

Mrs Jennifer Grego

# Amethyst Lodge

## Inspection report

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Date of inspection visit:  
13 November 2018  
19 November 2018

Date of publication:  
27 February 2019

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This service was opened in April 2018 and this was its first inspection, it took place on 13 and 19 November 2018 and was unannounced.

Amethyst Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service is registered for four people, on the day of our inspection two people were living in Amethyst Lodge.

At the time of the inspection the registered manager had not worked at the service since September 2018. There was no manager in place and no one had been asked to act up while a new manager was being appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This care service supports people living with a learning disability and should be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. Meaning, people with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. However, it was not always evident that the provider understood these principals, there was not always enough staff on duty to promote independence and choice.

We had not planned to inspect this location on this occasion. This inspection was prompted after we discovered breaches in another service owned by the same provider, which is in close proximity to Amethyst Lodge, and a third service also owned by them. All three services are managed and staffed by the same team. Having identified breaches of regulation in relation to staffing and quality assurance in Swanrise we decided to inspect the other two services.

We did not meet the people living in the service on this occasion, but we did observe how the staff who worked with them interacted with people who lived in the other services owned by the provider, that they also worked with.

Although both people who lived in the service had 1-1 care staff support, we found that there were not sufficient staff on duty to keep people safe. The 1-1 care staff worked long hours and there were no staff members available to stand in for the 1-1 care staff to have a break or to step in to offer assistance if it was needed in emergency situations. On the second day of the inspection, a decision had been taken to permanently add a floating staff member to the rota, however this person was to move between the three services within the same grounds and was not effective.

We saw that people did not always receive care that was personalised to their needs. People's daily

activities were sometimes restricted because of staff not being available to support them. Staff had not always been given update training to ensure their knowledge and skills were refreshed and kept up to date. Training and supervisions had fallen behind.

Risks in people's environment were assessed and steps have been put in place to safeguard people from harm without restricting their independence unnecessary. Risks to individual people had been identified and action had been taken to protect people from harm. However, because staffing levels were not sufficient, people were not always protected from risk.

The service had not been well led; failings in place prior the registered manager leaving had not been identified by either the provider or the previous general manager, who had also recently left. However, we acknowledge that these have now been identified and the provider was taking action to make improvements. An acting manager had not been put in place while a new manager was being recruited, which meant that those shortfalls were not being properly addressed in a timely manner.

People's needs were assessed and they received care in line with current legislation. The service was in the process of changing the care plans to a new format, they detailed and gave staff sufficient information to allow to get to know people and to meet their needs.

The staff had been safely recruited. People where protected from bullying, harassment, avoidable harm and abuse by staff that were trained to recognise abusive situations and how to report any incidents they witness or suspected.

Medicines were managed in a way that ensured that people received them safely and at the right time. Staff understood their roles and responsibilities.

People were asked for their consent by staff before supporting them in line with legislation and guidance. We saw examples of positive interaction between the staff and people supported by the service. People could express their views and staff listened to what they said and took action to ensure their decisions were acted on. Staff protected people's privacy and dignity. The service listened to people's experiences, concerns and complaints, which they took steps to investigate.

## 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 not always safe.

There were not always sufficient staff to support people to be safe.

The staff were safely recruited and understood their responsibilities to raise concerns. People were protected from bullying, harassment and abuse.

Risk assessments were in place and were reviewed.

Medicines were managed in a way that ensured that people received them safely and at the right time. People were protected by the prevention and control of infection.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

People's needs were assessed and care records were kept under review.

Staff had the knowledge, skills and support they needed to carry out their roles and training was being updated.

People were asked for their consent by staff before supporting them in line with legislation and guidance.

**Good** ●

### Is the service caring?

The service was caring.

Staff spoke about people in a respectful and caring way. People were able to express their views and staff listened to what they said and took action to ensure their decisions were acted on. Staff protected people's privacy and dignity.

**Good** ●

### Is the service responsive?

The service was not always responsive.

**Requires Improvement** ●

People took part in daily activities, but these were sometimes missed because there were not always enough staff on duty for them to go ahead.

Care plans were detailed and gave staff the information they needed to support people and to meet their needs.

The service listened to people's experiences, concerns and complaints and took steps to investigate them.

