Amberbanks Care Home Ltd

Amber Banks Care Home

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

At the last inspection on 07 July 2015, we found the provider was meeting all the requirements of the regulations. We rated the service as Good overall and in all five key areas.

We carried out an unannounced comprehensive inspection of Amber Banks Care Home on 05 and 09 May 2016 because we received information of concern about people's welfare and safety. We undertook a comprehensive inspection to assess if people who lived at the home were safe. We also checked if staff were caring, effective and responsive in meeting people's needs. Additionally, we evaluated the leadership and organisation of the home.

Amber Banks provides care and support for a maximum of 46 older people who may live with a physical disability. At the time of our inspection there were 29 people living at the home. Amber Banks is situated in a residential area of Blackpool close to the promenade. All bedrooms offer single room accommodation with en suite facilities. There are communal lounges, dining areas and a back yard, which had a seating and smoking area.

A registered manager was not in place. 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. The previous registered manager left two years ago and there have been seven managers in post since then. The new manager, who started in December 2015, told us they had sent an application to register with CQC in February 2016. However, our systems show we have not received this and the provider had no evidence to demonstrate the new manager had applied to register.

During this inspection, we reviewed staffing levels and skill mixes and found these were insufficient to meet people's requirements. One person told us there were not enough staff and as a result, "The activities co-ordinator is not happening. The show and cinema doesn't happen." We observed there were not enough staff to meet people's needs with a timely approach. Staff added there were not enough staff to ensure people received safe care and treatment. This included agency staff cover for short notice sickness, which meant staffing was not always adequate to monitor and support people continuously.

The management team had not continuously followed safe recruitment processes to ensure suitable staff were employed. They failed to check people's full employment histories, criminal records and references at all times. Although the provider had a training programme in place, not all staff received training and supervision to support them in their roles. Their monitoring system and associated records were poorly organised.

We discussed safeguarding individuals from abuse or harm and found staff were knowledgeable about related principles. However, we saw multiple concerns with people's environmental safety. We identified

problems with health and safety, fire and infection control. The management team did not have effective risk assessment processes to protect individuals from potential hazards. The provider failed to have clear oversight of environmental safety and had not maintained living conditions that promoted people's welfare and security.

We observed the provider failed to ensure people were protected from the unsafe management of their medicines. Staff were not enabled to focus on dispensing medicines without being distracted and medication was not always stored securely. The provider did not have scrutiny of related processes and had not checked these continued to be safe and efficient. Not all staff had medicines training provision, where required, following their employment at Amber Banks.

The provider failed to monitor people effectively against the risks of malnutrition and dehydration. For example, there were no associated risk assessments and there were gaps in records to assess people's food and fluid intake. Individuals who lived at the home told us the food was poor.
One person said, "I don't like [the catering system in place]. I get '[the catering system] stomach' [trapped wind] and there's too much additives."

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and associated Deprivation of Liberty Safeguards (DoLS). However, there was no recorded consent to people's overall and decision-specific care. There was no documentation of best interest processes, decision specific care planning or review of mental capacity. The provider had not protected people against the risks of inappropriate or unsafe care.

Staff referred people to other healthcare services when they developed further health needs. Nevertheless, the provider failed to update care records in order to meet their changing requirements. For instance, important hospital appointments were cancelled without any recorded follow-up. Care plans were not always revised after healthcare reviews to ensure support continued to meet the individual's needs

We found care planning was poor and did not always guide staff to be responsive to each person's needs. For example, actions to support people were brief and the frequency of support and how this should be done was unclear. We found gaps in records, which failed to ensure people were adequately assessed and monitored. Additionally, the provider failed to respond to people's needs with a collaborative approach to ensure support was appropriate and met their requirements. For instance, they responded to two people's complex needs in an unsuitable way, which was not responsive to their needs

Staff were kind, caring and encouraged relatives to visit Amber Banks. However, we noted consistency of staff who understood each individual's care requirements was not always in place. One person told us there had been a, "Mass exodus of staff." We observed staff spent minimal time engaging with people and did not always maintain their dignity. There was no evidence people were involved in their care to ensure this was personalised to their needs. Accurate and up-to-date records were not consistently maintained or securely stored to maintain people's confidentiality.

The provider did not have a clear oversight of the quality and safety of Amber Banks. They failed to ensure premises and equipment were monitored to maintain people's welfare. For example, there were no environmental safety checks and audits. The provider did not monitor other systems within the home, such as medication, infection control and care planning.

The environment and ethos of the home did not promote people's welfare. We saw there was a lack of clear leadership and cohesion within the management and staff team. For instance, service organisation, filing

systems and communication processes were poor.

There were limited arrangements to assess, monitor and improve quality assurance. For example, the management team had not sought or acted upon feedback from people about their experience of living at Amber Banks. Additionally, the provider failed to follow up on staff concerns or suggestions to improve the home.

