F M S (Scunthorpe) Limited

Amber House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Amber House is registered with the Care Quality Commission (CQC) to provide accommodation and personal care for a maximum of 13 people. It is situated in the village of Broughton, close to local amenities.

Accommodation is provided over two floors, in single bedrooms with en suite facilities. There is a large sitting room set out into two separate areas, a small sitting area and a dining/activities area. Two further lounges are situated on the ground floor. Enclosed gardens to the side and rear of the building are easily accessible.

We undertook this inspection on 29 and 30 March and 3 April 2017. The last inspection was carried out on 1 February 2016 where the service was found to be compliant with the regulations looked at with the exception of well-led. This was because the manager in post had not yet registered with the CQC.

The service now had a registered manager in post as required by a condition of their registration. A registered manager is a person who has registered with the Care Quality Commission (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.

Due to concerns found during the inspection, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Following the inspection, we met with the registered provider and have requested an interim action plan. We also requested, and have received, weekly updates to assure us actions have been taken to address the concerns. We found multiple concerns and are considering our regulatory response. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take at the back of the full version of the report.

We found concerns with how the service was governed. The CQC had not always received notifications of incidents which affected the welfare of people who used the service.

There was no effective quality monitoring system in place and audits completed had not been effective in identifying shortfalls within the service.

We found accidents had been logged, which highlighted specific issues but lacked analysis to ensure lessons were learned to prevent reoccurrence.

We found there was no staffing matrix tool used to determine staffing levels required for the residential, respite and day care services. This led to inadequate staffing levels within the service, people's care needs being overlooked and had led to people put at risk while out in the community.

Some people were at risk of not receiving their medicines as prescribed due to errors in recording.

There was a lack of robust risk assessment and management; staff had not always followed policies and procedures, guidance from health professionals and outcomes from risk assessments.

Some areas of the environment were potentially unsafe yet were constantly accessible to people, for example the laundry, where cleaning products were openly stored. These issues had placed people who used the service at risk of harm and injury.

Not all staff had received safeguarding training. Training provided to staff on restrictive physical interventions included the use of pain-inflicted techniques, which was not appropriate in this setting.

We found there was an inconsistent application of mental capacity legislation. Some people had assessments to determine their capacity to consent to specific restrictions such as behaviour management interventions but others did not. Best interest decision making was not always completed.

There were concerns with the management of infection prevention and control as some areas of the service required deep cleaning. Poor infection control procedures were observed which included soiled washing stored in baskets on the floor alongside clean laundry stored in open baskets; this created the potential for cross-contamination.

We saw from records that not all staff had received training to enable them to support people who used the service safely and to an appropriate standard.

Staff had not been receiving regular supervision in line with the registered provider's supervision policy.

People told us that the approach of some members of staff was kind and caring and they felt able to raise issues with them. However, others told us they had raised concerns with the registered manager about care and support, but their issues had not been addressed.

Not all interactions between staff and people who used the service were seen to be positive. For example, we overheard one member of staff ask someone if they wanted to use the toilet before going out; this was overheard by all of their peers and other people in the vicinity and did not promote the person's dignity. Another person, whose behaviours compromised their dignity, was not supported to engage in these behaviours in private, so was seen by their peers and others in a state of undress.

We found people's nutritional needs were met. There was a varied menu which provided people with choices and alternatives.

There was a range of activities offered by the day care facility, based within the service, for people to participate in. However, people told us that the way these were structured meant there was little flexibility available and they did not always wish to participate in group activities.

Staff were not always recruited safely, when positive disclosures were identified there were no assessments in place to mitigate any potential risks to people who used the service.

Complaints raised by relatives were not recorded and addressed in line with the registered provider's policy and procedure.

We identified a number of fire safety issues whilst undertaking an inspection of the premises. For example, four, floor-mounted hold back devices on fire doors were not working. These issues meant that people who used the service were placed at risk and would not be protected in the event of a fire.

We saw people's saw people's health needs were met. Staff kept a log of when people had contact with health professionals in the community. Staff followed advice about treatment plans the health professionals prescribed.

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.

Risk had not been managed effectively, which had placed people who used the service at risk of harm and injury.

There were policies and procedures to guide staff in how to safeguard people from abuse and harm; however, these had not always been followed.

Medication records maintained within the service were inconsistent and contained conflicting information which meant people were at risk of not receiving their medicines as prescribed.

