Avery Homes (Nelson) Limited

Amarna House

Inspection report

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Ratings

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

Overall summary

Amarna House is a purpose built care home that provides residential and nursing care for up to 80 older people. The home is divided into four units, each supporting up to 20 people, and is spread across two floors. On the ground floor, the Evergreen Unit provided residential care and the Autumn Unit provided nursing care. The first floor had two "memory care" units, which specialised in supporting people with dementia. These were called the Laurel Unit and the Willow Unit. The Willow Unit supported people with dementia or challenging behaviour who also had nursing needs.

We inspected this service on the 14 October 2015. This inspection was unannounced. At the time of our inspection there were 77 people using this service.

The service was registered under a new provider, Avery Homes (Nelson) Limited, in November 2014. This was the first inspection of this location following registration under the new provider.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who

Summary of findings

has registered with the CQC 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.

During this inspection we found that the service was safe. People's needs were assessed and comprehensive risk assessments put in place to reduce the risk of avoidable harm. Where there were safeguarding concerns, these had been appropriately identified and acted upon.

We received some negative comments about staffing levels and identified that staffing levels did fluctuate. However, we saw that staffing levels did not fall below the level deemed necessary to meet the needs of the people using the service and saw that the registered manager was recruiting new staff to enable them to provide a higher staffing level.

The service had an effective recruitment and induction process and provided on-going training to equip staff with the skills and knowledge needed for their roles. People were supported to eat and drink enough and, where necessary, were supported to access healthcare services. We saw that advice and guidance from healthcare professionals was incorporated into people's care plans. This ensured that staff provided effective care and support based on up-to-date knowledge on best practice. People were supported to make decisions and their rights were protected in line with relevant legislation and guidance.

People using the service were positive about the caring attitudes of staff. We observed that staff were kind, caring and attentive to people's needs. Staff encouraged people to make decisions and have choice and control over daily routines. People's privacy and dignity was respected.

We saw that there were systems in place to assess and record people's needs so that staff could provide personalised care and support. Care plans were updated regularly and information shared so that staff were aware of people's changing needs.

People told us they felt able to make comments, complaints or raise concerns and we could see that feedback about the service was used to make changes and improvements.

The service was well-led. The registered manager was proactive in monitoring the quality of care and support provided and in driving improvements within the service. We observed that records were well maintained. There was clear organisation and leadership with good communication between the registered manager and staff on each unit.

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?
The service was safe.

People's needs were assessed and risk assessments put in place to reduce the risk of harm.

There was a safe recruitment process in place to ensure only people considered suitable to work with vulnerable client groups had been employed.

There were systems in place to safely manage and administer medication to people using the service.

Good

Is the service effective?
The service was effective.

There was an effective recruitment, induction and training process to equip staff with the skills and experience to perform their roles effectively.

People were supported to make decisions and their human rights were protected in line with relevant legislation and guidance.

People were supported to eat and drink enough and to access healthcare professionals when needed.

Good

Is the service caring?
The service was caring.

Staff were observed being attentive, professional and unrushed when providing care and support.

Staff understood the needs of people using the service and encouraged people to maintain their independence and have choice and control over the support they received.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed and personalised care plans put in place to support staff to provide responsive care. Information was shared between staff and care plans updated when people's needs changed.

People felt able to make comments and raise concerns. There were systems in place to gather feedback and respond to complaints.

Good

Is the service well-led?
The service was well-led.

People told us that the service was well-led. People felt able to raise concerns and we saw that where concerns were raised, these were acted upon.

There were effective systems in place to monitor and audit the quality of care and support provided.

The registered manager used team meetings, supervisions and spot checks to encourage improvements and address poor practice.

Good

Amarna House

Detailed findings

Background to this inspection

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

This inspection took place on the 14 October 2015 and was unannounced. The inspection team was made up of two Adult Social Care Inspectors, an Expert by Experience (ExE) and a Specialist Professional Advisor (SPA). An ExE is someone who has personal experience of using or caring for someone who uses this type of service. A SPA is someone who can provide specialist advice to ensure that our judgements are informed by up-to-date and credible clinical and professional knowledge. The SPA who assisted with this inspection was a specialist in nursing care.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought relevant information from City of York Council's safeguarding and commissioning teams and looked at information shared with us via our public website.

