Athena Care Homes (Gaywood) Limited

Amberley Hall Care Home

Inspection report

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Date of inspection visit:
11 July 2023

Date of publication:
27 September 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Amberley Hall Care Home is a service providing nursing and residential care to up to 106 people. The service provides support to people with nursing and residential support care, including for people living with dementia. At the time of our inspection there were 97 people using the service.

The service consisted of 6 units, called Buckingham, Kensington, Sandringham, Balmoral, Windsor and Regency. Each unit was providing either nursing, nursing for people living with dementia, residential care or residential care for people living with dementia. Regency unit was used for people recently discharged from hospital. Staff in this unit worked in partnership with other healthcare professionals, some of whom were based on the unit, to aid people's recovery.

People's experience of using this service and what we found
Standards of care and support were found to be poor, particularly on the dementia nursing unit. People were not consistently supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We found examples of restrictive practices in use at the service, with a lack of consideration of least restrictive alternatives.

People did not receive their medicines as prescribed, and we identified gaps in the completion of corresponding records. People were not being protected from the risk of harm, including in the condition and cleanliness of the care environment. People had unsupervised access to items such as razors and personal care products, including prescribed creams placing people at risk, particularly those people living with dementia who were reliant on staff support and oversight to keep them safe.

People were not supported with regular repositioning to prevent them developing pressure ulcers. Where people were at known risk of falls, or at risk of leaving the service without staff being aware, the corresponding records showed gaps in the frequency of welfare checks being completed. People's basic standards of personal hygiene and presentation were not being consistently met, with areas of the service found to have malodour, and some people found to have unclean nails and teeth.

Response times to call bells and assistive technology to maintain people's safety was poor. Where people were involved in incidents, sufficient mitigation was not being implemented or followed by staff to prevent the risk of reoccurrence. People were not being supported by sufficient numbers of staff, and this was reinforced by people and relative's feedback.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 17 September 2021).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

This inspection was prompted by a review of the information we held about this service and due to receiving information of concern relating to the safety of people living at the service. A decision was made for us to inspect and example those risks. We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Amberley Hall Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to consent, protecting people from the risk of harm or abuse, providing safe care, the governance and oversight of the service, and the number of staff on shift at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Amberley Hall Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Consisted of 2 inspectors, 1 specialist medicine inspector and 2 Experts by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Amberley Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Amberley Hall Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used other information we hold about the service, and sourced feedback from the local authority quality assurance team. We used all of this information to assist us with our inspection planning.

During the inspection
We spoke with members of staff including the registered manager, deputy manager (who was also the service's clinical lead) 2 members of nursing staff, 5 care, 1 team leader, 3 ancillary staff and a member of activities staff. We spoke 13 people living at the service and observed care provided in communal areas. We spoke with 11 relatives about the care and support provided.

We reviewed a range of records, including 8 people's care records and 19 medication records and observed some of the morning medicines round. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The care environment was unsecured. We identified gates and doors leading from the building and surrounding garden that did not close securely. Prior to our inspection we had been notified 4 times where people had left the service without staff being aware.
- Risks were poorly managed. Where use of assistive technology had been implemented in response to serious incidents, to alert staff when people moved around the service, we found staff response times to the alert to be poor. This did not protect people from risk of further harm.
- People were not protected from the risk of pressure ulcers. We identified gaps in the completion of repositioning where people were assessed to require regular support to change their position to maintain and protect the condition of their skin. Relatives also raised concerns with us regarding poor nail and teeth care provision. A relative told us, "I do not think the personal care and hygiene needs are what they should be, I often shower [Name] to know they are clean."
- Checks of equipment were ineffective. We identified padded bed rail covers to be damaged, increasing the risk of the spread of infection and injury as the integrity of the covers were torn and broken.
- People were at risk of unsupervised access to care products. People, including those living with dementia, had unsecured access to razors, personal care products, prescribed creams and the contents of bags belonging to staff.
- Staff were not following people's care plans to maintain their safety. Where people were assessed to either be at risk of leaving the service or at risk of falls, their records specified frequency of staff checks on their welfare. From reviewing the corresponding records these showed timing were not being met as detailed in their care plans to maintain people's safety.

The provider did not mitigate risks to people receiving care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our inspection visit, we received confirmation of actions taken to address the building security risks identified.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA and identified examples of restrictive practices in use. We found a person who was visibly attempting to climb over their bed rails, and less restrictive, safer options had not been considered.
● Mental capacity assessments were not completed in line with the Act. Assessments lacked detail, were not consistently decision specific, and where key decisions were made, did not demonstrate least restrictive options had been explored, considered or discounted.
● The provider was aware MCA needed to be improved. The provider's own audits in April 23 identified the need for improvements with the recording of MCA and best interest decisions, but this had not been addressed when we inspected 3 months later.