Staffing levels were not consistently provided to meet people's assessed needs.

Some areas of the service required cleaning to ensure it met acceptable standards of hygiene.

Damaged fire-fighting equipment needed to be repaired or replaced to ensure it was working effectively.

Is the service effective?

Inadequate

The service was not effective.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards, which meant best practice guidelines, had not always been followed when people lacked capacity to make their own decisions.

Staff had access to training, supervision and support, but not always on a regular basis and there were gaps in training. A new supervision process had just started.

People who used the service told us they enjoyed the meals provided and were able to choose from a varied menu so their nutritional needs were met.

We saw people's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were observed as having a kind and caring approach, although we received mixed reviews from people spoken with.

Staff treated people with respect. There were some adjustments that needed to be made to ensure people's privacy and dignity was maintained.

Staff maintained confidentiality and stored people's personal information securely.

Is the service responsive?

Inadequate

The service was not responsive.

Some people who used the service did not have a personalised plan of care to enable staff to deliver person-centred care.

Instructions within behaviour support plans were vague and did not inform staff how to support people in the safest and least restrictive way.

The registered provider had a complaints policy and procedure in place but there was no evidence to show this was followed.

Is the service well-led?

Inadequate

The service was not well-led.

There were shortfalls in overall governance of the service and support and guidance for the registered manager.

A quality monitoring system to help to identify shortfalls, to learn from incidents, to survey people's views and to develop action plans to address issues had not been developed.

There were shortfalls in recording which meant there was not accurate and up to date information about people's needs, which could place them at risk of not receiving appropriate care and treatment.

The Care Quality Commission had not always received notifications of incidents which affected the safety and wellbeing of people who used the service. We have written to the registered provider about this.

Amber 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 registered 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 29 and 30 March 2017 and 3 April 2017and was unannounced. The inspection team consisted of one adult social care inspector and an inspection manager on the first day, two adult social care inspectors on the second day and one adult social care inspector on the third day.

The registered provider had not yet been asked to complete 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. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.
During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with four people who used the service and one visiting relative, three visiting professionals, eight members of care staff, the domestic, the cook and the registered manager. Following the inspection, we spoke with four health and social care professionals and three relatives.

We looked at the care files for five people who used the service. We also looked at other important documentation relating to people who used the service such as five medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We also looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, minutes of meetings with staff, quality assurance audits,

complaints management, maintenance of equipment records and three staff recruitment records.

A tour of the service was completed and we spent time observing care. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were unable to talk with us.

Inadequate

Is the service safe?

Our findings

We found concerns regarding how risk was managed within the service. During the inspection, we saw building work was underway to the exterior of the building. Despite a risk assessment in place which stated the front door of the building should be used to enter and exit the building, we observed on several occasions people using the side door and walking through the area where building works were in progress. This meant people were at the risk of harm from risks associated with a building site.

People's care plans contained personal emergency evacuation plans (PEEPS). However, we saw these were not detailed in how people who used the service should be evacuated or what level of support they required. The care plan for one person identified they were reliant on support from two staff for all transfers and the care plans for two other people identified they were intolerant of loud noises and become anxious and agitated. The PEEPS in place did not identify these vulnerabilities. Nor did they identify how people should be supported to evacuate the building in the event of a fire during the day or at night, when staffing levels were reduced.

The risk assessments for people supported while out in the community did not provide all the control measures to guide staff in how to minimise risk. This was despite an incident which had occurred on 8 March 2017, when a person had left the group unnoticed by staff; inadequate levels of staff had been provided for the outing.

Accident records indicated one person had sustained a laceration to their right forearm when they had put their arm through a glass panel. This resulted in the person requiring hospital treatment. A risk assessment had not been completed and no control measures were introduced following this incident to guide staff on how to support the person to prevent a reoccurrence.

Risks in the environment had not been managed appropriately to ensure people were safe. For example, there was no window restrictor in place in a person's bedroom situated on the first floor of the building. This meant the window could be fully opened.

We identified a number of fire safety issues whilst undertaking an inspection of the premises including inadequate fire control measures. For example, four floor mounted, hold back devices on fire doors were not working and two overhead mounted fire door closures were not fitted to the wall and left hanging above the door.

We contacted the fire service and shared the details of our findings with them. In response to this they arranged an urgent visit to the service on 30 March 2017.