As part of this inspection we spoke with 13 people who used the service and five visitors who were relatives or friends of people living at Amarna House. We spoke with the registered manager, the deputy manager, a team leader, a unit manager, four nurses, three senior care workers, nine care workers, a member of the administration team, an activities coordinator, the chef, the maintenance person for the home and a visiting healthcare professional.

We looked at nine care plans, five staff recruitment and training files as well as a selection of records used to monitor the quality of the service. We observed interactions throughout the day between staff and people using the service. This included observations of planned activities and lunch being served on two of the units. We also observed a staff handover meeting and a daily meeting between senior staff and managers within the home.

Good

Is the service safe?

Our findings

People using the service told us “I feel safe here. There are good staffing levels at night. There’s someone there all the time with pretty good response if I press the bell.” Another person said “It feels safe here. A member of staff always takes you and brings you back in the lift from the hairdresser.”

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse and provided training to equip staff with the skills and knowledge to appropriately identify and respond to signs of abuse. Staff we spoke with described the types of abuse they might see and what action they would take if they had concerns. The registered manager described the local authority safeguarding procedures and our checks of the safeguarding file showed that there had been nine alerts raised by the registered manager in the last ten months. The local authority’s safeguarding team had looked at all the alerts and no further action had been necessary. We found evidence that appropriate action had been taken by the registered manager on each occasion to ensure people were kept safe from harm. The CQC had been notified of these alerts. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

One member of staff we spoke with said “The environment promotes safety, there’s call buttons, bed sensors and crash mats. Staff are adequately trained to deal with the client group; we all receive a large amount of training and management are aware of issues on the unit and can support if needed.” We saw that there were risk assessments in place that recorded how identified risks should be managed by staff. These included individualised risk assessments for falls, skin integrity, nutrition and moving and handling. We saw that risk assessments had been updated on a regular basis to ensure that the correct information was available for staff providing care. This helped to keep people safe, but also ensured they were able to make choices about important aspects of their lives. Information was recorded in people’s care plans to guide staff on how to support people who displayed particular behaviours that needed to be managed in a specific way to ensure the person’s safety. The staff told us that restraint was not used within the service.

We observed safe moving and handling practices throughout the day and saw that people were supported to mobilise independently around the home. We saw that where issues with staff's moving and handling practices had been identified, the registered manager had appropriately addressed this and further training had been provided. We saw that, where necessary, doors were locked with a key code system, but otherwise doors were left open for people using the service to move freely between their rooms and shared communal areas.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. We saw that there was a monthly 'Falls Team Meeting' where the registered manager met with staff to review the care and support of people who had multiple recent falls. We saw that minutes were produced and action plans put in place to further reduce risks and prevent avoidable harm.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment. These records showed us that agreements were in place to ensure equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the passenger lift, fire alarm, the nurse call bell system, moving and handling equipment including hoists and slings, the electrical wiring system, portable electrical items, water systems and gas systems. We found that the fire risk assessment was reviewed in February 2015 and fire drills were carried out each month. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person on wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

The registered manager spoke with us about the registered provider’s business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care,

treatment and support needs met. This was last reviewed in September 2014 and scheduled for review again in 2016. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were kept in the fire safety folder and were up to date.

We looked at five staff recruitment files and saw that application forms were completed, references obtained and checks made with the Disclosure and Barring Service (DBS) before staff started work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. These measures ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured that staff were aware of what was expected of them.

The registered manager carried out regular checks with the Nursing and Midwifery Council (NMC) to ensure that the nurses employed by the service had active registrations to practice.

Before our inspection we received concerns about staffing levels within the service. On the day of our inspection we observed that care was provided in an unrushed manner and people who used the service did not raise concerns about staffing levels. However, a visitor said "There is enough staff to maintain care, but ideally, with more, the staff could interact more with the residents." A member of staff told us "You can't have eyes everywhere, especially at lunchtime" and another said "Staffing levels at times can be good, we have asked for 5 [care workers] as 90% of people require a full hoist."

