Tamby Seeneevassen

Amber House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Amber House is a residential care home registered to provide accommodation and personal care for up to 44 older people, including those who are living with dementia. At the time of the inspection there were 22 people using the service.

People's experience of using this service: People were not kept safe from harm. Risk assessments were not up to date, specific or followed by staff to ensure individuals were safe.

Processes and records were not maintained to ensure people always received their medicines safely as prescribed.

Some people told us they had to wait for staff support. We observed staff not meeting people's needs in a timely way. This had impacted on people's dignity and showed not all staff had respect for people.

Care was not always person-centred. Some staff had good knowledge about people's needs but this was not always captured and reflected in care planning. People's diverse needs were not always considered.

Staff did not receive appropriate training or assessment of their competency to ensure they had the appropriate skills to meet peoples' individual needs. Lessons had not been learnt from accidents and incidents to reduce the likelihood of reoccurrence.

People, their relatives and health care professionals had mixed views about the care provided. Person-centred care was not reflected within people's care plans and associated records.

The provider failed to ensure that improvements were made. This is the fifth time the service has been rated overall as below 'good' and the provider had failed to deliver on the action plan following the last inspection. There was no registered manager in post at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Rating at last inspection: Requires improvement (report published June 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: CQC took enforcement action and the provider made the decision to close the service.

Follow up: We will continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme. The provider will continue providing regular updates to their action

plan. If any concerning information is received, we may inspect sooner.

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

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 safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two inspectors and an Expert by Experience on the first day of inspection and two inspectors on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

There was no registered manager at this inspection. Services are required to have a manager registered with the CQC. 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. We told the provider when we would be returning for the second day.

What we did: Before the inspection we reviewed information available to us about this home. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority. The provider sent us a provider information return prior to the 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.

During the inspection we spoke with the general manager, two senior care workers, two care workers, and the chef. We spoke with seven people who used the service, relatives of four people and three professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

We looked at three people's care records in full and three peoples care plans in part. We reviewed medication administration records and a selection of documentation about the management and running of the service. This included recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At the last inspection this domain was rated requires improvement. We made a recommendation about risk assessments, as they did not always reflect people's health needs and risks in the environment had not always been identified. At this inspection we found a lack of improvement in risk assessments.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.
• People were at increased risk of developing pressure sores as care was not being delivered in line with the care plan and risk assessments. People did not receive pressure relief as required and people were left for long periods of time sat in their wheelchairs.
• People were at increased risk of injury due to poor moving and handling techniques and systems in place failed to identify this. New staff were observed to be working unsupervised without the appropriate training or competency checks in this area.
• Risk assessments and care plans lacked detail to ensure that risks could be mitigated against and some risk assessments were out of date. This included areas such as people's mobility and how to meet their tissue viability care needs.
• People were placed at risk of environmental factors such as fire safety, risk of burns and falling. Environmental risks assessments failed to clearly describe how to reduce the risk.
• People were place at increased risk as specific health needs and professional advice was not incorporated into care planning or risk assessments. People were not referred to dieticians, supported to complete exercises or provided a safe diet in line with guidance.
• People were at risk of recurring accidents and incidents because systems in place to monitor them were not being used effectively. Lessons learnt were not always considered.

Preventing and controlling infection.
• People were not protected from the associated risks of infection. We identified dirty bed linen on the first and second day of inspection. Some floors were not sealed to allow effective cleaning and equipment such as cushions, wheelchairs and slings were unclean.
• Cleaning schedules in place were unclear and not accurate. Some items were recorded as cleaned yet were dirty. Some equipment was not included on the cleaning schedule.

Using medicines safely.
• The provider failed to ensure the proper and safe use of medicines.
• People did not always receive their medicines as prescribed. A lack of effective processes in place for stock rotation meant some people went without their prescribed creams.
• Protocols were not always in place to ensure staff knew when 'as required' medication should be administered. Those that were in place lacked the required information to ensure safe administration. It was unclear from the records whether people's medication needs were being met.

• Staff lacked guidance around people's medications and side effects as care plans for people's medication were out of date and failed to give detail.
• The service could not be assured that people's medication was effective as medicines were not being monitored for this.

