Gracewell Healthcare Limited

# Amherst House Care Home

**Inspection report**

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## Ratings

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

## Overall summary

Amherst House Care Home provides care and treatment for up to 60 people, some of whom may be living with dementia. The home is divided into four units, with three units providing nursing care and the fourth residential care. On the day of our inspection 47 people were living in the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The area manager was acting as the manager and had begun the application process to become the registered manager.

There were an insufficient number of staff deployed in the home. We read staffing levels did not meet the minimum requirement at times and particularly during the night people could go without appropriate care.

Staff felt supported by the manager, although they told us morale was low due to a lack of staff.

Robust records were not held about people which meant new or agency staff may not be working to the latest information.

# Summary of findings

Staff had not always followed legal requirements in respect of restrictions or decisions made on behalf of people. Although we found staff had a good understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

Staff supported people in an individualised way and offered them a good range of activities, however people who spent a lot of time in their room did not have much attention from staff at times.

Some elements of correct medicines management were not followed by staff, although we did see staff administer medicines safely to people.

Staff had considered all risks for people to demonstrate people were safe living at Amherst House, but some of these risks were not individualised.

People could choose the food they ate and meals times were social. However, staff were not proactive with keeping good records about people's dietary requirements.

Staff treated people in a kind and caring manner, we observed lots of attention care of people and it was evident staff had a good understanding of the individual needs and characteristics of people.

Staff were aware of their responsibilities to safeguard people from abuse or able to tell us what they would do in such an event.

People's care would not be interrupted in the event of an emergency and if people needed to be evacuated from the home as staff had guidance to follow.

Staff were provided with training specific to the needs of people. Staff were given the opportunity to progress professionally and meet with their line manager on a one to one basis. Appropriate checks were carried out to help ensure only suitable staff worked in the home.

Quality assurance checks were carried out by staff as well as the provider and feedback was sought from relatives. Residents and staff were involved in the running of the home. Regular meetings were held where all aspects of the home could be discussed. A complaints procedure was available for any concerns.

Staff responded to people's changing needs and people had access to external health services.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# 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 safe.

Staffing levels were not appropriate to meet the needs of people.

Risks of harm to people had been identified but these were not always individual or personalised.

People's medicines were not always managed safely as staff did not obtain evidence of returned medicines.

The provider employed staff to work in the home who had undertaken appropriate checks.

**Is the service effective?**

Requires improvement

The service was not always effective.

Consent to care had not always been sought appropriately for people who lacked capacity.

Staff had not sought legal authority in relation to restrictions on people.

People were involved in decisions about their meals but some records in relation to people's food were not kept up to date.

Staff had access to a wide range of training.

Staff supported people to receive care from external healthcare professionals to help them remain healthy.

Staff were given the opportunity to meet with their line manager regularly.

**Is the service caring?**

Good

The service was caring.

Staff showed respect, dignity to people and respected their privacy.

People were encouraged to be independent.

People were supported by kind, caring staff when needed.

Relatives and visitors were able to visit the home at any time and were made to feel welcome.

**Is the service responsive?**

Requires improvement

The service was not always responsive

People were able to go out and take part in activities but we found staff did not provide individualised activities for people who remained in their rooms.

Staff responded to people's changing needs.

# Summary of findings

Information about how to make a complaint was available for people and their relatives.

**Is the service well-led?**

**Requires improvement** 

The service was not consistently well-led.

Care records were not always complete or up to date.

The home had a registered manager, but staff said they did not always feel supported by management.

Staff and the provider carried out quality assurance checks to ensure the home was meeting the needs of people.

People and their relative were involved in the running of the home and staff met regularly as a staff team.

# Amherst House Care Home

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection that took place on the 17 September 2015. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We had asked the provider to complete a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, this inspection was carried out earlier than scheduled as we were responding to some concerns we had received about the home.

As part of our inspection we spoke with seven people, eight staff, four relatives, the registered manager, the provider's regional manager and one healthcare professional. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink.

We reviewed a variety of documents which included six people's care plans, nine staff files, medicines records and policies and procedures in relation to the running of the home.

We last inspected Amherst House Care Home in July 2014 when we found no concerns.