Not ensuring risk was assessed and steps taken to mitigate risk to ensure people received safe care and treatment was a breach of regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We looked at the way the staff handled and administered people's medicines and found prescribed PRN (as required) medicines were not recorded on individual's medicines administration records. We were unable to find information when the medicines should be administered or when they had been given. We also found protocols in place did not give clear instructions and did not follow the instructions on the box the medicines had been dispensed in. For example, the instructions on the box stated '1 mg of Lorazepam to be administered one and a half hours before accessing respite services and 1mg twice daily. The individual protocol for the person identified 1mg of Lorazepam to be administered in any 24 hour period, 'prescribed to aid him when he is in a heightened state of anxiety and does not respond to other strategies that are in place'. There was no medication administration record in place for this prescribed medicine. This could put the person at risk of not receiving medicines as prescribed by their GP.

Not ensuring people received their medicines as prescribed was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We found concerns regarding infection prevention and control. We saw there was no dirty to clean flow within the laundry room. Soiled washing was being stored in baskets on the floor alongside clean laundry also stored in open baskets, creating the potential of cross contamination.

We also observed staff cleaning urine spills without using personal protective equipment (PPE). Colour coded mops were available to use in different areas of the service but we saw that these were being stored and washed together. This meant service users were put at risk of unnecessary infections and staff did not follow good practice guidelines with regard to cross infection.

Areas of the environment required a deep clean, and were in need of repair and refurbishment. For example, each of the downstairs toilets had dirty pull cords and dirty floors and the toilets were stained. Corridors were dusty and in bedrooms, bed linen was stained, high cleaning had not been completed leaving a build-up of dust in light fittings, the top of windows and the tops of wardrobes.

The registered manager told us staff had received training in Infection control, but were unable to provide documentation to support this. They also confirmed that infection control audits were not carried out. We were told by the registered manager that a cleaner worked three hours for five days a week, but there was no deep cleaning schedule in place to show when this had been completed, when we requested a copy of this.

We shared our concerns with the Infection control nurse who visited the service and completed an audit on April 5th 2017 and identified areas where the registered manager needed to take action to improve infection control practices within the service.

Not ensuring the service was clean and people were protected from the risk of infection was a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff had received safeguarding training and in discussions, demonstrated they were aware of policies and procedures in alerting and referring allegations of abuse. However, we found staff had not always followed safeguarding policies and procedures in practice. For example there was a recorded incident on 21 March /2017 this had been reported to the deputy manager in the manager's absence. The deputy manager then began an investigation rather than consulting with the local safeguarding team to establish if this is what was required or whether the safeguarding team would complete their own investigation. This could mean

vital evidence had been corrupted or the investigations were not carried out in manner which protected the service users.

During the inspection we were told by staff and visiting professionals the training that staff received on restrictive interventions, known as BASIS training, included details and a demonstration of unapproved interventions that inflicted pain on the service users. Professionals visiting the service during the inspection told inspectors they had offered to support the registered manager with training specific to the needs of each service user and support with developing behaviour support plans, but their offer had not been accepted. This had the potential to place the service users at risk of harm due to staff using techniques which were not acceptable practice in care homes.

Not ensuring people were protected from the risk of harm and abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

There had been several days when there was insufficient staff on duty to provide the necessary care and support to people. This had impacted on the delivery of care for specific people who used the service. For example an incident which had occurred on 8 March 2017 when a person had left the group unnoticed by staff, inadequate levels of staff had been provided for the outing.

There were other examples where staffing levels had not been provided in sufficient numbers to meet people's assessed needs. For example, during the weekend beginning 24 March 2017, we saw that a total of nine service users were in receipt of one to one funding which meant a member of staff was delegated to work with them on an individual basis to ensure their needs were met effectively and safely at all times. An additional nine service users were also using the service on the day, but only eleven staff had been identified on the rota.

When we spoke with the registered manager they told us they did not use a dependency tool to calculate staffing levels for the service. They were unable to show us any systems they used to establish the amount of staff which should be on duty to ensure service users were supported on a one to one basis and other service users' needs were effectively met.

Not ensuring there was sufficient qualified and experienced staff at all times was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We discussed staff recruitment with the registered manager and they described the action they took to ensure full employment checks were carried out prior to new staff starting work in the service. When we looked at three staff recruitment files, we found two had positive disclosure and barring service (DBS) checks. One of these staff members had not declared the offences on their application form contrary to the provider's recruitment policy which the registered manager told us would preclude any one from working at the service.