The registered manager told us that during the day, they aimed to have four care workers and one nurse on duty on each of the two nursing units and four care workers on duty on each of the two residential units. We reviewed staff rotas and found that the nursing units were staffed to this level; however, we found on the Evergreen Unit that there were only three care workers on the rota for 12 out of the 16 days before our visit and there were only three care workers on the rota for 11 out of 16 days on the Laurel Unit. We saw that on one day there were only two care workers on the Laurel Unit due to sickness. At night, the registered manager told us they aimed to have two care workers on each of the four units and one nurse and one senior care worker on duty. We saw that at night, the number of staff on the rota fluctuated with a minimum of nine and a maximum of 12 staff on duty.

The registered manager told us they had a dependency tool to work out how many hours of care were needed to meet the needs of the people using the service. This had not been updated at the time of our visit, so we asked the registered manager to complete this and send it to us. From this we saw that the actual number of care hours provided was above the level deemed necessary to meet the needs of the people using the service. The registered manager told us that staffing levels within the home as a whole were 10% above what was required and this extra provided a contingency in the event of sickness, absences or annual leave. Where there were staff shortages on one unit, the registered manager told us that staff were redeployed to ensure that people's needs continued to be met by the staff team within the home as a whole.

People who needed help to take their medicines had medication care plans in place detailing the level of support required. We saw that these were updated every 6 months or more frequently if needed. We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, stored, recorded, administered and returned when not used. People using the service told us "The medication comes on time. They always come and find me."

New or repeat prescriptions were sent to the home by the G.P. Staff told us this enabled them to make a copy and check the prescriptions before they were sent to the chemist. Medications were supplied in blister packs along with printed Medication Administration Records (MARs). Blister packs are a monitored dosage system and contain a 28 day supply of that person's medicines, colour coded for the times of administration. MARs are used to document medication given to people who used the service.

We observed that medicines were administered in line with guidance on best practice, that people were given a drink of water to help them swallow their medicine and that staff ensured medication had been taken before accurately recording this on people's MARs. Prescribed creams for topical application were dated on opening and all were discarded monthly. A topical administration chart was used to inform staff where cream needed to be applied.

Good

Is the service safe?

We observed that medications were securely stored, that the area was clean and tidy and that a daily record was kept of the treatment room and fridge temperatures and these were found to be correct. This showed us that medicines were stored at the correct temperature.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were securely stored and records showed these were checked when given and also on a daily basis. We noticed the pages in the controlled drug book were not correctly indexed and the member of staff agreed to address this.

Staff we spoke with who were responsible for administering medication understood the principles of best practice regarding correct administration, discarding spoilt medication, covert medication, homely medications and self-administration. Drug audits were completed monthly for each person using the service as part of the 'resident of the day' scheme run at the home. We found that all medicines we checked could be tracked and there was a clear audit trail from ordering to receiving to administration to returns. This showed us that there was a system in place to safely manage and administer medications.

Good

Is the service effective?

Our findings

People using the service told us "The staff are always kind and new staff are trained." A visiting healthcare professional we spoke with said "Staff seem to be knowledgeable and friendly, they know an awful lot about them [people using the service]...they seem to take on board everything that we ask for."

New staff completed induction training to equip them with the skills and knowledge to carry out their roles effectively. We reviewed training files and saw that induction checklists were used and activities or training were signed off when completed. Topics covered during the induction training included health and safety, fire safety, infection control, moving and handling, food hygiene, safeguarding vulnerable adults, challenging behaviour, person centred care planning and dementia awareness. We saw that staff completed a short test paper after training sessions to demonstrate they had understood what was being taught. Staff we spoke with told us that in addition to completing induction training, they had to do three supervised shifts before working on their own. We reviewed the rotas and saw new staff were scheduled for three supernumerary shifts before becoming part of the team. One member of staff told us they felt "This was more than enough, but I could have continued supervised shifts if I was not comfortable." This showed us the service had an effective induction programme to support and develop new staff.