Requires improvement

# Is the service safe?

## Our findings

People said they felt they were in a safe, secure place and they never felt threatened in anyway. They told us, "Everyone looks out for each other", "I feel absolutely safe because before I came here I used to ring my son in the middle of the night because I was scared." One person said, "I am safe because I can ring my bell and someone will come." However, staff gave us a different view.

There were an insufficient number of staff deployed to meet people's needs. The registered manager told us there should be three nurses, two care staff and a 'floating' member of staff on each floor. However, staff told us this was often not the case and we heard for the previous two days one floor did not have a 'floating member of staff'. This was confirmed by the rotas we looked at. Staff told us they were often rushed and wished they had time to spend with people. One staff member said, "We are not able to give the proper care they deserve. There are incidents where people have fallen over and no carers have been present."

People were cared for by staff who may not know them or understand people's needs or preferences because these staff were new to the home. The registered manager said staff had left and levels had fallen below the minimum requirement but he and the deputy manager covered where they could. The registered manager said, "We need to do a great deal of recruitment" as they were relying too much on agency staff. They told us they used the same three agencies as much as possible to try and guarantee some consistency of staff. However, we heard from the provider's area manager that on two occasions despite being told by the registered manager sufficient numbers of staff were on duty, they had arrived on site to find gaps in the rota.

Staff said the use of a lot of agency staff distressed some people as there were a lot of new faces. This was confirmed by people we spoke with. One told us, "They come and do their job and then go." Staff said if permanent staff were on duty they could manage, however if they had agency staff things took longer and they had to prioritise people's care needs. For example, those who might need to get up earlier because of hospital appointments. A relative told us they had found their family member sitting in wet clothes when they visited because staff had been too busy. There were a significant number of people who required the assistance of two members of staff but we heard that last week there was no senior carer, nurse or team leader on one unit and a member of staff was on their own all day in another. A relative told us they had visited to find their family member sitting in wet clothes and on another occasion falling out of the bed.

People were not provided with sufficient care at night. One member of staff said one person was found of the floor (due to lack of staff). Another member of staff told us they had concerns for people at night as they did not feel that night staff looked after people and people were left in wet pads. They told us there was only one nurse and three carers covering the home at night for the last three nights. And a further told us, "There is a difference with the support at night. When you come on duty in the morning there are pads in the bin, water jugs not filled." Staff said, "We are understaffed and morale is low. People (staff) are tired and weary."

The lack of a sufficient number of staff deployed is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place to help keep people safe. Care plans included risk assessments in relation to people's mobility, nutrition and skin integrity and contained guidance for staff. For example, where people were at risk of their skin breaking down (for example, developing pressure sores) or if people were on a particular medicine. However, we did find that measures had been put in place to reduce some risks. For instance people had pressure mattresses, hospital profiling beds, their own sling and pressure cushions to help ensure they were at a reduced risk of pressure sores.

Staff recorded medicines delivered to the home but did not hold records for medicines which were returned which meant they were unable to be assured at any one time which medicines had been collected. We saw large boxes in two of the clinical rooms which were full to the top of medicines waiting for returned and disposal. We asked staff how they logged these and what records they held once the medicines had been collected by the pharmacy. Staff showed us a recording book which they completed in relation to the medicines before they placed them in the box. However, staff said they were not given any 'receipt' when the medicines were collected so were unable to demonstrate to us they could accurately account for

Requires improvement

# Is the service safe?

medicines returned and those remaining at the home. Following the inspection the registered manager provided us with a receipt for the medicines collected the following day.

**We recommend the provider ensures staff always obtain proof of collection for returned medicines.**

There was a safe system to store and administer people's medicines. We saw staff wore tabards when they were carrying out rounds in order they weren't distracted when dispensing medicines. Staff checked each person's Medicines Administration Record (MAR) to see what medicines people required before dispensing them into a pot to give to people. We watched how staff told people what medicines they were having and chatted with them whilst checking they were taking all the medicines they needed to. Staff knew how people liked to take their medicines. For example, one staff member said one person, "Likes to have her medicines in separate pots, then she will take them one at a time with a drink."

Staff locked the medicines cabinet each time they were away from it and ensured the cabinet was within their sight whilst they were in people's rooms. At the end of the medicines round the cabinets were returned to the clinical rooms and locked to the wall. We looked at people's MAR records and saw that each contained a person's photograph and details of any allergies. We found the GP had signed the homely remedies (medicines which can be bought over the counter) medicines list and where people required either homely remedies or PRN (as required) medicines guidance was available for staff to show how people may indicate they were in pain and required them. Where it indicated people could have one or two tablets staff recorded how many had been given. We noted that staff double signed medicines that were handwritten onto people's MAR records and we saw people had medicine reviews carried out.