### **Is the service well-led?**

The service was not always well-led.

Quality assurance systems were not robust; shortfalls in staffing we found during our inspection and management shortfalls had not been identified.

The provider had not kept an oversight of the service.

The service provided an open culture. People were asked for their views about the service and their comments were listened to.

**Requires Improvement** ●

# Amethyst Lodge

## 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 undertaken 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 is the service's first inspection and was prompted after we discovered breaches in another service owned by the same provider, which is in close proximity to Amethyst Lodge, and a third service also owned by them. All three services are managed and staffed by the same team. Having identified breaches of regulation in relation to staff in Swanrise we decided to inspect the other two services.

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This inspection was unannounced, the site visit activity started on 13 November 2018 and ended on 19 November 2018.

The inspection was undertaken by one inspector. We reviewed two people's care records, records relating to the management of the service, training records, and the recruitment records of three staff.

We did not meet the people living in the service on this occasion, but we did observe how the staff who worked with them interacted with people who lived in the other services owned by the provider, that they also worked with. We spoke with the general manager/area manager, two deputy managers, who also worked in that capacity in the provider's two other services that were in close proximity and four staff

members.

We reviewed information we held about the service, including notifications we received from the service. Notifications are required by law which tells us about important events and incidents and the actions taken by the service. We also reviewed information sent to us from other stakeholders for example the local authority and members of the public.

We reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

# Is the service safe?

## Our findings

This was Amethyst Lodge's first inspection, we found that people did not always receive a service that was safe and rated this key question Requires Improvement.

On the first day of our inspection we found that people were not protected by sufficient numbers of staff being available to keep people safe. Both people living at the service had a 1-1 care staff member with them for 12 hours of the day because they needed to have staff with them to help them manage their behaviours that challenge and to keep them safe. However, there was no back up staff to support the 1-1 care staff, if they needed a comfort break or so they could be relieved to have a meal break.

Staff were not given scheduled breaks and were expected to work without a break throughout a twelve hours shift. In an emergency, involving another person using the service, staff would need to leave the person they were working with to assist their colleagues.

Staff we spoke with all told us that there were times they did not feel safe because there were not enough staff. Neither were they confident that other staff would be able to offer them support quickly if they needed it. Staff felt that there were times during a twelve-hour shift working with the same person, they became tired and needed to have a break to help with concentration.

Care staff were also responsible for housekeeping duties and preparing meals, with the help of the people living in the service if they could.

On the second day of our inspection, we were told that the provider had put an extra 'floating' staff member on the rota. However, they were expected to cover all three of the provider's locations that were in very close proximity to each other, meaning that they would possibly not be available to support the service that needed assistance.

When the previous registered manager left, the post was left vacant and the deputy managers were expected to take over the manager's tasks. Both the deputy managers, who carried out their roles over the three services, were expected to cover shifts and had very few office hours, meaning that several management tasks were not kept up to date. Not having the vacancy covered by an acting manager also meant that there was no one available to step in to offer support to the staff if needed in difficult situations.

There were not sufficient staff on duty to properly protect people and staff from harm. This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing.

Risks to people were assessed and steps had been put in place to safeguard people from harm without restricting their independence unnecessarily. Risks to individual people had been identified, but action put in place to protect people from harm may not always be taken because of insufficient staff being on duty to carry them out.

The people living in the home sometimes exhibited behaviours that challenged others. We saw that there

was detailed information regarding the triggers for people and ways to manage the behaviours to protect the person and others around them.

However, poor staffing levels meant that not all risks could be protected against. Some people's risk assessments said that if people were upset or displaying challenging behaviour the person should be supported by two staff. At the staffing levels, set during our inspection, the only staff available to help where those already working on a 1-1 basis.

People were supported by staff who had undergone required recruitment checks to ensure that they had not previously been deemed unfit to provide care and support. We saw that references from previous employers of new recruits had been obtained. Disclosure and Barring Service (DBS) checks had been carried out to show the applicant's suitability for this type of work. The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

Staff told us and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. They told us what action they would take and who they would report concerns to in order to protect people. Staff understood the different types of abuse and knew how to recognise signs of harm and understood their responsibilities to report issues if they suspected harm or poor practice. They were confident that action would be taken if they reported any concerns. One member of staff said, "We have a list of people and phone numbers who we can go to if we think something's up." Staff were also aware of the whistleblowing policy and said they would feel confident to use the process if they thought it was necessary.

