Miss Elizabeth White

Amber House

Inspection report

68-70 Avondale Road
Gorleston
Great Yarmouth
Norfolk
NR31 6DJ

Tel: 01493603513

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Amber House is a residential care home providing accommodation and personal care for up to 22 people with a learning disability, or autistic spectrum disorder. At the time of inspection, 15 people were using the service.

Amber house was registered for the support of up to 22 people. This is larger than current best practice guidance. The service consists of three buildings which have been combined. Two of the buildings are joined at ground floor level by a covered annex which serves as an entrance to all buildings. There is a small conservatory area, dining room, activity room, and a garden area that people can access.

People's experience of using this service and what we found
The service had developed a closed culture under the current management structure, which placed people at risk of harm. Where people had experienced potential abuse, the registered manager had not informed key agencies to ensure investigations were undertaken and plans put in place to keep people safe.

Risks in relation to people's care was not always sufficiently detailed to ensure people were cared for in a safe way. There was not always accurate guidance in place for staff about how to manage or reduce risk.

The dependency needs of people were not considered to establish the required staffing levels to meet these needs. The deployment of staff did not account for people's individual needs. Staff told us they needed more advanced training in managing behaviours that may challenge them. Other areas of training were overdue.

Care records were not always accurately detailed, or sufficient to ensure people's needs and preferences were documented. Documentation procedures did not enable staff to have effective oversight of people's care. This placed people at risk of harm. There was a lack of oversight and learning in relation to incidents and accidents.

People received their prescribed medicines, however, some documentation required additional detail where medicines were given 'as required'. Procedures needed to be more robust to ensure medicines were secured safely.

The provider's systems for monitoring and improving the quality of the service had not been effective. Issues identified at our last inspection remained and we identified further concerns. There was a lack of strong leadership, consistency and oversight at the service. Regulatory responsibilities had not been met.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and

judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care did not maximise people's choice, control and Independence. Daily routines were designed to support the collective needs of the group, rather than deliver tailored care. This meant that care was not person-centred and did not promotes people's dignity, privacy and human rights. The culture, values, attitudes and behaviours of leaders and care staff did not ensure people using the service led confident, inclusive and empowered lives.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 22 October 2019) and there were multiple breaches of regulation. The provider completed an improvement plan after the last inspection to show what they would do and by when. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted due to concerns we received about the failure to protect people from avoidable harm or abuse, poor staff culture and governance. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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

We found evidence during this inspection that people were at risk of harm. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
Following the inspection we issued a Notice of Proposal to cancel the providers registration. The provider made representations which were not upheld. We subsequently issued a Notice of Decision to cancel the providers registration, and this service is no longer in operation.

The local authority worked closely with the provider to ensure people were supported to move into alternative accommodation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led

Details are in our well-led findings below

Amber House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Amber House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced although checks were completed prior to entry to ascertain COVID-19 status.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with five members of staff including the provider and registered manager.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three care staff, and two relatives. We also liaised with the local authority and the community learning disability team.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12.

- Risk assessments for falls did not lead to robust management plans to guide staff on how to reduce the risk as far as possible. Staff had not considered and obtained medical advice in a timely manner on how people should be clinically managed following a head injury. We found this to be the case for two people living in the service.
- Incidents and accidents had not been logged and analysed to see how risk to people could be minimised and reduce the likelihood of a recurrence.
- Systems in place for managing people's risk of constipation was not safe, and systems used to record information were unclear. No one was allocated to have oversight of any concerns which did not enable concerns about people's health to be quickly identified.
- Choking risk assessments were in place, but held limited detail, and did not specify action to take in the event of a person choking. Where new risks were known, records hadn't been updated so all staff were aware and the risk could be mitigated as far as possible.

Learning lessons when things go wrong

- Accidents and incidents were not appropriately recorded. Incident records could not be provided for incidents which had occurred in the service during 2020. Effective collation of falls data had recently started, but this was only in response to a request made by the local authority.
- The registered manager and provider had not learned from previous breaches of regulation which placed people at risk of harm. They had failed to address concerns we raised during our previous two inspection visits. This meant people continued to be placed at risk of harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure that systems were in place to ensure adequate staffing levels. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Not enough improvement had been made, and the provider remains in breach of Regulation 18.