We found a number of breaches 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.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

We found staffing levels and skill mixes were not always adequate to meet people's requirements. People, staff and visitors told us staff numbers were poor. The provider failed to follow safe systems at all times to ensure suitable staff were employed.

The provider had not always maintained the environment to ensure people received safe care and treatment. We identified concerns with health and safety, fire and infection control. People were not supported to live in secure premises that continuously promoted their wellbeing.

The provider had failed to ensure people were protected from the unsafe management of their medicines. Staff did not always use a secure approach when they dispensed and stored medication.

Staff had a good understanding about protecting people against abuse.

Is the service effective?

Inadequate

The service was not effective.

The provider had failed to monitor people effectively against the risks of malnutrition and dehydration. There were no associated risk assessments in place and people told us the food was poor.

Staff demonstrated a good understanding of the MCA and DoLS. However, there was no recorded consent to care in people's records. There was no documentation of best interest processes, decision specific care planning or review of mental capacity.

The provider had a training programme in place. However, they failed to ensure all staff had training and supervision to support them in their roles. The system to monitor and retain associated records was poorly organised.

Staff referred to other healthcare services in order to meet

people's changing health needs. Nevertheless, the provider failed to update care records to assist staff to meet people's changing requirements.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff were kind and caring. However, they spent minimal time engaging with individuals who lived at Amber Banks. People's dignity was not always consistently maintained.

The provider had failed to maintain accurate and up-to-date care records. People's documentation was not always suitably and securely stored to maintain their confidentiality. There was no evidence people were involved in their care to ensure this was personalised to their needs.

We found relatives and friends were welcomed and encouraged to attend Amber Banks. Staff supported individuals to maintain their important relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was poor and did not always guide staff to be responsive to each person's needs. We found gaps in records, which failed to ensure people were adequately assessed and monitored.

The provider had failed to respond to people's complex needs with a collaborative approach. Care was not always designed appropriately to meet their needs.

People were comfortable throughout our inspection. However, we saw they were provided with limited opportunity for meaningful stimulation. People told us there had only been one activity in the last month.

Systems were in place to assist people or their representatives to make a complaint if they chose to.

Is the service well-led?

Inadequate

The service was not well-led.

The provider failed to ensure premises and equipment were monitored to maintain people's safety. They did not undertake

environmental safety checks and other audits to assess systems and management processes were effective.

There were limited arrangements to assess, monitor and improve quality assurance. The management team had not sought feedback from people about improving all areas of their experience of living at Amber Banks.

The environment and ethos of the home did not promote people's welfare. We saw there was a lack of clear leadership and cohesion within the management and staff team.

Amber Banks Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced comprehensive inspection of Amber Banks on 05 and 09 May 2016. This inspection was undertaken because we received information of concern about people's welfare and safety. We inspected the service against the five questions we ask about services: is it safe, effective, caring, responsive and well-led. This was because we wanted to check people's safety and wellbeing whilst they lived at Amber Banks.

On the first day of our inspection, the inspection team consisted of two adult social care inspectors and an inspection manager. On day two, an adult social care inspector carried out the inspection.

Prior to our unannounced inspection on 05 and 09 May 2016, we reviewed the information we held about Amber Banks. This included notifications about incidents that affect the health, safety and welfare of people who lived at the home. We checked safeguarding alerts, comments and concerns received about the home. At the time of our inspection, there were a number of safeguarding concerns being investigated by the local authority.

We spoke with a range of people about this service. They included four members of the management team, seven staff, five people who lived at the home and two relatives. We also spoke with a visiting healthcare professional. We discussed the service with the commissioning department at the local authority. They told us they had multiple ongoing concerns about Amber Banks and had suspended the home to new admissions. We did this to gain an overview of what people experienced whilst living at the home.

We also spent time observing staff interactions with people who lived at the home and looked at records. We checked documents in relation to six people who lived at Amber Banks and ten staff files. We reviewed records about staff training and support, as well as those related to the management and safety of the home.

Inadequate

Is the service safe?

Our findings

Staff, people and visitors told us they felt staffing levels were poor and did not always keep individuals safe. On discussing staffing levels, one person said, "They're all rushing around." Another person stated, "I had a hospital appointment two weeks ago for a brain scan. It was cancelled due to lack of staff." A staff member explained, "I always think there should be more. When there are more residents in they don't increase staff numbers." A visiting healthcare professional told us they were concerned about poor staffing levels at the home. They added they often had to wait a long time to gain access to the building or to discuss care with staff.

Amber Banks was a large, intricately designed building. We were informed at least eight people required two staff to attend to their needs. This included individuals with complex, challenging behaviours. At night, there were not enough staff to ensure other people were safely monitored and supported. A staff member told us, "I've come on duty on a few occasions when a staff member has just gone off sick and not replaced. It's meant there's been me and one other staff member. It's not good really." Another staff member said sickness was never covered with agency staff and added they had to, "Just get on with it." The management team stated normal shift patterns consisted of a senior care staff member from 08:00 to 21:00. There were an additional three care staff throughout this time. Furthermore, a member of the management team worked 08:00 to 17:00 Monday to Friday. Night shifts consisted of two staff, one of which was a senior care staff member. Other support staff included housekeeping, laundry, maintenance and cooks.