The registered manager had not followed the recruitment policy in place, by recruiting staff who had failed to disclose their previous convictions at interview and by not developing risk assessments to mitigate any potential risks to service users from staff with positive DBS.

Not ensuring fit and proper persons were employed was a breach of regulation 19(1) (a) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory

response to this breach and will report on any action once it is completed.

Some people who used the service had communication and language difficulties and because of this we were unable to fully obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.
Despite the concerns we found in relation to providing a safe service, we received a mixed response from relatives and professionals we spoke with about the care provided. Comments included, "When we have visited him in the service he appears happy and has asked to go back" and "Yes, I would consider him to be safe, if he didn't like anything he would tell us."

Others told us they had difficulty finding staff when they visited the service and were not always aware who their relatives one to one support was being provided by as they had found their relative on their own or alone in their bedroom.

Inadequate

Is the service effective?

Our findings

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 Act 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.

We found the application of MCA was inconsistent. For example, some people had restrictions in place such as only being able to access cigarettes and coffee at certain times, even though both people had been assessed as having capacity. When we spoke with the person who used the service, they told us they had to perform daily tasks in order to have a cigarette, this included getting up at a reasonable time, making their bed and bringing their laundry down. This practice by the staff did not uphold the person's dignity and restrictions had been placed on their freedom to exercise choice. There was no evidence to show this had been discussed with them or had been agreed as the least restrictive option.

Another person who used the service was having their mattress removed from their bedroom throughout the day. We were unable to find any documentation within the service to show the decision to remove the mattress had been discussed and recorded as in their best interest as the least restrictive option for them. When we spoke with the registered manager about this they told us the discussions had taken place, but was unable to provide any records to show this.

We spoke with a visiting professional who supported the service with behaviour management, they told us they had not been involved or had been asked to attend any best interests meetings in relation to anyone they were supporting who lived at the service.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

In discussions with relatives, they told us staff supported them to make choices and decisions and they had access to health professionals when required. Comments included, "The service have arranged for the consultant to see him at Amber, so it is much better for him." Another told us, "He requires consistent boundaries and a consistent approach and he responds well to good communication and this is what our experience of the service has been."

Other relatives told us they felt staff didn't have the skills to communicate effectively with their relative and were adopting the wrong approach to promote positive engagement with them, which they felt had contributed to their relative withdrawing and spending long periods of time alone in their bedroom. They told us, "Since the day care service has increased, communication between the service and ourselves has deteriorated considerably."

When we looked at people's care plans we found not all of these contained completed personal profiles or details of people's likes and dislikes and preferred methods of communication. One care plan stated 'Provide me with my preferred method of communication' but did not detail what this was or how staff could achieve this. There was no available information to describe what different ways the person who used the service may express pain, fear, happiness or sadness.

We asked the registered manager how they consulted with people who used the service and obtained their views, they told us that they asked them, but residents meetings were not held.

We found overall people's nutritional needs were met. However, there were some exceptions; for example when we spoke to the relative of one person who used the service they told us they had been assessed as being unable to cut up their food independently as a result of a physical condition, yet when relatives visited during mealtimes they found their family members meal was being offered to them without being cut up. Similarly another relative expressed concerns that when they visited their family member they found numerous chocolate and sweet wrappers in their bedroom, which they should only have in moderation as they had diabetes.

Most people who had nutritional concerns had these identified by using a recognised nutritional screening tool/assessment. When concerns were identified, people were referred to a dietician.

People's weight was monitored to ensure this remained within acceptable levels for their height and build. The menus provided people with choices and alternatives and in discussion with the cook, it was clear they had an understanding of special diets and received information about people's nutritional needs from care staff. The people who were able to speak with us told us they enjoyed the food and choices were made available to them.

Not all staff we spoke with felt supported by the registered manager. There was a plan to start individual supervision meetings where staff could discuss training and development needs and issues relating to their role.

We saw records which showed staff had received infrequent supervision and appraisal. For example, one staff member had received only one supervision in the last year yet the registered provider's supervision policy detailed the frequency of supervision should be every eight weeks. Another staff member had received two supervision sessions. Of the five supervisions records we looked at, none of the staff had received supervision every eight weeks. Where issues had been raised during supervision, there was no record of agreed actions having been discussed to address these.