The provider was not ensuring staff were adhering to the Mental Capacity Act (2005) in their practice and approach to people's care. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Inspection findings resulted in CQC making safeguarding referrals to the local authority to protect people in relation to the use of restrictive practices identified during the inspection.
● Lessons were not being learnt as an outcome of safeguarding incidents. We reviewed actions taken by the service as an outcome of serious incidents that had happened at the service. We were concerned to find assurances we had been given were not being implemented into practice at the inspection. We could not be assured the seriousness of incidents and risk of reoccurrence was being recognised.
● Staff did not understand how to protect people from harm and act in people's best interests. We found staff demonstrated a lack of recognition of the risks relating to supporting people, particularly those people living with dementia to promote their safety and welfare. Inspection findings were reinforced by the fact there were gaps in the completion of safeguarding training by staff.
● Local safeguarding policies were not being followed. Where people had experienced multiple falls, the service were not following the local authority safeguarding and falls reporting processes.

The provider was not ensuring staff had the required skills and knowledge of safeguarding processes to protect people from harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, we received assurances from the provider that staff were booked onto refresher courses for safeguarding training.

Staffing and recruitment
● There were not enough staff to meet people's care needs. This was of particular concern on the dementia nursing unit. Our observations identified staff were unable to provide personal care to protect people's dignity in a timely way, due to there not being enough staff available. Inspection findings were supported by a relative who told us, "I do not think the attention is as good as we thought, a lot of residents left on their own for long periods."

● Staffing levels impacted on response times to call bells and assistive technology. This did not ensure people's assessed needs were being met and was placing people at increased risk of harm and injury. A relative told us, "Honestly, I don't think there is enough staff. A few occasions press the call bell when [Name] needs the toilet, long response times." Another relative said staffing was, "Awful at weekends. Slightly better during the week."
● Fire practice drills were not being completed at night time. The lack of night time evacuation practices did not ensure staffing levels required to achieve safe evacuation processes had been assessed.
● Assessed dependency levels were not being followed. We identified the service were not implementing staffing levels reflective of people's assessed needs through use of the provider's own dependency tool. This was of particular concern on the dementia nursing unit. A relative told us, "The atmosphere is a bit flat most days, residents sitting in the lounge, no staff members sometimes 1 sat in there not necessarily talking to them."
● Dependency assessment findings were not being acted on. For May and June 23, the provider's dependency tool had repeatedly identified the need to consider implementation of 1:1 care for a person, but this had not been acted on to ensure their safety.
● Training was not being implemented into practice. We reviewed the service's mandatory training matrix and identified gaps in relation to the completion of training, and competency checks. This was reflective of inspection findings and the need for greater oversight of implementation of training and guidance into staff practice.

Sufficient levels of suitably trained, competent staff were not in place to keep people safe, in line with the service's own assessed staffing numbers. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, we received assurances from the provider that staff were booked onto refresher training courses.

● The service completed pre-employment checks to ensure staff were safe to work with people living in a care setting. This included the completion of Disclosure and Barring Service (DBS) checks, which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff completed an induction programme when commencing employment at the service.

Using medicines safely
● Medicines were not stored securely. Oral medicines and medicines prescribed for topical application such as creams and emollients were not stored securely to ensure people could not access them without staff supervision.
● We identified medicine discrepancies. The service's electronic Medicine Administration Record (MAR) system showed discrepancies with people's oral medicines. The records did not confirm medicines had been given correctly and at prescribed doses. We also noted gaps in records for the application of topical medicines such as creams and a lack of body maps to show where the cream needed to be applied.
● 'As required' medicines protocols (PRN) lacked detail. People's PRN protocols lacked person-centred detail and when more than 1 pain-relief medicine was prescribed on this basis, there was a lack of detail about the person's overall pain-relief strategy.
● Records did not confirm patches had been correctly applied and rotated. The electronic MAR system did not confirm that the sites of application of the patches on people's bodies had been properly rotated to reduce the risks of skin irritation.
● Independent management of medicines was not risk assessed. The service promoted a person's

independence to manage some of their own medicines, however, this decision had not been risk assessed to ensure it was safe to do so.

Risks relating to the management of people's medicines were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was found to be visibly unclean with areas of malodour. The service contained damaged equipment and surfaces which impacted on the ability to keep them clean and reduce the risk of the spread of infection.

● We identified the need for the provider's policies and procedures to be followed to protect people and staff from the spread of infection and improve overall infection, prevention and control practices. The areas of concern identified during this inspection had not been found through the provider's own quality checks of the condition and cleanliness of the care environment.