We reviewed rotas from the previous five weeks, which confirmed there were not always enough staff to meet people's needs. We found there were six shifts when less staff were on duty than was required. A staff member said, "It gets really hectic in the mornings. Sometimes we only have three staff on duty." Additionally, there were periods of up to three hours on 21 shifts when staffing numbers were lower. We noted ten night shifts did not have a senior care staff member working. Two further shifts had new employees, who should have only been shadowing staff, included in the required numbers. The designated activities co-ordinator only worked one shift to provide activities. This was because they were required to undertake care staff duties for their remaining shifts during the four weeks we reviewed. Although they were trained to deliver personal care, this meant there was nobody available to provide activities for people. This staff member also covered housekeeping sickness and leave, without having any relevant training. Staff were not always enabled to focus on their duties when their workload was increased to cover housekeeping tasks.

We observed staff were hurried in their duties and did not always respond to people's needs with a timely approach. For example, we saw one person called to two staff and explained she urgently needed the toilet. One staff member was new and shadowing the other. Consequently, the person had to wait before other staff became available. Although staff tried to reassure them, they became increasingly distressed and kept saying, "I'm so desperate." When we discussed staffing levels with staff, people and their representatives, they said there were not enough staff on duty. One person stated, "There's definitely not enough staff on duty. People are not looked after properly." A relative added Amber Banks was, "Understaffed." A staff member told us, "There's not enough staff. We have several residents who require two staff, which means if

another staff is doing meds people often have to wait." Additionally, people and staff said there had been a large turnover of staff in recent months. This meant consistency of staff who understood each individual's care requirements was not always in place.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure staffing levels were adequate to keep people safe.

We found the provider did not always follow safe systems to protect people from the employment of unsuitable staff. Staff files contained references and criminal record checks obtained from the Disclosure and Barring Service (DBS). However, the management team had obtained one staff member's DBS and a reference after they had started to work at Amber Banks. The employee had worked with vulnerable people for four months without the provider checking they were safe to do so. The management team had not always obtained references from staff members' last employer, which meant they had not safely reviewed their previous performance.

We noted there were gaps in staff employment histories recorded on their application forms. Others contained years of when the staff member was employed, not the full dates. This meant the provider had not always checked staff backgrounds to ensure they were suitable to work with vulnerable people. We found one staff member had not documented recent DBS concerns on their application form. The management team said the employee raised the concerns at the interview stage. However, there were no records related to this discussion and a risk assessment was not implemented to protect people from potential risks.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to follow required, safe recruitment procedures to ensure staff were suitable to work with vulnerable people.

We reviewed systems the management team had to protect people from an unsafe environment. During our inspection, we found multiple concerns with people's safety, wellbeing and security. The management team had not undertaken an audit to check environmental safety since July 2015. This meant the provider could not confirm people were protected against risks and hazards.

The management team told us one person had gone missing during the weekend before our inspection. We reviewed how this occurred and noted the individual had left via the conservatory. A member of the management team said the door was left unlocked. This happened again four days after our inspection. The management team were unable to provide an adequate response about the continued lapse in security. We found we were able to walk through the back yard and exit the external gate on multiple occasions. A staff member told us the gate was alarmed to alert staff it had been opened. We tried the gate and saw the alarm was not working. We noted this had been addressed on the second day of our inspection. However, this meant people lived in premises that were not properly secured.

We were told Amber Banks had been repointed because of poor weather over the winter. However, we found extensive damp had not been attended to in seven bedrooms and a bathroom we looked at. Additionally, windows in two bedrooms we checked had gaps around the edges where we felt external air blowing in. An en suite in one person's bedroom had cracked, loose tiles with missing sealant and their wallpaper was peeling. Another bedroom wall light had no covering and a bed base was in need of replacement. This showed people lived in an environment that did not always maintain their safety or promote their health and wellbeing.

Window restrictors were in place on large windows to safeguard individuals against potential harm or injury from falls. We checked the small windows in every second floor room and a sample of rooms on the first and ground floors. We found these were large enough for people to climb through, but had no restrictors. We were unable to open the window in bedroom 31, which meant it could not be aired or cooled if required.

Hot, running water was not always available throughout the home. Bedrooms situated on either end of Amber Banks on each floor supplied cold or tepid water. The management team were unable to explain these inconsistencies. Additionally, the service's legionella safety testing was not current, which meant the provider could not confirm water was safe to use. The provider did not have oversight of whether water was delivered within health and safety guidelines. This placed people at potential risk from scalding where water could be too hot or too cool for personal care. The service's electrical and gas safety certification was up-to-date.