The lack of appropriate monitoring and assessment of risk, care and support and medicines management meant people were not receiving safe care and treatment. This was a breach of Regulation 12, (safe care and treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
• Relatives told us there was not always enough staff to keep people safe. They told us, "They could do with more staff" and "When incidents happen in the main lounge, nine times out of ten, there is not a carer to be seen. However, I think this has improved slightly recently."
• Staff told us that staffing numbers fluctuated and sometimes this meant they felt they couldn't meet people's needs.
• When considering staffing numbers, the provider had not taken into account the layout of the building and people's specific needs such as behaviour and communication. This impacted on how quickly staff were able to respond to people's needs and keep them safe.

Failure to have sufficient staff to meet people's needs is a breach of Regulation 18, (staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Recruitment checks were robust.

Systems and processes to safeguard people from the risk of abuse.
• The home did not always identified concerns to be reported to the local authority safeguarding team. Records showed that on more than one occasion social workers had to prompt the home to refer matters to the local authority safeguarding team.
• Staff had completed safeguarding training and were able to tell us what action they would take to reduce the risk of harm to people.
• The service had a log in place of safeguarding incidents and communicated with relevant authorities when necessary.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance.
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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• The service was not working within the principles of the MCA. Best interest's decisions were not in place for restrictions such as lap belts and sensor mats.
• Some people's DoLS had expired without the appropriate application being made to reapply.

Failure to work within the principles of the MCA is a breach of Regulation 11, (consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience.
• Not all staff were sufficiently supported or inducted in their roles. Eight staff had not received appraisals; for some staff this had been outstanding for over four years. Supervision records were task focused and failed to promote staff's wellbeing and development. Staff told us that they felt supported by management.
• Staff were not suitability trained or competency checked to meet the needs of people. Competency checks in moving and handling were not in place and staff were not trained in specific health needs.

Failure to have suitably trained and supported staff is a breach of Regulation 18, (staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.
• Professional advice in relation to nutritional needs was not always followed. One person required to be weighed weekly, but this did not consistently happen. Professionals advised another person should be referred to a dietician, but this had not been done. People were left unsupervised during meals against

professional advice.
• Systems in place to monitor people's fluid intake were ineffective. Charts provided inaccurate amounts, were not totalled and records did not prompt when action should be taken.
• The chef had some knowledge about how to meet one person's dietary requirements but had not attended training or been given specific guidance to support them with this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• Care plans failed to adequately instruct staff on how to deliver effective care to meet people's diverse needs.
• People's assessments were not always detailed or reflected people's individual needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
• We received mixed opinions from professionals as to how well the service worked with them. Professionals told us, "The service contacts us when it's appropriate" and "I don't think that the service flags things up with professionals quickly enough."
• We saw records of communication with agencies including social workers, district nurses and chiropodists.

Adapting service, design, decoration to meet people's needs.
• The service had made improvements to the environment since the last inspection. The building had been redecorated and conservatories added. The outside space had been made into a court yard and further work was planned to develop this area with people who use the service.
• Relatives told us how much the environment had improved. One told us, "There has been a significant investment recently in the building; there is a much better smell and feel about the home."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence.
• Not all staff demonstrated respect for people. Staff did not always promote people's dignity. For example, people were supported with dirty slings, had dirty bedding and were left to sit in wheelchairs for hours instead of being transferred into a comfy chair. One relative told us, "Certain staff don't treat residents with dignity and respect."

People's rights to be treated with dignity and respect were not met. This was a breach of Regulation 10, (dignity and respect), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some care plans included detail about what people could do for themselves. People told us they were supported to remain independent with personal cares.

Ensuring people are well treated and supported; respecting equality and diversity.
• People's diverse needs were not always considered. For example, one person's sight and cognitive impairment was not considered when completing a risk assessment.
• People's needs were not always met by staff in a timely manner. People were waiting to be moved into 'comfy' chairs from wheelchairs for hours during the inspection. People shouted for support from the toilet, but inspectors had to intervene and approach care staff as the people shouting could not be heard. One person told us, "It takes ages for staff to come when I ring the buzzer, staff might come in and say I am seeing to someone else and then they forget to come back."
• People told us staff did not always have time to spend with them. One person told us, "They [staff] just bring the meal and don't have time to talk to you they are rushing."