Visiting in care homes

● People and relatives confirmed they were welcome to visit the service, and spend time indoors and outside in the gardens, as well as accessing the local community. A relative confirmed they were able to stay at lunchtime to eat and or support their loved one during their meal.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Daily walk arounds completed by the management team were ineffective. Staff storing personal bags and belongings in communal areas of the service, rather than securely in the staff room had not been identified prior to our inspection through the service's own walk arounds and checks. This placed people at risk of harm.
- Provider audits were not identifying areas of risk. The provider's own audits had not identified the level of environmental security concerns found during this inspection. We also identified actions from audits rolling over from month to month without being addressed. For example, an external door was not closing correctly had been identified by the service's fire safety checks in March 2023, but remained unfixed when we inspected 4 months later.
- Notifiable incidents had not been reported. We identified medicine incidents which met the threshold to be reported to the local authority safeguarding team and to CQC. The gaps in reporting had not been identified through the provider or service's own audits and quality checks.
- Quality audits were not identifying issues. From reviewing people's care records we identified information which had been incorrectly copied into people's care records, as well as inaccurate or out of date information. This had not been identified through the service's own audit processes.
- There was a lack of learning and improvement at the service. We were concerned the service had not acted on feedback from a local authority assessment completed in January 2023, to ensure areas of concern had been addressed, and improvements made when we inspected 6 months later.
- There was a lack of incident analysis being completed. Records showed analysis of falls was only completed where the fall had resulted in an injury rather than looking for overall themes, trends, and preventative action. The lessons learnt sections of the analysis forms were being left blank and did not demonstrate sign off by the provider or registered manager.
- The provider did not have sufficient oversight of the service to keep people safe. Checks of equipment and window restrictors were not being signed off by the registered manager to confirm they had been completed to required standards. This did not safeguard those staff completing the checks on the manager's behalf.

The systems and processes to assess, monitor and improve the quality and safety of the service were not established or operated effectively to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Retrospective notifications were made by the service to the local authority safeguarding team and to CQC as an outcome of our inspection feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not consistently receive person-centred care. Some people were got up daily at 5.15am to 6am. A relative told us, "They seem to get everyone up in the same order which I do not really think is fair. They should rotate. They seem to have a time limit to get people up."

● Staff did not always feel empowered. Staff we spoke with gave positive feedback about their role and working at the service, however, 2023 staff survey results identified some staff felt unhappy or not valued, did not all feel they had the 'tools and equipment' required to meet the demands of their roles and did not feel their wellbeing was supported.

● People had the opportunity to give feedback on the running of the service. Regular meetings were in place for people to discuss any concerns or areas they wished to change, such as activities or meal options.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We received mixed feedback on standards of communication. Some people told us they had no concerns, and their relatives felt they were kept updated of any changes. One relative however, raised concerns that the service had made the decision to move their loved one without discussing this decision with them. Whilst a retrospective apology was received, the relative told us they felt standards of communication ahead of change needed improvement. Another relative said, "It is a big care home and I think things can get lost or forgotten with communication."

● The service followed the provider's complaint policy. The service had received 5 complaints in the 12 months up to our inspection. We could see the registered manager responded to each complaint in line with the provider's policies, and kept the complainant updated whilst any investigations were ongoing. Reviewing complaints was also a standard agenda point on the head of department meeting minutes.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Annual surveys were completed to source feedback. Feedback from people and their relatives as an outcome of the 2022 survey were mainly positive, although they did highlight some concerns around whether people felt safe living at the service, and the need for improvements to communication.

● Staff worked closely with health and social care professionals. Staff told us they had good working relationships with the GP surgery and sourced support from external professionals where required to ensure people's care needs were identified and met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not adhering to the implementation of the MCA (2005). We also identified examples of restrictive practice, with a lack of consideration given to least restrictive options. This was a breach of regulation 11 (1).

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not ensuring people were living in a clean and comfortable care environment. Infection, prevention and control risks were identified. People were not protected from the risk of harm. People were not receiving their medicines as prescribed. This was a breach of regulation 12 (1).

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The care provider was not ensuring staff were following safeguarding policies and procedures to maintain people's safety and protect them from harm. This was a breach of regulation 13 (1).

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not ensure good standards of governance and oversight were in place to maintain and drive standards of care at the service. This was a breach of regulation 17 (1).

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring sufficient numbers of suitably trained, competent staff were on shift to meet people's assessed needs and risks. This was a breach of regulation 18 (1).

The enforcement action we took:

Warning Notice.