Records seen showed that not all staff had received training to enable them to support service users safely and to an appropriate standard. Although records showed staff had received training in areas the registered provider considered to be essential, for example, epilepsy awareness and restrictive physical intervention. We found few staff had undertaken specific training about the needs of the people who used the service, for example, only 22 of 41 staff had completed training on an introduction to learning disabilities. Five of 41 had yet to complete any training on autism and none had undertaken any training in how to effectively communicate with service users with autism or any type of alternative communication skills or positive behaviour support.

Relatives we spoke with told us, "They could do with more downstairs rooms for the people who access respite and who are not fully mobile. I don't like [Name] having to use an upstairs room when they access respite care." Others commented, "There have been improvements to the service, but if they did more quick

checks they could make it even better", "It is a bit noisy, [Name] doesn't like a lot of noise, day care is moving and I think this will benefit everyone" and, "The staff can be quite abrupt if the manager isn't in the service, it can be quite a negative experience visiting there."

We found concerns regarding the maintenance of the building. For example, on corridors we found a meter cupboard door was falling off its hinges when unlocked. An unlocked cupboard was found to contain loose screws, a knife, an opened paint can and other debris. The unlocked cupboard had visible wires hanging and a light fitting without a bulb, connected to the electric supply. This meant that service users were at risk of harm due to the lack of maintenance and poor housekeeping.

The double sink in the kitchen had water temperatures of 55.1 degrees Celsius to the right hand sink and 53.1 degrees Celsius to the left hand sink, but there was no sign displayed to show the water was hot and service users had supervised access to the kitchen and were involved in food preparation and washing up after sessions. This was mentioned to the registered manager to address with staff.

When we asked the registered manager if anyone had responsibility of checking the environment to ensure that it was safe and fit for purpose, they told us this was the responsibility of the handyman who made daily checks. When we requested records of these checks, none were made available.

When we requested a copy of the most recent electrical wiring certificate we found this was dated 1/12/2012 and valid for one year. When we brought this to the attention of the registered manager they told us they would arrange to have this checked as a matter of urgency.

Not ensuring that the premises and equipment used by the service users was clean, secure, and suitable for the purpose for which it was being used, properly used and maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We saw people's saw people's health needs were met. Staff kept a log of when people had contact with health professionals in the community. Staff followed advice about treatment plans the health professionals prescribed.

Requires Improvement

Is the service caring?

Our findings

We found some areas of the service required improvement to ensure people's privacy and dignity were promoted. For example, during the inspection on the 29 March 2017 while undertaking a tour of the building we observed a person who used the service naked, compromising their dignity by undressing in public. Staff were observed to be having difficulty in assisting and encouraging them to dress in order to maintain their dignity.

At the time other staff and service users were present within the building and were able to observe them in their state of undress. When we asked the deputy manager about the person's needs, we were told that the person who used the service would remove all of their clothing on a regular basis to express their anxiety or dissatisfaction. They told us the person was unaware of the impact this behaviour may have on others or how it may compromise their personal dignity by engaging in such behaviours.

The incident of the person who used the service undressing was observed in a part of the building that was not private where they could be seen by other people using the service including people accessing day care services, this did not ensure their dignity and did not respect their right to privacy. When we asked the registered manager if the person had any provision to do this in private they told us no provision was available.

We found a mattress which belonged to another person who used the service stored in the hallway after being removed from their room. When we asked the registered manager why this had been done they informed us it was to help the person using the service to 'move on' with their daily routine. They told us the individual was living with autism and needed a very structured morning routine and would, if disrupted, go back to the beginning and start again. The mattress was removed each morning so the person using the service had to get out of bed and begin their routines for the day.

When we asked the registered manager for any documentation to support this decision, they told us they had discussed this with other professionals involved in the person's care, but were unable to provide any documentation to support these discussions having taken place and to demonstrate the purpose of the mattress being removed. Removal of the mattress without thorough consultation did not ensure the person's dignity was upheld as it restricted their ability to exercise choice in their daily lives.

During our inspection we heard staff asking a service user who was standing at the back of a group of their peers all getting ready to go out on an activity being asked by a staff member in a raised voice if they needed to use the toilet before going out. When we observed the situation we saw the request had been overheard by all of their peers who were getting ready to go out on an activity and everyone else in the immediate vicinity of the service user. We saw the staff member had not made any effort to approach service user or take them aside to ask them in a more discreet or appropriate manner. This action by the staff member did not ensure the service user's privacy was maintained or respected and did not uphold their dignity. We brought this to the attention of the registered manager to address with the staff team.