People were protected from the risks of abuse and harm. Staff received safeguarding training and there was information about safeguarding displayed throughout the home for both staff and people. This included the local authorities safeguarding procedure and local contact telephone numbers. Staff were able to tell us about abuse and knew how to report it in and outside the home. We saw the Surrey Multi-Agency safeguarding policy was available for staff. Staff said they could also use the whistleblowing procedure if they felt they were unable to approach their manager.

Accident and incidents incurred by people were recorded in order that staff could take action to prevent reoccurrence. We saw details of people's accidents and incidents were written down and any actions taken place by staff. These records were reviewed by the registered provider. A member of staff told us they carried out a visual risk assessment before activities to make sure there was sufficient space and no trip hazards to ensure people were safe.

People's care and support would not be interrupted or compromised in the event of an emergency. Guidelines were in place for staff in the event of an unforeseen emergency and there was a contingency plan in place in the event the home had to close for a period of time. We noted people had their own personal evacuation plan in their care records.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services. This was confirmed by staff we spoke with.

Requires improvement

# Is the service effective?

## Our findings

People who lacked capacity may have their freedom restricted without the legal process being followed by staff. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

We found only one DoLS application had been made in relation to one person who wished to leave the home. We saw the doors between the different units were not locked and saw people could move around on the individual floors as they wished. However, the stairwells and lifts had key-coded pads to access them. The registered manager told us that people who had capacity were provided with the codes and could use the lifts and stairs unaccompanied. However people who lacked capacity could only use the lift if they were escorted by a member of staff. These restrictions had not been considered by staff and DoLS applications not completed for those people it affected.

The lack of following legal requirements in relation to restrictions was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people may not be able to make or understand certain decisions for themselves staff had not always followed the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments had not always been undertaken in relation to consenting to care. We saw in care records some people who had capacity had their consent form signed by a relative, but there was no documentation to show they had the authority to do this. However, we did hear staff obtain people's consent before they acted. For example, we heard another member of staff gently persuade a person to have a cup of tea to distract them from wandering in to other people's rooms. We heard them ask for this person's agreement before they took them to the dining room. Staff were able to describe their understanding of the MCA and DoLS. One member of staff told us, "You should always assume capacity until you find out otherwise."

**We recommend the provider ensure the MCA is followed in relation to all decisions about individuals.**

People told us the food was good. We heard it was, "Excellent" or, "Good". One person said, "The roast dinner is excellent."

People were able to choose what they ate. We saw menus were placed on tables showing what food was on offer for the week. There were two choices of the lunch time meal each day and we noted there was a good variety of foods across the week. People could pre-order their preferred choice from the menu or ask for an alternative. For example, we saw that one of the main meals was curry, however we saw some people had asked for an omelette. We heard staff give people a choice of drinks with their meal and drinks were available throughout the day for people. One person particularly liked ginger beer and that was made available for them.

People had water available to them in their rooms and we noted that this was within people's reach. Staff checked people had enough and if their portion sizes were okay. We saw people sitting together around tables and we found a pleasant social atmosphere. We saw people were offered snacks throughout the day and fresh fruit was available. We saw people could choose where they wished to eat, for example in their room or the dining room.

People were supported by staff when needed. One person required a member of staff to assist them with eating their meal and we saw this happen. We saw the staff member assist the person at the person's pace, waiting for them to finish what they were eating before offering them more. We saw staff had ensured people were correctly positioned if they were eating their meal whilst in bed.

Although people's dietary requirements had been identified, staff had not always ensured the chef was made aware of how this may affect what people could eat. For example, one person was on a medication which meant they had to be careful eating foods such as spinach or brussel sprouts as they affected the medicines efficiency. We spoke with the chef about this who had not been informed by staff. We spoke with the registered manager about this who informed us after the inspection both staff and the chef had been provided with up to date information.