We saw that staff were required to complete refresher training on topics which included safeguarding adults, health and safety, infection control, food hygiene, moving and assisting people and fire safety. The registered manager told us that since being registered under a new provider in November 2014, all staff were required to redo their training. We saw a training matrix which detailed the progress that had been made to retrain all staff; for example 82.46% of staff had completed the registered providers training on moving and assisting people, 56.1% had completed infection control training and 58.62% had completed food hygiene training. The registered manager told us this training plan was being reviewed with the Area Manager to ensure that they continued to roll out new training courses to all staff. We reviewed individual training records and saw that these contained certificates of courses completed; this showed us that staff were receiving on-going training to support them in their roles.

We saw that the registered provider had a supervision policy in place. The registered manager told us that staff had three monthly supervision meetings and annual appraisals with their line managers and we were given the records of these to inspect. We saw that the records were detailed and up to date and the information in the supervisions confirmed that the line managers spoke with staff about their work practice and personal development.

We observed the morning handover meeting between staff on the night shift and day shift. We saw that each person using the service was discussed, an update given and important information about people's needs handed over. Where someone had been unwell during the night, this was handed over to the day shift to monitor and respond to. We saw that handover records were comprehensive and documented these conversations for other staff to look at. This system ensured that carer workers had up-to-date information enabling them to provide effective care as people's needs changed.

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. Where people lack mental capacity to make 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that 24 people who used the service had a DoLS in place around restricting their freedom of movement. We looked at eight of these records and found that each person required an escort when leaving the service to keep them safe whilst out in the community. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. A further 12 applications had been submitted and were waiting for the local authorising body to assess and approve the documentation.

Good

Is the service effective?

The registered manager told us that one person who used the service had an Independent Mental Capacity Advocate (IMCA) who had initially been involved when the person was authorised for a DoLS. The IMCA now visited them every five weeks. An IMCA is someone who supports a person so that their views are heard and their rights are upheld. IMCA's are independent; they are not connected to the carers or services that are involved in supporting the person.

People using the service or their representative had signed to show that they agreed with their plans of care and support. Staff we spoke with understood the importance of supporting people who used the service to make decisions for themselves. We saw in care records that staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. We saw recorded in three care files that the person had someone acting as their Power of Attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. It is important for carers to be aware when a POA is in place, so that decisions are made by the right person in line with previous wishes. However, we did not see evidence of what type of POA was in place. We discussed this with the deputy manager who immediately audited the personal files held for people who used the service. They confirmed that they held the paperwork detailing the scope of authority for the POA and would make this clear in people's care files.

People using the service were positive about the food and told us that food was served hot, the portion sizes were good and there were a variety of options available. We saw that each unit had its own kitchen which contained supplies of tea, coffee, cereals, yoghurts, bread, cheese, crisps and chocolate for people using the service to eat between mealtimes. We observed fresh fruit was freely available and were told that 'older' fruit was recycled into smoothies. People using the service told us there were plenty of drinks offered and various snacks in the morning and afternoon.

Meals were prepared in a kitchen on the second floor and delivered to each unit at mealtimes. A person using the service said staff asked what they wanted the day before, but told us they could change their mind on the day. We did not see any menus on display in the dining room, but observed staff telling people what was available and offering choice. One person using the service told us "I do feel listened to and they know what I like. I don't like mashed potato so they never give it to me." Whilst another said "You can eat what you want." We spoke with the chef who showed us the menu and how they kept information about people's dietary requirements and allergies. We saw that there were choices available and that alternative options were provided to meet people's specific dietary requirements, for example, pureed food for people with swallowing difficulties and fortified diets for people whose nutritional status was at risk.

We saw that people's personal preferences, dietary requirements and support needs were documented in their care plan. A visitor told us "My relative does get help with food. Sometimes it needs cutting up or she needs prompting. The staff do hover and when she's struggled I've seen them assist." People who used the service were weighed monthly or weekly if weight loss had been identified. A Malnutrition Screening Tool (MUST) was used along with Body Mass Index (BMI) scores to record and identify risks around nutritional intake. Entries in the care records we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment of their swallowing/eating problems. This showed us that there was a system in place to ensure that people using the service were supported to eat and drink enough.

