couldn't be in a better place, but the waiting time has increased." Another person told us, "Sometimes it's quicker to use the phone to ring for staff assistance than the call bell or shouting." Another person said, "Sometimes everything is all a bit of a rush, but staff are worked off their legs and I can do something for myself." Relatives told us they often went to the aid of people by going to look for staff. We observed relatives doing this during our inspection. One relative told us, "If [named relative] didn't have their needs met they would tell me and that hasn't' happened."

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.