A record of meal choices held in dining room were not always completed. We read in one chart those people who

# Is the service effective?

were diabetic or on a pureed diet were not always indicated on the sheets. For example, we saw two people had written, 'diabetic' against their name for today, but yesterday this had not been written in. We looked back and found the recording was inconsistent. We spoke with staff about this as it may mean new or agency staff may not be following up to date information. We were told they ensured there were never two new or agency staff working together on a unit and there would always be a permanent member of staff on duty.

**We recommend the provider remind staff of the importance of keeping people's dietary records up to date.**

People received support from staff who were able to access relevant training. One member of staff told us, "All staff who administer medicines receive training and are assessed by the (registered) manager to ensure they are competent before administering medication to residents." Other staff told us they had received training which included infection control, moving and handling and dementia. The registered manager said at present there was no clinical lead in the home meaning he and the deputy manager, who were both qualified nurses, checked the competencies of the nurses who worked at the home. We talked to staff about people with diabetes and they were able to describe to us how they monitored people to check their blood glucose levels.

Staff told us the training was good and they could ask for additional training in areas they felt were relevant for them. For example, one nurse had signed up for a wound training session and had arranged to spend time at a local hospice. Another staff member said the provider had a good approach to training. They said they had trained as a senior care and were undertaking their NVQ3. We observed staff working competently and independently without support. We read staff were able to meet with their line manager on a one to one basis, however we noted that seven staff were overdue their supervisions. The registered manager told us following the inspection this was being addressed.

People were supported to access health care professionals. People had access to various health care professionals involved in their care, for example the GP, optician, dentist, dietician or tissue viability nurse. We read how one person had a new food regime following a visit from a health care professional and we noted staff had updated the person's care plan accordingly. One person told us, "Once I had an angina attack, I rang my bell and the nurse and carer were there before you could touch your feet on the ground. They sent for an ambulance in the middle of the night – it was wonderful." We read in one person's care records they were losing weight and noted staff had referred them to the GP.

People were supported by staff who had a good knowledge of them. When we asked staff about individuals they were able to answer most of our questions without having to look at care records. We heard staff talk to people about family members or events that had happened. And we heard one member of staff say to one person, "I know you always like a cup of tea."

Good

# Is the service caring?

## Our findings

People told us they were treated with dignity and respect. People told us, "They (staff) find out your likes and dislikes and act accordingly" and, "They are always willing to chat and hear our views."

People were cared for by caring, empathetic, kindly staff who clearly cared for the people they were looking after. We saw people going up to hug staff and heard laughter, banter and informal conversation between people and staff. Staff and people knew each other well and were relaxed in each other's company.

Staff greeted people in a respectful way. One member of staff entered the dining room at lunch time and called out, "Hello ladies" to six women sitting at the table. We heard a staff member knock and enter someone's room with the greeting, "Hello, it's only me again." And another staff member entered people's rooms saying, "Good morning, did you sleep well?" We heard staff ask people if they would like a clothes protector on at lunch time, rather than automatically putting one on them.

People's privacy was respected. One person told us, "They always respect my privacy, they always knock and ask for permission before they do anything." Another said, "My privacy is always protected."

People were sensitively supported. One person got upset and we heard a member of staff ask them what was wrong. The staff member comforted and reassured the person and did not leave them until they were satisfied they were consoled. We saw another member of staff show a person how to get up out of a chair so they could copy them. The staff member used encouraging words and waited patiently until the person managed to stand by themselves.

People felt Amherst House was their home. We heard one person telling a visitor, "This is where I live" as they entered their unit. We heard lively conversation during the lunch period about the music that was playing in the room. Some people were singing along to the tunes.

People's wellbeing was taken into account by staff. We heard staff constantly asked people if they were okay or if there was anything they needed. One of the main meals at lunch time was curry and we heard staff check with people that the spiciness wasn't too much for them. One staff member checked everyone had had enough to eat and told them, "There's plenty more if anyone would like it." One person was concerned about their reading glasses and a staff member went to their assistance and another thought they had lost something and we saw staff put their arm around them and talk gently with them to distract them but at the same time not disregard the person's concerns.

Staff encouraged people to be independent, involved and make their own decisions. Staff told us there were no set times for people to get up in the morning or go to bed at night and we witnessed this. We heard one person say goodnight to everyone as they left the table from supper. Another person had told staff they would like to stay in bed all day and staff had respected this. One person told us, "I like to wash and shower myself and do so as much as I can." Another said, "I make my own decisions about day to day things."