People were able to talk to healthcare professionals about their care and treatment. One person using the service told us "I was at the dentist last week and they took me in a car and someone went with me." Comments from relatives of people using the service supported this; one person said "The GP visits routinely twice a week which is good" whilst another relative told us "The home let us know when they were concerned about my mother's weight and they sorted out some special drinks for her until the problem settled." We saw evidence that individuals had input from their GP's, district nurses, chiropodists, opticians and dentists. There was also evidence that other healthcare professionals such as the Speech and Language Therapy team, dietician, tissue viability nurse and respiratory nurse had been contacted appropriately. A visiting healthcare professional told us "There's very good communication, I can't fault the

Good

Is the service effective?

home, they are very quick to tell or ring us if there is a problem." All individual health needs, visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken as required.

We saw that there was appropriate signage to support people using the service to identify toilets, the dining room and to find their way around the home. In the dementia residential unit, people's rooms had a photograph and name on. There were also framed wall boxes of personal pictorial memories and objects to the side of some bedroom doors, which told the background story of each person using the service. We were told this was 'work in progress' being undertaken by the activity team to help people using the service identify their rooms.

Good

Is the service caring?

Our findings

People using the service told us "The staff always have a good word, they are caring and they do not push you to do things." A relative of someone using the service commented "There's a good atmosphere here – not only friendly – often laughter" and a visiting healthcare professional told us "It's one of the best homes, I'd put my relatives in here, staff are very caring, very friendly."

We asked a new member of staff if the people they worked with cared for people using the service. They told us "Yes definitely, it's evident in how they carry out their work. Staff are very patient, you don't hear cross words and they're always willing to do that bit extra." Staff we spoke with understood the importance of getting to know people using the service and developing positive caring relationships. One member of staff said "The residents' personal stories are very important to us – we need to know so we can talk to the residents." Another said "It's all about spending time with the residents in the afternoons – the butterfly effect – which is short positive interactions." We observed that staff interaction with people who used the service was respectful. Staff reacted to situations immediately, responding to call bells quickly, giving choice and promoting independence. A visitor told us that staff provided good care, explaining "The [member of staff] who brings the tea uses my friend's name, knows what they want and is friendly without being over the top." We observed that support provided was person centred, caring and kind.

Staff we spoke with displayed an in-depth knowledge about each person's care needs and personal preferences. Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift and by reading the care plans. We spoke with a new member of staff who told us "The care plans are quite comprehensive and really accessible – they are straight forward to use."

We observed that staff supported people wherever possible to make decisions and express their wishes and views. One person who used the service told us "They help you, but don't take over" and another person said "I have a shower twice a week – that is my choice." We noted that care plans contained information about people's wishes and views and we observed staff supporting and encouraging people using the service to make decisions and have choice and control over their support. We observed that care being delivered was not restrictive and people were supported to maintain their independence. For example, we saw one person ask a member of staff to pass their walking frame so they could go to the bathroom. The carer responded promptly and kindly, positioning it and providing verbal prompts. The carer stood close by to monitor, but did not intervene allowing the person to maintain their independence and get up in their own time.

We visited the service early in the morning to see whether people were supported to get up when they wanted to. When we arrived we saw that there were six people up and dressed. Staff we spoke with told us "Due to confusion, we have got some early risers…day is night and night is day for them. We cannot have a routine on the dementia unit." We were told that night staff did their last nightly check between 4:30-5:30am and provided assistance with personal care where necessary. Staff we spoke with explained that if people wanted to get up at this time or would not settle back to sleep, then they would provide support to get up. However, staff we spoke with said "We had a meeting with the managers and staff recently…The manager made it clear to the staff that no one who used the service should be woken up deliberately or taken out of bed unless they required personal care and support." The team leader told us "There is no rigid routine in this service, we give care and support as people need it."

People using the service told us "I come down to breakfast about 8.30, but some people come a bit later if they want a lie in" and "A [member of staff] showers me every day which is helpful. I have it at 7.30 every morning. I requested it at that time."