These are breaches of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure premises and equipment were safely maintained, secure and promoted people's health and welfare.

We reviewed risk assessment processes to check people were protected from potential harm or injury. Assessments covered, for example, movement and handling, falls and behaviour that challenged the service. However, we found documentation was poor and did not clearly guide staff about actions to manage risk safely. For example, assessments consisted of tick boxes and were not always personalised to each individual who lived at the home. They did not inform staff about how they should minimise risk to people when they supported them. For instance, one person's risk assessment informed staff they could be 'unpredictable' when being assisted. There were no details about how this should be managed. Fire risk assessments to ensure each person who lived at the home was safely evacuated had not been updated. The provider had not reviewed people's fire safety requirements in line with their changing physical and mental health needs. There were no medication or nutritional risk assessments to minimise associated hazards to people.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure staff were always guided to manage risks to people's safety.

We observed the home was clean, tidy and smelt pleasant. However, we found the building interior was in need of redecoration because bedroom, corridor and stairwell walls were dirty, marked and stained. The second floor bath hoist had ingrained dirt around the metal plates bolting it to the floor, as well as corroded armrests. This posed an infection control risk to people and staff who operated it. Furthermore, during the morning of our inspection we observed the ground floor toilet next to the dining area was stained. The toilet frame also had ingrained dirt where it was bolted to the floor. We checked this at the end of our inspection and found staff had not attended to it. The second floor shower was out of order and a staff member told us this had been the case since October 2015. Consequently, there was only one bathroom on this floor to serve 19 bedrooms. We asked to look at cleaning schedules and records to evidence related duties had been completed. The management team said these were taken home by the housekeeper to update, but they had resigned earlier in the year. This meant the requested documentation was unavailable and had not been completed since the staff member left.

The environment was not always maintained to ensure people received safe care and treatment. For example, one person's bedroom had trailing wires across the room to operate their bed, which was a trip hazard. An external engineer identified the bath hoist in the top floor bathroom was corroded. They evidenced this in the Lifting Operations and Lifting Equipment Regulations (LOLER) assessment on

26/01/2016. No action had been taken since to protect people's safety. Furthermore, we found fire safety concerns. These related to a large amount of piled, combustible rubbish stored behind the gate at the back entrance. This was located next to containers (which fell under the Control of Substances Hazardous to Health) that still held liquids. Additionally, this dangerous situation was positioned next to the smoking area. Although this was removed by the second day of our inspection, the provider had failed to protect people continuously from fire risks.

We have informed the local authority environmental safety officer and the fire service about our concerns. They have issued enforcement notices, which require the provider to take action to address identified problems.

These are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure premises and equipment were clean and maintained to a level that ensured people's safety. Additionally, required, up-to-date records were not in place to protect people's health and welfare.

We looked at how medicines were managed at Amber Banks. We found staff supported one person's preferences with their medication. Staff, the GP and the individual agreed for them to be administered at lunch because the person refused them in the morning. We saw the medicines trolley was locked when the staff member was away from it. We observed staff who administered medicines wore a 'do not disturb' tabard to inform staff, people and visitors not to interrupt them. However, we noted they were not enabled to focus on the safe management of medicines. This was because they had to answer telephone calls, provide personal care and deal with visitors whilst they dispensed medicines. People's medication care planning was poor. For example, staff did not always update or review them monthly, which was a requirement stated in care records.

Medicines were not always stored in a secure environment. For example, we saw 15 large pharmacy boxes, which contained the home's new medication order, were stored in the back office. We observed there were occasions throughout our inspection when the room was left unattended and the door was not always locked. Additionally, the large window, which led out into the yard and smoking area, had been left wide open. The provider had not undertaken audits of procedures, records, stock control, disposal and storage. Therefore, they did not have oversight of related processes and had not checked these continued to be safe and efficient. The management team had commenced medication competency testing of staff to monitor their related skills. However, we noted the first stage of three was undertaken in February and March 2016 without any further action. One staff member who administered medicines had been trained by their previous employer. The management team did not retrain them to ensure the staff member was safe and understood processes specific to Amber Banks. The staff member did not know what two people's medicines were and no sources of information about them were made available.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure people were protected from the unsafe management of their medicines. Staff did not have the knowledge and skills to administer medicines safely and there was no oversight to monitor related processes.

Staff were able to describe good practice in relation to protecting people from potential abuse. They were clear about reporting procedures and training records we looked at held evidence they had received related guidance. One staff member told us, "I would report to [the management team], you [CQC] and the local authority." Information was made available to inform staff about the contact details of the various organisations they were required to report to.

Inadequate

Is the service effective?

Our findings

When we discussed meals and menus with people, relatives and staff said they found the food was poor. One person stated, "The food is horrible, especially the system they have." Another person told us, "I would prefer the worst of home-cooking to the best of [the catering system in place]." A relative added, "The food is [negative swear word]. I have to go to [a food supermarket] twice weekly." A staff member said, "I think it's disgusting, I wouldn't eat it. Most people here don't like it and say it would be nice to have homemade food."