● The registered manager told us that dependency assessments had only recently been carried out to determine how many staff were needed to meet people's needs safely. Without an appropriate dependency tool, the provider had been unable to demonstrate there were enough staff on duty.
● The provider had not ensured staff were deployed effectively. One person was very isolated from the main service and activity records did not show that staff were regularly attending to them or monitoring their welfare.
● Staff did not always feel skilled to undertake their role. One staff member told us, "People can become agitated, and the training we have in managing behaviours is very basic. I have used methods from [previous training] with [person] often with positive results. Other staff are unaware of these methods because they have not been trained."
● Staff training in several subjects was overdue. The registered manager did not have an effective system in place to ensure training completed was understood by staff and that their practice was effective.
● Recruitment procedures were in place and disclosure and barring checks had been undertaken to check staff suitability for the role. However, we found that one staff member had no photographic identification on their file. After being recruited, staff undertook an induction and shadowed other experienced staff.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made, and the provider remains in breach of Regulation 12.

● People received their medicines as prescribed, and staff received their training online. Staff were competency assessed, however the manager told us that three staff were overdue this.
● Protocols for medicines that were prescribed 'as required', were in place, but required more detail so staff were clear on when these should be given.
● Each person had a medication profile in their room which included how a person liked to take their medicines. However, there was no information on the profile of medicines taken or any side effects. It was also not documented when were last reviewed.
● The keys for the medicine's cabinet were not safely secured; these were located in the kitchen, which was unlocked at the time. One staff member told us that recently the keys were left in the cabinet by a staff member, which they reported.

Systems and processes to safeguard people from the risk of abuse
● We received contact from two whistle-blowers alleging that abusive practices were taking place by staff working in the service. We made referrals to the local authority safeguarding team, and these allegations are being investigated.
● The service had ineffective systems in place to protect people from abuse or the risk of abuse.
● The registered manager received a letter in October 2020 from a staff member informing them of abuse against a person which had taken place in the service in August 2020. The registered manager had not referred this to the local authority safeguarding team and was investigating this internally.
● A complaint was raised by a person regarding staff shouting at them and breaching their privacy, but this

was also dealt with internally. No record of this incident could be produced by the registered manager, who stated the documents relating to the incident had 'gone missing'.

Failure to report these incidents meant there was no independent oversight to ensure people were fully protected, and constitutes a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The inspection team was not screened for symptoms of COVID-19 on arrival at the service.
- There were daily and weekly cleaning schedules in place, however, these did not show cleaning taking place more than once a day and did not include a more frequent schedule for frequently touched items such as door handles. There was not robust evidence of enhanced cleaning or increased frequency of cleaning.
- Staff were observed wearing face masks during their contact with people and throughout their shift. We did however notice some staff wore the face mask inappropriately. For example, not covering their nose or lowering it to below the chin.
- The registered manager confirmed individual risk assessments were completed for staff where higher levels of risk were known. However, one staff member assessed as needing to wear a mask at all times was seen without this whilst on duty in the service. The registered manager was unclear why.
- All staff had infection control and COVID-19 specific training, but the registered manager said these had not been marked so it was unclear if there were gaps in staff's knowledge and levels of competence.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the found the providers' governance systems were not sufficiently robust to identify where improvements were needed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 17.

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

- The service was not person-centred, and people were not empowered to lead active and meaningful lives. Support was consistently provided in a task-focused way which did not reflect people's individual needs and preferences. Daily routines were designed to support the collective needs of the group, rather than deliver tailored care.
- A closed culture had developed under the current management structure. For example, staff told us of 'cliques' that had formed between staff groups, and there was a culture of bullying among them. One staff member told us, "I feel that certain company policies and practices have developed an abusive culture within what once was a lovely, happy and caring home." On speaking with one person, they told us, "[Staff member] shouts at me."
- The registered manager's opinion of whistle-blowers was that they were, "Making trouble." They did not understand the importance of having a culture which was open and encouraging of staff and others to speak up.
- The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had failed to bring about prompt, sustained and meaningful improvement in the service. At the last two comprehensive inspections the provider was rated as requires improvement. The leadership of the home has failed to drive through the required improvements and the quality and safety of the care and support provided has deteriorated further.
- There were gaps in how the service assessed and monitored the quality of its provision. Quality assurance mechanisms in place had proved ineffective at identifying areas for improvement.
- There were no clear lines of accountability in the service and responsibility was not taken for the failings