People received their medicines in the way that they wanted from staff who had received training in the administration of medicines. Medicines were stored appropriately in locked cabinets. We saw that details of people's medicines were recorded and all administrations had been signed by staff. We also saw protocols for people who had been prescribed PRN (as needed) medicines which contained information on when the person would need the medicine. We noted that each person's care plan also provided staff with guidance on how the person preferred to take their medicines.

The service was clean and hygienic. Staff were trained in infection control and food hygiene, those we spoke with understood their roles and responsibilities in relation to infection control and hygiene. There were systems in place to reduce the risks of cross infection. Liquid soap, hand sanitiser and disposable paper towels were available for people to use. There were gloves and aprons for staff to use to help limit the risks of cross contamination.

## Is the service effective?

### Our findings

This was Amethyst Lodge's first inspection, we found that people received a service that was effective and rated this key question Good.

People were supported by staff that had received training and support to enable them to do their jobs effectively. However, training and supervisions had fallen behind, this had been recognised and action had been taken to arrange training and resume staff supervisions.

Staff told us they had recently been offered update training and felt they were now mainly up to date, they had also begun to have supervision again. Staff received training including health and safety, first aid and infection control. They were also offered training that was appropriate to supporting people living with a learning disability, for example working with people with autism and developing communication skills. This enabled them to develop the skills they needed to carry out their roles and responsibilities.

On speaking with staff, we found them to be knowledgeable and skilled in their role. We were told the service supported staff to gain industry recognised qualifications in care. This meant people were cared for by skilled staff, trained to meet their care needs.

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. The home had regular contact with a GP surgery that provided support and assisted staff in the delivery of people's healthcare. Records showed that people were supported to attend hospital and other healthcare professionals away from the service. For example, specialist clinics and diagnostic tests.

People helped in planning the week's menu. Staff were knowledgeable about supporting people to eat healthily and meeting their individually assessed dietary needs. Staff gave us examples of people's specific food needs.

The service worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. People were supported to maintain good health and had access to health professionals if needed. We saw in each person's care plan that a hospital passport had been written to provide hospital staff with information on how best to meet the person's needs while they were in hospital. Staff accompanied people on visits to hospital to reduce the risk of the person becoming distressed by the process.

The service had been adapted to give people space where they could relax and have their own possessions around them.

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".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

Management of MCA and DoLS had been well managed, staff knew when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions. Where people lacked capacity, the care plans showed that relevant people, such as their relatives or GP had been involved in making decisions about their care. Any decision made on behalf of a person was done in their best interest and the least restrictive option was chosen so that people could still make some decisions for themselves and keep control of their lives.

## Is the service caring?

### Our findings

This was Amethyst Lodge's first inspection, we found that people received a service that was caring and rated this key question Good.

We did not meet the people living in the service on this occasion, but we did observe how the staff who worked with them interacted with people who lived in the other services owned by the provider, that they also worked with. We saw those interactions between people and members of staff were caring and supportive and demonstrated that staff listened to people. While we talked with staff, it became apparent that clearly knew people living at Amethyst Lodge very well and could tell us specific information about them. People's care plans contained a description of their personal history, their personal care abilities and support needs and their social interaction skills. They were very detailed.

The care plans focussed on the promotion of people's choice and independence. For instance, they included guidance on the best way to communicate with the person, what they were able to do for themselves, where they needed prompting and what support they preferred. This helped staff become familiar with people's likes and expectations so they could build good a relationship with them.

There was evidence in the care plans that people and their families had contributed to the assessment and planning of their care. Staff contacted people's families, and encouraged people to make contact directly if possible, to ensure that they were involved with people's care. We were told that family members would be invited to an annual review of the plans. Where they could, people had signed their care plans to show that they had taken part in writing the care plan and were happy with the content.

Staff told us that they knocked on people's bedroom doors and waited to be invited in before entering. They always made sure doors were closed during personal care to protect people's dignity. Meaning that staff were aware of the importance of respecting people's human rights and of preserving dignity and showing respect when asking people if they needed support with personal care.