People we spoke with felt their privacy and dignity were respected. One person said "If you insist on a female GP or carer, they will arrange it." We observed that support provided in communal areas was appropriate and maintained people's dignity. Personal care was provided in people's rooms with the doors shut to maintain that person's privacy. One member of staff we spoke with said "We always do personal care behind closed doors; if people are going to be naked we cover them up with a towel."

There was no one receiving end of life care at the time of our inspection. We saw that care files contained a care plan for future wishes and in some instances Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We noted that the future wishes care plans we reviewed

Good

Is the service caring?

documented that people wanted to remain at Amarna House rather than being admitted to hospital if receiving end of life care. This information was not kept together with the DNACPR so it could get missed if staff were unfamiliar with that person's wishes. We discussed this with the deputy manager who later showed us that they had started looking at using emergency health care plans to be kept with DNACPR's. This assured us that this issue would be addressed.

Good

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and comprehensive care plans were developed outlining how these needs were to be met. The nine care plans we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. Records evidenced that the information had been gathered from the person themselves, their family and from healthcare and social care professionals involved in the person's care. Some people had signed their care plans to show they agreed to the contents. For people who wished to have additional support with making decisions about their care, information on how to access an advocacy service was available from the registered manager.

Care plans were reviewed on a monthly basis and any changes to care were implemented straight away. For example, a medication care plan had been updated as the GP had recently visited to change that person's medication. We saw that another person with recent weight loss had been referred to their GP, who prescribed high calorie drinks, a high protein diet and extra snacks. This person's care plan had been updated to reflect this and to support staff to provide responsive care to meet these changing needs.

There was evidence of a wide range of activities available to people using the service. There were two activity coordinators working at Amarna House. We saw that there was a weekly activity plan displayed in the corridors of all the units and also a personal copy kept in people's bedrooms to alert people using the service and relatives of forthcoming events and activities.

We saw that activities were varied and innovative. One person using the service told us "The activities are much better now with an activity team in place. I can tell a tale reasonably well and the creative writing for me is good. There was also an excellent photography programme for a few weeks and before that poetry." We saw that people using the service had been on a boat trip recently and photos of this were displayed in the main entrance hall. People told us "It was enjoyable" and "I like to do something different." We observed a chair exercise class in the morning attended by 13 people using the service and a craft session in the afternoon attended by a small group of people who were making autumn wreaths. We observed that the activity coordinator was engaging and inclusive. They knew the people involved with the activities and clearly had a good relationship and rapport with them. We could see that people enjoyed and benefited from these activities.

Some people using the service told us there were not a lot of activities that suited them and one person commented "We could do with a few more little casual chats – but we also need some down time!" A relative of someone using the service said "There is a lot of 'fill' rather than activity" and felt that their relative would enjoy more outings as they could be left in their room for too long sometimes.

We observed that this issue was discussed in a meeting on the morning of our inspection, during which the activities coordinator said that they were looking at ways to include people who might not be able to join in certain activities or who spent large periods of time in their room. We saw that the registered manager had purchased a Dictaphone and this was given to the activities coordinator who explained that they were planning an oral history project to involve people who might not join in group activities.

People were supported and encouraged to maintain contact with their family and friends. One person said "I have my own telephone line in my room so I can ring my family twice a week for a chat." Other people using the service told us they were encouraged to go out with relatives "I go out with the family if they've got a car" and "If I want to go shopping my niece takes me in a wheelchair." A relative of someone using the service told us they were always made to feel welcome and could visit at any time "It's very homely - we can make tea or coffee ourselves anytime in the little kitchen, we just help ourselves."

There was a complaints policy and procedure on display in the entrance hall of the service. This described what people could do if they were unhappy with any aspect of their care and support. We saw that the service's complaints process was available in large print format. Information held by us about the home and a review of the registered provider's complaints log indicated that there had been 15 complaints made about the service in the last 10 months. All had been investigated by the registered manager and

Good

Is the service responsive?

resolved; we saw that the complainants had been provided with a written response. People using the service told us they felt able to raise complaints or concerns if they needed to.

The service held monthly resident and relatives meetings to discuss changes in the service and to provide an opportunity for people to give feedback. We saw meetings had been held in July, August and September 2015 and issues discussed included staffing levels, upcoming events and suggestions for activities within the home.