Not maintaining people's dignity is a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who lived at the service were sharing all communal areas with people accessing the service for both day care and respite services. This meant there were times where the service was very busy and noisy, which was disruptive to service users living with autism and those with complex needs who needed continuity and minimal change to their routine and surroundings. We observed people becoming anxious and distressed as the number of people accessing day services increased and the environment became busier and the noise level increased. This did not allow for people's personal preferences or lifestyle being respected.

When we asked the registered manager if the day service provision had a negative impact on people who lived at the service they told us that it had and alternative provision had been purchased to provide the day care service in a separate building. We were told the new day service location would not be ready until September 2017 and the day care service would continue to be provided from the service until this time.

We saw the lunchtime experience could be improved further. For a lot of people mealtimes are the highlight of day and should be a sociable and pleasant experience. The dining room was large, busy and noisy with people who used the service on a permanent basis accessing their midday meal at the same time as people using the day care service facilities. We observed some people because of their diagnosed conditions were intolerant of the noise levels and were being supported to have their meals in lounges, rather than being offered the opportunity to have their meal at a quieter time.

Visitors had mixed comments about the staff team, these included, "The staff are lovely and they understand [Name] needs." Another told us, "I have no concerns at all, he is well cared for, staff are friendly and caring." Others told us, "I find that staff can be quite judgemental and make assumptions rather than describing situations and they adopt the wrong approach" and "When we visit we often find them in bed at 3pm in the afternoon, fully clothed without anything to stimulate them."

Health professionals also had mixed comments about the staff approach. They said, "Staff are always friendly and welcoming, some are better than others" and "Staff don't appear to share their skills on how they work with people with their peers." Others told us, "Some of the language used in records is shocking it is judgemental, opinionated, unprofessional and derogatory."
We observed some staff were attentive and there was positive interaction between them and people who used the service, these care staff provided explanations to people prior to completing tasks. When assisting people to engage in activities staff were patient and used encouraging and positive language.

Other staff who were designated to work on a one to one basis with people were not always within the vicinity, which was seen to cause some people distress, calling out and shouting and attempting to find them.

When we arrived at the service on the first day of inspection we were shown into a lounge by the home's administrator. Shortly afterwards one of the people who used the service entered the room and sat down. When the registered manager arrived approximately ten minutes later, the person appeared to become very excited and we saw the registered manager engage in positive intensive interaction with them. (Intensive interaction is an approach to teaching the pre-speech fundamentals of communication to children and adults who have severe learning difficulties and/or autism and who are still at an early stage of communication development.)

Approximately ten minutes later a staff member arrived and encouraged the person who used the service to go with them. We later established with the registered manager that the person was in receipt of one to one support, but had been left on their own during this time.

Telephone calls and discussions about people's health care needs with professionals were done in private in the administrators or the team leader's offices. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. Staff records were also held securely in the administrator's office.

When we asked the registered manager about how they consulted with people who used the service, they told us they asked people for their views, and informed us that residents meetings were not held within the service.

Inadequate

Is the service responsive?

Our findings

We found concerns regarding the lack of assessment and person centred care planning information available within people's care records. Of the five care plans we looked at two were not fully completed.

During the inspection we looked at five care plans, these contained risk assessments, which described the behaviours the person may display. We found the quality of the instructions for staff to follow to keep people safe were varied and brief. For example, 'use distraction techniques' but with no description of what these distraction technique should be or for how long these should be used. Others described 'habitual behaviours', but did not detail what these were or how staff could recognise them, "provide me with my preferred method of communication", but did not describe or offer guidance as to what this was. The care plans we looked at referred to specific guidance (P.R.I.C.E (Protecting Rights in a Caring Environment) for staff to identify when staff would be expected to use 'agreed' interventions as a last resort and in what circumstances. However, when we tried to find the information referred to as being available in section 11 of the persons care plan, no information was found. We looked at the other four care plans and found there was no information available in these.

Another behavioural support plan for a person who used the service instructed the staff to use 'verbal reassurance' but with no examples of what type of verbal reassurances were effective and in which circumstances this approach should be used. This meant service users were at risk of receiving care which did not meet their needs of kept themselves and others safe from harm.