Care files we looked at did not contain nutritional assessments to manage the risk of malnutrition. The management team failed to guide staff about how to prevent each person's individual needs in relation to their nutritional support. Staff were required to check people's weights on a weekly or fortnightly basis where they were known to be at risk. However, we saw in one person's records staff had identified they had a poor appetite. They were only weighed every three to four weeks. Staff documented in another individual's records their weight should be checked fortnightly. We saw this had not been undertaken as frequently as required.

We found one person's weight chart showed they had lost seven kilograms since 28 February 2016. Additionally, they had progressively lost 18 kilograms in the last ten months. Staff had completed the weight chart incorrectly, which failed to chart the weight loss we saw. Actions taken and care planning was poorly updated, with limited effective guidance about how to support them. The individual was only weighed on a monthly basis. Monitoring charts were poorly designed because portion sizes and fluid amounts were not included and they did not enable an effective overview. Staff did not complete fluid and food charts correctly and there were gaps throughout the records we looked at. This meant the provider had failed to monitor people effectively against the risks of malnutrition and dehydration. Additionally, staff told us the weighing scales were out of order since the beginning of April 2016. Consequently, they did not know if people were underweight and the management team failed to manage people's nutritional support adequately and safely.

The cook provided a choice of meals during breakfast and lunch. Nevertheless, one person told us, "We have tea at 4 pm. Until the next morning, we occasionally, once a week if we're lucky, get a biscuit." The management team showed us 12 responses from a food system survey undertaken in April 2016. We noted eight people were dissatisfied. We observed meals were disorganised and did not always promote their wellbeing. For example, condiments were not offered to people who chose to sit in the lounge. We saw one person tell a staff member they had not had their dessert 55 minutes after lunch was served. The staff member returned with this and proceeded to place it on their table. There was no apology, explanation of what it was or checks to see if they wanted an alternative. We did not find lunch was promoted as a social occasion. Support from staff, although caring, was fleeting and lacked meaningful conversation. People were still eating their breakfast mid-morning before being served lunch less than two hours later. This did not assist those individuals who had poor appetites. A visiting community nurse told us they had attended to give one person a food-sensitive injection. They added they found the individual was still eating their breakfast at 10:10, which was not supportive of their medical condition.

We found kitchen cleaning records in place and noted the kitchen and food storage areas were clean and tidy. Staff had maintained records of food and appliance checks to ensure the effective management of food safety. However, we noticed the kitchen door was left open throughout most of our inspection and there was no fly screen in place.

These are breaches of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to effectively monitor people's weights and protect them from the risks of malnutrition.

We discussed consent to care with a staff member, who explained, "I help them get washed and dressed and ask what they want." However, there was no evidence people or their representatives had signed consent to demonstrate their agreement to care. Care records we looked at did not contain recorded overall or decision-specific consent. Although staff were caring, we did not observe them consistently checking for each person's consent or offer choice whenever they supported people. One person who lived at the home told us, "This is my home and I can't come and go as I please because they change the code on the front door and don't tell me it."

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure recorded consent was in place.

Policies and procedures were in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). CQC is required by law to monitor the operation of DoLS. We discussed the requirements of the MCA and the associated DoLS with the registered manager. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensures, where someone may be deprived of their liberty, the least restrictive option is taken.

The registered manager told us six people had a DoLS in place to deprive them of their liberty in order to safeguard them. We found the management team had undertaken suitable processes to obtain legal authorisation to deprive these individuals. Care records included a mental capacity assessment and involvement of Independent Mental Capacity Assessors to enable people to have a voice. When we discussed the principles of the MCA and DoLS with staff, they demonstrated a good understanding. One staff member said, "I'll help people do what they want to do." However, there was no documentation of best interest processes, decision specific care planning or review of mental capacity.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to retain records related to best interest decisions, decision specific care planning and review of mental capacity.

Staff training provision we reviewed included the MCA, movement and handling, environmental and fire safety, safeguarding, understanding dementia and communication. One staff member stated, "I've done first aid, movement and handling and my induction training. I feel confident in my role." However, the management team were not initially able to locate all staff training records. We noted systems to monitor and maintain them were poor. For example, staff files were not retained in the same filing system and records were missing. This meant there was no effective oversight of training requirements at Amber Banks. We found one staff member had no training or induction since they commenced in post.

We asked to review supervision records to check staff were supported in their roles. Supervision was a one-to-one support meeting between individual staff and the management team to review their role and

responsibilities. This consisted of a discussion about performance, work and personal needs, training requirements and standards of care. However, the organisation and filing of supervision records was poor because the management team were initially unable to locate them. We found not all staff received supervision or received support sessions on a regular basis. For example, one staff member had only been provided with one supervision since 2013. The management team were unable to find associated records for two other employees. Induction training records were not always signed by staff or were completely blank. Additionally, interview records were not always completed to indicate where issues might require further support or training.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure all staff had training and supervision to support them in their roles. The system to monitor and retain associated records was poorly organised.