## Is the service responsive?

### Our findings

This was Amethyst Lodge's first inspection, we found that people did not always receive a service that was responsive to their needs and rated this key question Requires Improvement.

Staff supported people with activities that reflected their interests and pastimes. They told us that the focus was on what the individual wanted to do, whether that was sitting having a chat, watching their favourite soap on the television or joining in a planned social activity. However, trips out were sometimes restricted because there were not enough staff on duty support people while out of the service. Some people were assessed as needing two members of staff to go out with them for their own safety. The staffing numbers did not allow for those people to get out unless extra staff were put on duty for a planned trip. We were told that this was not routinely done and, if a staff member was ill and not at work, the trip would be cancelled so the absence could be covered. This meant that spontaneity was not catered for.

Records showed that the service had told people what they needed to know about the service before they moved and they were asked about how they wanted to be supported once they had moved in. Families were included during the assessment process. Staff told us that as many agencies as possible were contacted to have an input into people's assessments. Professionals such as speech and language or their social workers for example. Care plans were developed from the assessments and recorded information about the person's likes, dislikes and their care needs. Care plans were very detailed and gave enough information for the carer to understand fully how to deliver care to people in a way that they wanted to be supported. The outcomes for people included supporting and encouraging independence in areas that they were able to be, such as choosing their own clothes, what they like to eat and how they wanted to live their lives.

The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The complaints procedure was displayed in the service and there was an easy read copy in people's care files. The general manager said that they encouraged people to raise concerns at an early stage so that they could learn from them and improve the service. They also commented that they always took steps to investigate complaints, learn by their mistakes and to make any changes needed.

People were asked about their preference in regard to their end of life care, but had not wanted to talk about this part of their life. The deputy manager said that they respected their wishes in this regard, all the people they supported were young adults in good physical health. However, if anyone was to become unwell advice and input from palliative care professionals would be promptly sought. When needed, people would be provided with appropriate support, equipment and medicines to ensure they were comfortable, dignified and pain free at the end of their lives.

# Is the service well-led?

## Our findings

This was Amethyst Lodge's first inspection, we found that people did not always receive a service that was well-led and rated this key question Requires Improvement.

The service was poorly led; after two recent management changes, it had been identified that there had been management shortfalls. An acting manager had not been put in place while a new manager was being recruited, which meant that those shortfalls were not properly addressed in a timely manner. Consequently, staff training, meetings and supervisions had not been taking place. Nor were meaningful quality assurance checks being carried out and the provider did not carry out provider quality assurance visits to assure themselves that the service was being properly managed and that people were receiving a good quality of service.

The general manager, who was new to the post, had been spending several days a week in the service and changes and improvement were planned, but they also had other responsibilities in their role and their plans were taking time to be implemented.

The deputy managers did not have sufficient allocated office hours to manage the service effectively in the absence of a manager, they had been rostered to work on shift so they were unable to keep up with the day to day management tasks.

Staff told us that the management team was supportive, but they did not feel there were sufficient staff on duty and that there were improvements needed to improve the service people received.

The quality of the service offered to people had not been maintained since the service opened. Failings, in place prior to the registered manager leaving in September 2018, had not been identified by either the provider or the previous general manager. This indicated that there were insufficient systems in place to monitor the quality of service the provider offered people.

There were not sufficient staff to keep people safe and to enable them take part in activities outside the service. Having no extra staff on shift to enable 1-1 care staff to have a meal or comfort break meant that people were not always having their assessed needs met when they were left for staff to help other staff who need support to have a break or to help out in emergency situations

The failure of the provider to replace the registered manager with an acting manager led to the service being further short staffed because the deputy managers were expected to work shifts and to manage all three of the locations the provider had in very close proximity to each other. All the staff worked between the three services.

There were not sufficient quality assurance systems in place to safeguard people and to assure people received a good quality of service. This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

However, we acknowledge that these shortfalls, apart from staffing levels, had been identified prior to our

inspection and the provider was acting to make improvements.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  There were not sufficient, robust quality assurance systems in place to safeguard people and to assure people received a good quality of service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There were not sufficient staff on duty to properly protect people and staff from harm.