When we spoke to the registered manager and asked them to find the information, they were unable to locate it. The five behaviour support plans we looked at were not descriptive and were open to individual interpretation. For example, the information in another person's behaviour support plan advised staff to; leave the room, use only light holding techniques but without any description of what this should be. This meant staff did not have important information about people's needs and how to respond to changes in need.

Of the five care plans and behaviour support plans we looked at only six of 32 staff had signed to say they had read and understood the content.

When we spoke to staff about the training in behaviour management they confirmed they had received training in restrictive physical interventions. Staff told us that during the training the trainer demonstrated a technique which they referred to as a 'figure of four' technique this included a pain inflicted hyper flexion on the person's wrists to manage their behaviour. This is a type of intervention that is sometimes used in secure units. Staff told us this would never be used unless it was written within people's behaviour support plans.

When we spoke with the registered manager and deputy manager about why they had chosen this type of training and whether it was appropriate, they told us that following the training they had told staff not to use this intervention. When we asked how this had been done they told us it had been done through staff meetings and supervisions. We asked for copies of the minutes of these discussions, but were told the

discussions had not been documented. Staff spoken with were unable to confirm these discussions had taken place.

Service users were at risk of harm because detailed information on how to recognise escalating anxiety and behaviour were not person centred and had not been detailed. Instructions within behaviour support plans were vague and did not inform staff how to support people in the safest and least restrictive way. This could be open to interpretation by staff and put the service users at risk of receiving improper and unlawful restraint.

Not ensuring people were assessed and not designing care or treatment to ensure these needs were met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

As part of the inspection we spoke with visiting professionals and relatives. They told us they had raised a number of formal complaints recently to the registered manager, about continuity of staff, staffing levels, the impact the increasing numbers within day care had contributed to increased noise levels and their family member's anxieties, subjective recording in daily records and not following care plans.

Another relative told us they had met with the registered manager and the local authority to discuss their complaint. We looked at the record of complaints and, despite a complaints procedure being in place and process to follow, there was no record of any complaints since 2015. We spoke with the registered manager and they told us there had been no complaints since the last recorded one in 2015.

When we explained that following discussions with relatives they had raised a number of issues with us and told us they had spoken with the registered manage about these, they told us they hadn't thought they were complaints, so hadn't recorded the details of these. We asked the registered manager if action had been taken following these discussions with relatives and professionals and they confirmed they had, but were unable to show us any details of what issues were raised and how these had been resolved.

Not ensuring complaints received are acted upon was breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Inadequate

Is the service well-led?

Our findings

Throughout this inspection report we have concerns and a number of regulations have been breached. Failure of the registered provider to comply with specific regulations 9, 10, 11, 12, 13, 15, 17, 18 and 19 is a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We had concerns with the overall governance of the service. There were two service areas where service users had distinct needs, residential care and day care services. Service users accessing both areas had been assessed as having complex needs and minimal systems or processes were in place at the service to ensure the service provided was safe, effective, caring, responsive or well led.

The registered manager who is also the nominated individual for the service, told us they met monthly with all of the directors of the service on a monthly basis, whilst the owner was a regular visitor to the service to speak about the progress of the building work: there was no system in place to evidence they completed a tour of the building, checked relevant records, spoke to service users, relatives and staff or completed any audits to assure themselves of the quality of the service provided to service users. When we requested copies of audits completed by the owner, the nominated individual or directors, they told us that none were available.

There was no structured quality monitoring system in place that ensured identified shortfalls were addressed in a timely way. There had been an environmental health inspection on 27 June 2016 which had identified; the chest freezer was damaged in places and could not be effectively cleaned and identified this could be a cause of food contamination. The environmental health officer had told the service that in order to comply with the law. They had also identified number of unfinished walls to the kitchen which required tiling, grouting, sealing, painting and filling, stating the areas could not be effectively cleaned until the repairs were completed. The report referred to this as being a priority and needing to be completed within a month. A third action identified the need for the wash hand basin in the kitchen to be brought into service immediately. These issues had not been addressed by the date of the inspection dated 29 April 2017.

The registered manager told us that she and the deputy manager completed monthly in house audits of medication. When we looked at medication audits records we saw the last one had been completed in November 2016 for example for one person who used the service, we found conflicting instructions for the administration of their prescribed Lorazepam medication. The instructions on the box stated 'I mg of Lorazepam to be administered one and a half hours before accessing respite services and 1mg twice daily. The individual protocol for service user F identified 1mg of Lorazepam to be administered in any 24 hour period, for 'prescribed to aid him when he is in a heightened state of anxiety and does not respond to other strategies that are in place'. There was no medication administration record in place for this prescribed medicine. Stock levels for this medicine were not maintained and when we requested records of these the deputy manager was unable to provide these.