Staff referred to other healthcare services in order to meet people's changing health needs. Records contained documentation of visits and appointments with, for example, GPs, Speech and Language Therapists and the local hospital. However, we saw important hospital appointments had been cancelled without any follow-up. For example, one person told us they could not attend their appointment due to poor staffing levels. Additionally, staff had written on another person's hospital letter their screening test was cancelled due to the individual's 'poor mobility'. There was no further documentation about whether this was rearranged or any suitable arrangements the service made to accommodate the person's needs.

Furthermore, outcomes to professional appointments were not always transferred to people's care plans. For instance, a GP visited one person and noted they had a chest infection, which they prescribed medication to treat. Staff did not update the individual's care plan and their daily records did not show further monitoring of their health. This meant staff did not always document or monitor people's ongoing health requirements to ensure support continued to meet their needs. A visiting community nurse told us staff were not always effective at following instructions. They gave an example where one person's important injection had been delayed. This was because staff had failed to document the healthcare professional's directions and act upon their requests.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure care records were updated in order to assist staff to meet people's changing requirements.

Requires Improvement

Is the service caring?

Our findings

We observed care and support, reviewed six people's records and discussed this with staff, people and relatives. A staff member stated, "I like my job, I enjoy helping the residents." However, when we discussed staff approach with one relative they said, "You expect people [the staff] to talk to people, but there is no interaction." A person who lived at Amber Banks told us, "They are always changing staff and I can't get used to them. I like to see the same staff, as sometimes people I don't know come to help me."

We saw staff had a caring, cheerful and courteous attitude. However, they spent minimal time engaging with individuals who lived at Amber Banks because there were not enough staff on duty. Furthermore, they provided limited interaction when they completed records in the lounge where people were present, which were not always meaningful. We noted people were left in the lounge areas unattended for up to twenty to thirty minutes at a time. When staff entered, they did not always speak and where conversations were started, they were brief. A visiting healthcare professional told us they felt staff cared, but they did not have enough time to support people.

Although staff were kind, we found they did not always maintain people's dignity. For example, we observed a visiting professional attended to review one person's wound dressings. A staff member accompanied them to the lounge where other people were present. The staff member exposed the dressings, including the individual's bare back, without checking if they wanted to go somewhere more private. They did not ask the person if they agreed with this.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to maintain people's dignity and respect at all times.

We observed there were occasions throughout our inspection when staff and the management team had failed to protect people's confidentiality. For example, the entrance office was left unattended whilst their safeguarding information was left on view. We noted individuals who lived at the home stood waiting for staff at the door or went in to the room. Furthermore, staff were required to lock care records in cabinets in the lounge. However, throughout our inspection we saw people's personal documentation left unattended on a desk or on top of the cabinets. These were fully visible to other people and visitors who accessed the lounge.

Staff were required to record when they completed aspects of each person's personal care on a daily basis. This included showers/baths, denture/teeth care, change of bed linen, nail care and hair wash. However, we saw staff documented on these charts people did not receive regular personal care. For example, one person's chart indicated they did not have their bed linen changed for a month. Likewise, bath/shower or denture care had not been provided for over three months. Another person's record showed the individual only had a shower once or twice a month.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to operate a consistent approach to maintain accurate and up-to-date care

records. Additionally, people's documentation was not always suitably and securely stored to maintain their confidentiality.

We reviewed how people and their representatives were involved in their care to ensure it met their needs and wishes. Staff recorded people's requests with, for example, name preference, activities and future hopes. A staff member told us, "It's about making sure we follow people's preferred routines and making sure they get what they need." However, we noted people's choices about care were not always reviewed in line with changing physical, social or mental health needs. For example, their funeral wishes were not updated to reflect any additional or changed requirements. There was no evidence the management team and staff had discussed care planning with individuals who lived at Amber Banks. Furthermore, staff evaluation of people's care did not demonstrate they were included to check support continued to promote their independence.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to evaluate people's preferences, involve them in their care planning and include individuals in support review. Consequently, the provider did not always design care to ensure this met their personalised needs.

We observed relatives and friends were encouraged to attend Amber Banks. Staff supported individuals to maintain their important relationships. People said staff were friendly with relatives and this helped them to retain and enhance their social skills. One person told us, "Visitors are always welcomed."

Requires Improvement

Is the service responsive?

Our findings

Staff, people and their relatives said staffing levels were poor, which meant they lacked activities and opportunities for social stimulation. One person told us the activity provided on the day of our inspection was the first one for a month. They added, "[The activities co-ordinator] has brilliant ideas, but has to cover when short staffed." A staff member stated, "People don't do anything, not all the time. [The activities co-ordinator] has to do care to cover." Another staff member stated, "There's not enough staff to provide as much activities as we'd like."