Staff supported and responded to people when they needed it. We heard one person ask a member of staff to make some hot drinks for two people and assist them afterwards. We saw the staff member carry the tasks out immediately as the person wished.

People's individuality was recognised by staff. We heard one member of staff comment on someone's clothes and how nice they looked. They went on to discuss with this person how they could add a scarf or some jewellery. Another staff member told someone how nice their room smelt when they entered.

Visitors were able to visit when they wanted. One person told us, "My family can take me out as long as I let staff know. I don't feel my freedom is restricted." Visitors told us they were made very welcome and were listened to by the carers and management. We saw good interaction between staff and relatives.

Requires improvement

# Is the service responsive?

## Our findings

There was a range of activities during the week but we noted there was little organised on a Saturday and Sunday. We also felt staff were not proactive in arranging individualised activities for those people who spent a lot of time in their room. Although we were told activities staff carried out one to ones with people, we saw little evidence recorded in people's notes to show these had happened. One person's notes indicated they had declined participating in activities consistently, but we did not see evidence staff had considered alternatively ways to get this person engaged or entertained to help reduce any loneliness or boredom they may feel. Another person's care records last indicated they had participated in activities in August of this year.

People were provided with activities and could access the community. We read activities ranged from hair and nails, pat the dog, art, and a walking club to looking at the papers. We saw one person returned from the organised walk in the afternoon. It was clear they had really enjoyed it. We heard them say, "That was smashing." Staff responded to them with enthusiasm and engaged in conversation about walking and the benefits of it. People could get together in a small café area on the ground floor of the home and we saw this happen on the day. Several people were in the salon during the morning of the inspection having their nails or hair done. There was a lot of chatter going on and it appeared to be quite a social event. There were computers available for people in the lobby area, an indoor cinema and an activities room, although we did not see any of these being used on the day. People's spiritual needs were met. We read the Roman Catholic priest held services in the home and some people attended the church which was located next to the home.

The environment was not entirely suitable for people living with dementia. For example, we found although the environment was very clean, modern and bright, corridors all looked very similar and despite people having memory boxes outside of their rooms to help orientate people many of them were empty. We saw one person walking around a lot during the day going into other people's rooms thinking they were theirs. There was little physical stimulation for people living with dementia. For example, tactile items or textured surfaces. We saw a shop display cabinet containing haberdashery items, however it was placed at the end of one corridor where people would not routinely pass by. We did not see staff encourage people to look at it.

**We recommend the provider consider alternative ways to ensure everyone living in the home have access to individualised, meaningful activities.**

People were involved in their care plans wherever possible. We noted people who had capacity had signed a consent form to agree to the care and treatment that had been arranged for them. Care plans contained personal information about people from their childhood, family life and work. We read staff checked people's weight, skin integrity, food preferences and oral health. Pre-admission assessments had been completed to determine whether the home was a suitable place for people to live. We read that the medical history of a person was recorded together with information on how they wished staff to communicate with them. For example, staff had recorded in one person's care plan, 'get closer to me, don't speak quickly but speak clearly'.

Staff responded to people's changing needs. One person had a sore on their heel and staff had arranged for the GP to see this person the previous day. One person hadn't been weighed since May 2015. We spoke with staff about this as they were at risk of losing weight. Staff told us they were waiting for appropriate scales to be delivered in order to weigh this person, but in the meantime the GP saw this person regularly and they had no dietary problems.

People were provided with information on how to raise a concern or make a complaint. There was an easy to read complaint policy available in the home. We read one complaint had been resolved and another one was being dealt with by the regional manager. Everyone we spoke with told us they had never had a reason to make a complaint but would know how to do so if the need arose. One person said, "I would go straight to the manager." And another told us, "I would tell the person concerned first but would go over their head to the manager if it happened again."

Requires improvement

# Is the service well-led?

## Our findings

Records held were not always complete which meant new or agency staff who did not know people might not be providing care or working to the most up to date information. For example, we read information relating to one person who had a skin injury. The records were completed in an inconsistent way. We spoke with staff about whether this person still had the injury and staff had conflicting information about this person and the care they required, particularly in relation to whether or not they should be turned at specific times.