Supporting people to express their views and be involved in making decisions about their care.
• Some staff we spoke with demonstrated a good knowledge of people's personalities, day to day individual needs and what was important to them. However, staff did not know about people's specific care needs as reflected within the care plans.
• Staff told us they had not read care plans for a while and were not involved in the care planning process.
• People and their relatives were not invited to regular meetings to involve them in planning all areas of care delivery.
• People who we spoke with told us they did not know how to access an advocate. Advocacy services were not advertised within the service. Advocates represent the interests of people who may find it difficult to be heard or speak out for themselves.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Care planning failed to reflected people's person-centred needs. For example, people had generic risk assessments in place.
• Reviews were not meaningful and failed to capture people's change in needs. For example, one person's care plan for tissue viability has been reviewed yet not updated to include a change in this person's needs.
• People's wider needs were not being met through the provision of activities. Activities were not regular or effective at meeting people's interests. Relatives told us they didn't see many activities within the home. Staff members told us the provision of activities was just starting to be improved.

Failure to provide person centred care was a breach of Regulation 9, (person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns.
• There was only one recorded complaint since the last inspection. This was not dated and failed to clearly record what action was taken in response.
• We received mixed opinions from relatives about complaints. One relative told us, "I spoke to the manager once as I wasn't happy, they dealt with it there and then." Another relative told us, "I wouldn't have any faith in management if I made a complaint, I never see management."
• During the inspection we observed a relative making a complaint to the general manager.
• Information shared did not always meet the communication needs of people with a disability or sensory loss, as required by the Accessible Information Standard.

End of life care and support.
• The care plans that we looked at provided some information about people's choices at end of life. This required further development to ensure their wishes would be respected at this time in their lives.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection the domain was rated requires improvement. We had identified a breach in Regulation 17, (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we checked and found the provider was in continued breach of Regulation 17. This is the third consecutive inspection were a breach of regulation 17 had been identified. This is the fifth occasion were the service has been rated below good.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The provider had failed to deliver on their own action plan, agreed with CQC following the last inspection.
• The provider had failed to ensure that the service was being managed effectively to meet the regulatory requirements.
• There was no registered manager in post. There had not been a registered manager for six months prior to the inspection. The area manager was covering the service in the absence of a registered manager.
• Internal audits and systems in place had failed to identify or address the concerns we have identified during the inspection. For example, to assure peoples' safety and that staff were trained and supported in their role.

Continuous learning and improving care.
• This was the fifth occasion where breaches in regulation had been identified and the service had been rated below good. The provider had failed to effectively evaluate their current performance and support the improvements necessary to improve service delivery in all the areas necessary.
• Investigations into incidents, accidents and service delivery were not effective which meant learning, reflective practice and service improvement not been achieved.
• Where areas of improvement had been identified little or no action was taken to address this. For example, the general manager was aware of staff's lack of appraisals, yet action had not been taken to ensure this was addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.
• The provider failed to seek feedback to improve standards at the service. The general manager told us they were in the process of seeking feedback from relatives however, the relatives we spoke with told us they have not been invited to meetings or completed surveys.
• There was no records of people or relatives being engaged or involved in the service. Relative communication records within people's files were not completed.

• We received mixed opinions from health care professionals about partnership working. One health care professional gave positive feedback, yet another felt that staff were not proactive in contacting other professionals for advice.
• Records demonstrated contact with local professionals, however, feedback from professionals was not always acted upon.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
• There was a lack of person-centred culture being promoted within the service.
• The unstable management had impacted on the home. People told us, "There are that many staff leaving and going. You don't know where you are." A relative told us, "I feel sorry for the staff that work here. They go through managers like I don't know what."

Inadequate oversight, monitoring, learning and engagement with people and relatives, meant this was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not receive person centred care.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff failed to promote people's dignity or show respect.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in line with the MCA.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to increased risk through a lack of care planning, risk assessments, lessons learnt and effective medicines processes.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes where not in place to

provide the necessary oversight and learning to improve the service.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff to meet people's needs. Staff were not suitably trained or supported to meet people's needs.

The enforcement action we took:

CQC took enforcement action and the provider made the decision to close the service.