Although people were comfortable throughout our inspection, we saw they were provided with limited opportunity for meaningful stimulation. For example, one person's care plan contained information about providing sensory activities to give a sense of wellbeing and improve memory. Other documented activities included food smell sensations, foot or hand massage and gentle movement to music. We did not see these provided on both days of our inspection. This and the activity that we observed as the first such event in a month was because staffing levels were low. The designated activities co-ordinator had been utilised to provide care instead. During lunch, one person was served their meal in front of the television, which prevented other people present from watching it. We observed people were asleep for long periods and were not encouraged to engage with each other. A relative of one person suggested they could take another person out because they were unable to go on their own. The relative added, "I offered to take [the person] out, but the management said no."

Care planning was poor and did not always guide staff to be responsive to each person's needs. For example, support actions consisted of simple statements about changing or turning individuals regularly. There was no clear information about how this should be done and the required frequency of support. For instance, the management team recorded use of pads and staff to encourage using the toilet to support one person's continence care. There was no explanation of how this should be undertaken and what equipment or type of pad should be utilised. Where one person developed pressure ulcers, staff had mapped this on a chart. However, there was no record of what action had been taken to manage these. Another person had scratches along their arms, which there was no documented monitoring of in their daily notes. There were gaps in records, which meant people could not be properly assessed. Documentation was not always signed by staff to identify who had completed the records.

Care planning and provision was not always responsive to people's needs or preferences. For example, one person told us, "The staff are caring, but always short staffed. 50% of the days they don't empty my catheter until told more than once." We noted staff had not always updated care plans on a monthly basis, where this was required. Entries were brief, with limited information and did not always check support continued to meet people's changing needs. For example, staff recorded on one person's nutritional evaluation they continued to eat their meals well. There was no other information, but the individual was on a food chart because they had a poor appetite. There was no evidence people or their representatives were involved in the formal review of care. Staff had not always discussed this to ensure care continued to meet their requirements and preferences.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had poor care plan and monitoring records, which failed to ensure people were adequately assessed and monitored. The provider had not always completed documents to guide staff to improve people's welfare.

We found the management team responded to two people's complex needs with an approach that penalised them and was not responsive to their needs. For example, one person said they turned their hot tap on during one night because they were cold. A staff member explained the home had run out of hot water the following day. In response, the management team had installed push taps to prevent them running too long. This action had not responded to the fact the person was cold. Staff explained another person who had behaviour that challenged the service, was blocking the guttering outside their window with rubbish. Behaviour management was not appropriately supported because the management team responded to this by nailing their window shut. On another occasion, staff recorded in daily records they had removed this person's furniture after they had tried to barricade themselves in. This did not promote the individual's independence or provide a supportive, safe and homely environment. Although behaviour management charts were completed, these were not reviewed to identify triggers and actions to respond to the individual's support requirements.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to respond to people's complex needs with a collaborative approach that was appropriate and met their needs.

We reviewed the complaint processes the provider had to enable people and their representatives to comment about their care. The management team told us they had not received any complaints since our last inspection in July 2015. We saw information about making a complaint was made available to people. This included the steps to take and how the provider would respond to concerns raised.

Inadequate

Is the service well-led?

Our findings

People gave us mixed comments about the management of Amber Banks. For example, one person said, "[The new manager] is very good, I like her very much." However, another person said, "There's been a massive turnover of staff. [The new manager] is our seventh manager." A third person stated, "I don't see [the management team] that often."

The previous registered manager left two years ago and there have been seven managers in post since then. The new manager, who started in December 2015, told us they had sent an application to register with CQC in February 2016. However, our systems show we have not received this and the provider had no evidence to demonstrate the new manager had applied to register. We found multiple concerns with management and risk systems, care provision and the organisation of Amber Banks. There was clear evidence of poor oversight from the management team and provider, along with limited support for the new manager. We were told the provider had only attended the home once since December 2015.

We found the provider did not have scrutiny of the home's quality assurance and procedures to maintain people's safety and welfare. For example, there were no medication, environmental safety, infection control or any other audits to check related processes were safe. The legionella safety checks were out-of-date. There were no associated risk assessments for legionella, as well as environmental and asbestos safety. Additionally, we observed multiple concerns with environmental safety, risk assessment, staff training and supervision, care planning, infection control and medicines management. Health and Safety audits were not undertaken and environmental checks were not in place. The provider did not have a health and safety policy and there was no associated risk assessment. They had not monitored processes in the home to protect people from unsafe, unsuitable and poor care. The lack of oversight meant identified concerns could not be acted upon to improve the quality of care.