There was an annual 'Service User Questionnaire' canvasing opinions and feedback from people using the service. This was sent to 85 people in February 2015. We saw that the results had been collated and were generally positive. Comments from this questionnaire were recorded and any actions taken by the registered manager in response. This showed us that there was a system in place to gain feedback and listen and learn from people's views and experiences.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration. There was a registered manager in post on the day of our inspection and so the registered provider was meeting the conditions of registration. The registered manager was supported by a deputy manager, four unit managers as well as other heads of department and an office administrator.

We observed that there was a calm atmosphere within the service and care and support was provided throughout the day in a professional, relaxed and unrushed manner. We observed that the registered manager was a visible presence within the home and was positive, proactive and focused on the needs of the people using the service and on delivering a high standard of care and support. We observed that there was a good level of organisation at all levels within the service; staff we spoke with knew what they were doing and what was expected of them. We saw that there were clear lines of communication between the registered manager and the four unit heads and other heads of departments. The registered manager knew what going on within the service at an organisational level and about the specific needs of people using the service.

People we asked felt that the registered manager treated staff with respect and staff we spoke with felt the registered manager was approachable, listened to their opinions and was open to discussion. This led to a positive atmosphere within the service.

We asked people if they thought the service was well-led. A relative of someone using the service told us "There have been a lot of changes around new staff and reorganisation, but it has been handled well…the management ethos is open and relaxed, whilst being attentive." Another visitor said "The manager is visible, friendly and around the home. They encourage interaction." Staff we spoke with told us "It's a happy place to work and we all cover for each other" and "My unit manager is fantastic. They give a lot of encouragement and are a good role model. I've never had to, but if I had a problem I would go to my unit manager or overall manager."

People we spoke with consistently told us they felt able to address concerns or issues with the registered manager and we were given a number of examples of how changes had been made as a result. One person using the service said "If there was a problem, I'd go to the boss" whilst another person said "I would go to the manager if something was not right. For example, there was a mix up over my prescription, which was delayed in getting to me. We had a good talk about it and they got on to the chemist. I was certainly taken seriously." A relative said "Early on we mentioned that our loved one was on a table at lunchtime with people who did not communicate, because the personal interaction was not good. We told the management and its better now. She was moved to another group and is better matched. So she has integrated well now and is in the lounge more often chatting."

The registered manager held team meetings with staff to share information and discuss important issues or changes. We saw comprehensive minutes for meetings held in June, July and September 2015. We saw that where staff identified issues, the registered manager responded to these. For example, we saw that staff had identified that there were not enough slide sheets (used to assist with repositioning people in bed); we saw that the registered manager had addressed this by purchasing more and we saw that additional slide sheets were kept in stock to avoid future problems. We also saw that the registered manager used team meetings to communicate important information, discuss changes and address concerns around best practice.

The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. We saw recorded evidence that they completed a daily walk around the building, checking health and safety issues and chatting to staff, people who used the service and visitors. The registered manager also held a "10@10" meeting with heads of department each morning to discuss what was happening in the home and share information or concerns about the service. The registered manager told us this helped them keep up to date with key points of concern and ensured the service ran smoothly. Minutes of these meetings were available for our inspection.

Quality audits were undertaken to check that the systems in place at the home were being followed by staff. We saw that each unit had a 'resident of the day'; this meant their care files and MARs were audited to identify any gaps or issues with recording. The registered manager carried out monthly audits of the systems and staff practices to assess

Good

Is the service well-led?

the quality of the service. The last recorded audits were completed in September 2015 and covered areas such as finances, reportable incidents, recruitment, complaints, staffing, safeguarding and health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. For example, the registered manager identified that there had been issues with staffing levels and explained that they had recently completed a recruitment drive to address and resolve this. We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. We concluded that this was an effective system for monitoring the quality of care and support provided and for driving improvements with the service.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We saw that there was a volunteer group called “Friends of Amarna House” involving people who used the service, relatives and people from the local community. This group met monthly to coordinate activities and arrange for volunteers to visit the home to spend time with people using the service. This showed us that the registered manager was developing links with the local community to effect meaningful and positive changes for people using the service.