We noted in the topical medicines charts for people held in one unit information had not been completed by staff. For example, we read one person cream should be applied, 'twice a day' but there was no indication on the body map to show where the cream was to be applied. We read in another person's care plan it was noted in March 2015, 'high risk of choking, would like a referral to the speech and language therapy team (SaLT) if needed'. In May 2015 staff had noted, 'eating a normal diet'. Staff were unable to provide evidence to show whether or not this person had been referred to SaLT or how they had reached the decision that this person was not at risk of choking. Another person's care plan noted the person was to be turned 'regularly' but there was no guidance to staff on how often 'regularly' was.

Daily notes were recorded as tasks meaning staff may not get a good sense of a person's mood or identify trends in someone's behaviour. For example, we read daily notes were written, 'assisted to wash, put nightie on or provided personal care'. The regional manager confirmed care plans were, "Not where they should be" but staff were working hard to resolve this.

The lack of robust record keeping was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in the home and most staff told us they felt supported by them. They said they saw him out on the floor each day and felt he knew the residents. The regional manager told us the registered manager had carried out a lot of work since starting at the home and things were improving, but felt there was still work to do. People knew the registered manager and said he was approachable as were the nurses and care staff.

Despite this we heard from staff that morale was low. One member of staff said, "Staff are tired, weary and shift patterns can change. It is hard to plan your week as we get the rota one week in advance and we used to get it monthly." Staff told us they felt unsupported by management at times. One told us, "I have mentioned a few issues as we need to improve the way we are, but it is not taken seriously." And another said, "We have not always been supported by management." Staff said they felt the home needed more staff to improve things for people living there and for them working there.

The regional manager confirmed there were a number of staff hours to recruit to and told us they were supporting the registered manager in their recruitment drive by considering different ways of attracting new staff to the home. The regional manager was present in the home on a regular basis to support the registered manager and staff. A relative told us management was very good but as far as staffing was concerned they felt it, "Was a fire-fighting process dealing with what you had, rather than what you should have."

**We recommend the provider continues their recruitment drive to meet their required staffing levels.**

Staff agreed the culture was to develop, "Friendly caring relationships between residents, visitors and staff." Staff felt everyone wanted a happy, well-functioning establishment. Some staff had worked at the home since it opened and one said, "It's been great as you have grown with the residents, you have got to know them and they you."

Quality assurance checks were carried out by staff as well as the provider to monitor the level and quality of the care provided to people living at Amherst House. For example, medication audits. We read from the last audit shortfalls had been actioned. For example, in relation to the recording of PRN medicines. Records relating to infections, pressure sores or weight loss were kept by the registered manager and analysed monthly to enable them to identify trends within the home. Provider audits took place and we read the report from the one held in July. We noted this had identified some areas highlighted in this report. For example, risk assessments were not indicative of people's needs and care plans were not always up to date, although deadlines for completion of these pieces of work had not been set by the provider.

Requires improvement

# Is the service well-led?

Maintenance was reported and carried out. We saw each unit held a maintenance book in which staff could log issues or faults. We saw the maintenance person checking water temperatures in the home on the day of the inspection.

People and relatives were involved in the running of the home. We saw on the noticeboard an advert for a residents and relatives meeting. We were provided with the minutes of the most recent meetings and saw that a large number of residents and relatives attended. We noted people were encouraged to ask questions about the running of the home and they received an answer. For example, we read at the July meeting relatives had raised concerns about the garden and the number of weeds. In the August meeting notes we read that the registered manager informed people that a maintenance person had been employed and confirmed one of their duties would be to maintain the garden.

Staff told us they worked well as a team and helped each other out. This was evident on the day when we saw several caring and nursing staff working across the units together. This meant staff knew people in the home, rather than just their individual units. We read staff met regularly and noted from the minutes of recent meetings they discussed staffing levels, maintenance, activities and record keeping. One staff member said, “I really like it here. It is a nice place to work.” Another told us, “I want to give them the best, I want to strive for the best.” And a further told us, “I like my job. I believe residents are getting good care, staff are friendly and residents are happy.”

Staff had a good understanding of their responsibilities, for example sending in notifications to the CQC when certain accidents or incidents took place. We found during our inspection the registered manager had a good knowledge of the home and its residents and was able to answer our questions easily or provide us with the information we required.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The registered provider had not ensured there was a sufficient number of staff deployed at all times.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**The registered provider had not followed legal requirements in relation to restrictions.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**The registered provider had not ensured robust, contemporaneous, accurate records were held for people.** |