The provider's systems within the home were poorly organised, maintained and stored. For example, staff were unable to locate training and staff files we requested. Medicines were stored inadequately and infection control records were unobtainable. Important Lifting Operations and Lifting Equipment Regulations recommendations had been missed because the provider did not have a clear awareness of what action was required. Information we requested following our inspection took a long time to be sent. This was because they were not immediately to hand or were not available. For example, the management team failed to send us maintenance and equipment checks for us to assess people's safety.

This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure premises and equipment were monitored to maintain people's safety.

We checked if staff felt supported and well led by the management team. We received mixed comments about this. For example, two staff spoke highly of them and one said, "[The management team is] really supportive." They added following difficult personal circumstances the management team, "Gave me the time I needed." However, one staff member told us, "They don't come out onto the floors to support us. If I

had any problems I wouldn't go to them, I would go to the senior." Other staff commented the management team were not always available for support and assistance with care provision.

We asked to look at team meeting records to evidence they took place. We also wanted to review how the provider followed up on staff concerns or suggestions to improve the home. However, the management team were only able to provide us with one record of minutes from a team meeting. This was not dated and there was no documentation of attendees. Furthermore, we were unable to confirm staff who were not present had updated themselves to important information. The record referred to actions a staff member was assigned to undertake. However, this employee left in February 2016 and it was unclear if there had been another meeting since or if identified actions had been completed. Additionally, the minutes outlined an area of poor care we were unable to verify had been addressed.

We did not find Amber Banks had a welcoming atmosphere. The environment and ethos of the home did not promote people's safety and wellbeing. We observed staff rushed between their duties because they were short staffed. They provided limited interaction with people, which were not always meaningful. We saw there was a lack of clear leadership and organisation within the management and staff team. Lines of accountability, service organisation and communication systems were not always clear and vigorous. For example, we noticed important care and telephone messages were written on scrap paper. These were left on the lounge desk or had fallen to the floor, which demonstrated poor and ineffectual communication processes.

People and their representatives were not always supported to give feedback to the management team. We asked to look at satisfaction questionnaires and were shown surveys in relation to food systems and meals. The provider failed to provide us with evidence they checked other areas to assess people's experiences of living at Amber Banks. Additionally, we found individuals had made negative comments on the food surveys and rated parts of the meal system as poor. We were unable to confirm the provider had acted upon identified concerns to improve quality assurance.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to assess, monitor and improve the quality and safety of the home. Additionally, they did not maintain records to check management systems.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's preferences were recorded, but not reviewed in line with their changing physical and mental health. People were not always involved in their care planning. Care planning was not always collaborative or followed people's preferences. Staff and the management team had taken punitive actions to manage people's challenging behaviour. Staff communication with individuals was fleeting and not always meaningful.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect was not always maintained. We observed a staff member exposed one person's back in a communal area to assist a district nurse to review their wound dressings. They did not check with the individual if they wanted to go somewhere more private. People did not always live in an environment that was conducive to their wellbeing and dignity.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no overall or decision specific consent documented in people's care records (there was no recorded consent in all 6 records we looked at). We did not observe staff consistently offering choice or seeking people's consent prior to

supporting them.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found multiple concerns with people's environment and fire safety. We identified areas of poor infection control and there were no records in place to evidence good practices. The provider had not taken action in relation to recommendations made in the LOLER report. Risks, including environmental and care, were not properly assessed or mitigated. This included trailing wires (which were addressed by the second day of our inspection).

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People, staff and relatives told us the home's catering system did not meet their needs. Staff had not always monitored and responded to people who lost weight in order to protect them from the risks of malnutrition. Care planning, risk assessment, review and records were poor and not always informative. This meant staff were unable to monitor and manage people's nutritional support requirements safely. The main meal was disorganised because there were not enough staff to support people.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We found multiple concerns with people's environment and safety. There was extensive damp in a large number of rooms. This meant not all bedrooms were fit for people to live in. Hot water was intermittent. Corridors, bedroom and communal area walls were dirty, stained and in

need of redecoration. There was poor security in the building and one person went missing from the home. Environmental risk assessment was poor.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not always protected against the risks of inappropriate care because records were poorly maintained and had missing information. Care planning, daily notes and risk assessment was poor and not always informative. Monitoring and care charts were inadequate, had gaps in them and indicated people did not have regular personal care. There were no records related to mental capacity assessment review or decision specific care planning. There were multiple breaches of confidentiality.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always safely recruited. We found concerns with a DBS, which the provider had not risk assessed or properly managed to protect vulnerable people. Full employment histories were not always checked. One staff member was in place prior to having a DBS check undertaken and another's references were not obtained from their current or last employer to review their performance.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People, visitors and staff said staffing levels were poor. People did not always have their needs met in a timely way and were left unattended for long periods. Appointments were cancelled due to lack of staff. There were multiple shifts when staffing

levels were lower than required and sickness was not always covered. Activity and meal provision was poor because there were not enough staff. The provider did not have oversight of staff training and not all staff received training, or supervision

The enforcement action we took:

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