that led to people receiving poor care. The registered manager blamed the staff for the poor documentation but was unable to describe how they supported them to develop key areas of practice. No disciplinary meetings had taken place where staff were considered to be failing.
● Accidents and incidents at the service were not routinely recorded in a way which enabled them to be analysed and reviewed for trends.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager did not understand their responsibilities under the duty of candour requirement and did not recognise the importance of being open and transparent with everyone associated with the service.
● When we asked the registered manager if anyone living in the service had made a complaint, they told us they had not. Following the inspection, they told us that one person had raised a complaint. This did not demonstrate an open and honest approach. They also told us that all of the documentation relating to the complaint could not be found.

Continuous learning and improving care
● We identified wide spread and significant shortfalls in the management of risk and delivery of care during our inspection.
● Quality assurance processes were not effective and did not address issues identified in our previous inspection. For example, during our last inspection it was identified care records were not sufficiently detailed. The provider had re-written these and introduced an electronic system, but we continued to find inconsistent and unclear information.
● Staff did not always feel they received the right training. People's physical needs had become more complex as they became older, and staff did not always feel suitably trained to meet the needs of people. Staff's understanding on action they should take if a person suffered a head injury was inconsistent.
● Best practice guidance wasn't being utilised to mitigate risk as far as possible, for example, in relation to falls.

At our last inspection the provider had failed to comply with their legal requirement to notify us of specific incidents. This was a breach of regulation 18 of the CQC (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 18 of the CQC (Registration) Regulations 2009.

● The provider had not submitted all reportable incidents to CQC, such as safeguarding concerns. Incident documentation was not completed, therefore we could not be sure that other incidents had not been notified to the CQC.
● Where notifications had been submitted, these were not always without delay.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● 'Resident' meetings had taken place but were not meaningful. For example, there was no details of outcomes of meetings or actions taken forward in response to the meeting.
● There was no evidence of the service sourcing regular feedback through the use of advocacy services.
● Relatives we spoke with had mixed views about the care delivery, with one relative telling us, "The standards of care have gone down, and I've got concerns about staffing levels and practices." They also told us they had raised concerns about their relative to the registered manager but had not received feedback. We also received a complaint directly from another relative following the inspection about concerns they

had about their relative's care.
● The provider had not fully established practices and procedures to ensure peoples equality characteristics of disability in respect of dementia care were being considered and supported in line with their needs; we observed poor practice by staff when one person was using inappropriate language towards them.

Working in partnership with others
● The registered manager had not been open and transparent with external stakeholders and agencies. For example, when incidents occurred, they had failed to inform CQC and the local authority safeguarding team.
● The community learning disability team had offered support to the registered manager, which included face to face training. This had not been followed up by the registered manager.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted all reportable incidents to CQC, such as safeguarding concerns. Incident documentation was not completed, therefore we could not be sure that other incidents had not been notified to the CQC. Where notifications had been submitted, these were not always without delay. 18 (1) (e)

The enforcement action we took:

NoP to cancel registered provider and manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not always accurate and lacked clear guidance for staff. Accidents and incidents were not analysed routinely to identify themes and reduce risk. 12 (1) (2) (a) (b)

The enforcement action we took:

NoP to cancel regsitered provider and manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to report safeguarding incidents meant there was no independent oversight to ensure people were fully protected. 13 (1) (2) (3)

The enforcement action we took:

NoP to cancel registered provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised. 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

NoP to Cancel registered provider and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were deployed effectively. Staff did not always feel skilled to undertake their role and some areas of training were overdue. 18 (1) (2) (a)

The enforcement action we took:

NoP to cancel provider and registered manager