During the inspection, we saw care plans had been audited but these had failed to identify that only six of 32 staff had signed to show they had read and understood care plans. The audits had also failed to identify in the care records for other people who used the service the instructions referred to in behaviour support plans in section 11 were missing from people's care records, this meant staff did not have the information they needed to support people safely when they were anxious or upset. In another person's care file, reference was made to, 'supporting me with my preferred method of communication' there were no details of what this was or any further description of how they communicated different things for example pain or hunger, to guide staff.

We saw that some environmental audits had been undertaken but these had failed to identify the issues raised during the inspection, for example, the broken window lock in room 8, food stuffs being stored on the floor of the kitchen annex, damaged fire safety equipment such as, four floor mounted hold back devices on fire doors were not working, two overhead mounted fire door closures were not fitted to the wall and left hanging above the door, fire extinguishers were not wall mounted and left standing on the floor, wedges were being used to keep the doors open to the registered manager and deputy managers offices, intumescent strips from fire doors throughout the building were found to be missing or damaged and unlocked cupboards containing items such as loose screws and a knife which potentially could put people at risk of harm.

We found no evidence of analysis of accident and incidents, to ensure systems could be put in place to mitigate risk and make improvements where needed. For example, an accident where a person who used the service had sustained a laceration to their right forearm after putting their fist through a pane of glass and requiring them to receive hospital treatment. A computerised system was in place that identified when incidents occurred, but did not evidence what actions had been taken following the incident to mitigate risks. When we asked the registered manager where this information was recorded they told us discussions in relation to this had taken place, but were unable to provide any formal records to show what action had been taken.

Minutes of monthly directors reports dated 20/12/2016 and 02/02/2017 did not evidence that accidents and incidents were discussed and actions plans following these were put in place following these.

Not having systems in place for good governance is a breach of regulation 17 (1) (2) (a) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that risk assessments in people's care plans lacked clarity and detailed guidance which instructed the staff in how to keep people safe. For example, the behavioural support plan for a person who used the service instructed the staff to use 'verbal reassurance' but with no examples of what type of verbal reassurances were effective and in which circumstances this approach should be used. This meant people were at risk of receiving care which did not meet their needs in order to keep themselves and others safe from harm.

We saw no evidence of meetings which had been held with the service users, their relatives or people accessing day care/respite facilities so they could have say about how the service was run. We asked the registered manager if these were held and they confirmed they were not in place. There was no evidence the registered provider had used surveys or other means to obtain stakeholders views and input in relation to the service. When we asked the registered manager for records of surveys or records of any other type of consultation processes with families, professionals, staff and people using the service, they told us the only tool they had in place was a suggestion box. This meant service users were not given the opportunity to have a say about how the service was run or suggest changes.

During the inspection on the 29 March 2017 we spoke with a visiting relative who told us they had raised a number of complaints, when we checked the complaints log none had been recorded since 2015. During the inspection other relatives shared similar concerns that their complaints and concerns had not been addressed. We spoke with the registered manager and asked them what action had been taken to resolve relative's complaints and why the details of these had not been recorded within the complaints log. They told us they thought the relative's complaints had only been concerns and had been dealt with at the time, but were unable to provide us with any records to demonstrate that action had been taken in respect of the issues raised and dealt with to their satisfaction. This meant the registered provider had no effective systems in place to manage and learn from complaints and make improvements to the service as result of any findings.

Not having systems in place to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

During a discussion with the registered manager, they were clear about their registration responsibilities regarding notifying the Care Quality Commission (CQC) about incidents which affected the health and welfare of people who used the service. However, we had not received notifications for two incidents where people had injured themselves and required hospital treatment.

Not notifying us of incidents which affected the safety and welfare of people who used the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the registered provider reminding them of their responsibility regarding notifications to CQC.

Following the inspection, we have received weekly updates on progress. The registered provider also agreed to a voluntary suspension of any further admissions to the service until systems could be improved. This has shown us the registered provider has taken our concerns seriously and has taken steps to address the shortfalls. The registered provider has also agreed to relocate the day service provision to a separate location so it does not continue to impact negatively on the people using the services at Amber House.