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?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

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

Summary of findings

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.

This inspection took place on 4 June 2015 and 8 July 2015 and was unannounced. A specialist advisor visited the home on 11 August 2015 to check the electrical installation systems, as we had not been assured of the home's safety by information provided by the home. Information about the specialist advisor's findings and the subsequent action that needed to be taken by the registered provider is included in this report.

We previously visited the service on 16 January 2014 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 41 older people, some of whom may have a dementia related condition. The home is located in Bridlington, a seaside town in the East Riding of Yorkshire. It is close to town centre facilities and the sea front. Most people have a single bedroom and some bedrooms have en-suite facilities. On the day of the inspection there were 29 people living at the home.

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We have written to the registered provider to inform them that it is a legal requirement for the service to have a manager who is registered with CQC.

We observed some good interactions between people who lived at the home and staff on the day of the inspection. However, we were concerned that two staff were from another service operated by the registered provider and were not familiar with people's needs, and another member of staff was not able to communicate effectively with people due to language difficulties.

We saw that there were insufficient numbers of staff on duty to meet the needs of people who lived at the home and to enable them to spend one to one time with people. Staff had been interviewed and appointed even though they did not have the skills needed to carry out their role.

Staff told us that they were happy with the training provided for them. However, records evidenced shortfalls in the training that was considered to be mandatory by the home, and that was needed to evidence that staff had the skills and knowledge to keep people safe and promote their well-being.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff but these were rarely used. Some areas for improvement that had been identified following surveys or meetings had not been acted on so there was little evidence that quality monitoring was having an impact on the way the service was being operated.

There was a handyman in post and some in-house checks were being carried out to promote the safety of the premises. However, some maintenance that needed to be undertaken by a qualified contractor was overdue. A lack of auditing in respect of the safety of the premises meant that some health and safety hazards had not being identified and remedial action had not been taken. Some quality audits had been undertaken by the manager or senior staff, although the infection control audit that we saw did not include a record of when actions had been completed to evidence that improvements had been made to protect the safety of people who lived, worked at or visited the home.

People told us that they felt safe living at the home. Most staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely.

Summary of findings

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

There were numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These are reported on in more detail in the main part of this inspection report.

Summary of findings

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 that there were insufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met.

Staff had been offered employment even though it was clear that they would not be able to communicate effectively with people who lived at the home.

The premises were not being maintained in a way that ensured the safety of people who lived, worked or visited the home. The fire safety system was unsafe.

The arrangements in place for the management of medicines were robust and staff had received training on the administration of medication and safeguarding adults from abuse.

Is the service effective?

Inadequate

The service was not effective.

There was a lack of evidence that staff had completed induction and on-going training that equipped them with the skills they needed to carry out their role.

People were supported to make decisions about their care and we found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and met, and people's special diets were catered for. People had access to health care professionals when required.

Is the service caring?

Requires improvement

The service was not always caring.

People who lived at the home and their relatives told us that staff were caring and we observed some positive interactions between people who lived at the home and staff on the day of the inspection. However, it was clear that some staff were not able to communicate effectively with people who lived at the home.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Is the service responsive?

Requires improvement

The service was not always able to respond to people's needs.

Summary of findings

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded. However, the records seen in one care plan evidenced that the person's needs were not being met.

Some people told us they were not able to take part in their chosen activities.

There was a complaints procedure in place and we saw there had been no formal complaints made to the home during the previous twelve months. However, some people told us that complaints were not listened to and not acted upon.

Is the service well-led?

Requires improvement

The home was not well led.

The service was being managed by a manager who was not registered with the Care Quality Commission.

There were insufficient opportunities for people who lived at the home, relatives, staff and care professionals to express their views about the quality of the service provided. Action had not always been taken to make improvements that were identified following meetings and surveys.

Some audits had been carried out by the manager or staff to promote the safety and well-being of people who lived and worked at the home. However, there was a lack of evidence that remedial action had been taken when shortfalls were identified.

Amber House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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.

The inspection took place on 4 June 2015 and was unannounced. The inspection team consisted of an Adult Social Care (ASC) inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age. As a result of receiving information of concern about staffing levels, we returned to the home for a second day on 8 July 2015. On the second day the inspection team consisted of a CQC inspection manager and an ASC inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. On the day of the inspection we spoke with five people who lived at the home, three members of staff, three visitors and the general manager. We also received feedback from a health care professional.

On the day of the inspection we spent time observing the interaction between people who lived at the home, relatives and staff. 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 observed the serving of lunch and looked around communal areas of the home and some people's bedrooms (with their permission). We also spent time looking at records, which included the care records for three people who lived at the home, recruitment records for two members of staff and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

On 4 June 2015 people who lived at the home told us that there were insufficient numbers of staff on duty. One person said, "There is too much for the staff to do here, but it doesn't affect me" and another person said, "I use the call button but nobody comes. Staff are busy and I understand – I sometimes wait half an hour." Some visitors told us that they thought there were enough staff on duty, but one person said, "Not always. Now and again the commode needs emptying and I keep mentioning it." A member of staff told us that people did not receive as many showers as they would like due to staff not being available.

On the day of the inspection the registered manager was on annual leave and we saw that there was a senior care worker on duty to replace the manager, plus four care workers. Two care workers were from another service owned by the organisation; although they were very pleasant and caring it was evident that they did not understand people's needs as this was only their second day working at the home. For example, we heard them ask people if they liked sugar in their tea; some people were living with dementia and may not have been able to give a true account of their needs. Another member of staff was from overseas. Again, they had a very caring demeanour but we had a discussion with them and it was clear their spoken English was very poor. We saw them interacting with people who lived at the home and it was evident that there were communication difficulties, especially when they were supporting people living with dementia. Although there were sufficient numbers of staff on duty on the day of the inspection, only two of these were permanent staff members.

Staff explained the standard staffing levels that had been decided upon to support the number of people living at the home. We checked the staff rota for the week prior to the inspection and noted that there were three occasions when there was one member of staff less on duty than the identified levels. On two occasions there were two members of staff on duty overnight instead of three.

There was a cook on duty each day and a domestic assistant on duty from Monday to Friday. This meant that, from Monday to Friday, staff were able to concentrate of supporting the people who lived at the home. At weekends care staff were also responsible for some domestic and laundry duties and this meant they did not have as much time to spend with people.

We were told that there were vacancies for a deputy manager, two senior care workers, a care worker and a domestic assistant. This meant that staff were having to work additional shifts to cover these vacancies and, on occasions, staff from other services within the organisation were being asked to cover shifts. However, some shifts were not being covered and this left the home with insufficient numbers of staff to meet the needs of people who lived at the home.

We returned to the home for a second day as a result of receiving information of concern about staffing levels. On 3 July 2015 we received information stating there would be insufficient numbers of staff on duty on the morning on 4 July 2015. We contacted the general manager who confirmed this was the case; they quickly telephoned us back to inform us that they had arranged for a 'bank' care worker to cover the shift. We were concerned that this shift may not have been covered unless we had intervened. This would have left people living at the home at risk of harm, as communal areas of the home may have been unsupervised for long periods of time and people may have had to wait longer for attention.

On 7 July 2015 we received further information of concern about staff shortages at the home. The contact told us that there were three staff on duty that night but none of them were trained to administer medication, and that two staff did not have English as their first language.

As a result of receiving information of concern, we re-visited the home on 8 July 2015. We asked the manager about the number of staff on duty the previous evening and they confirmed that the three staff on duty had not completed training on the administration of medication. We also received email confirmation from the general manager on 8 July 2015; they told us that the information we had received was correct. They said that they had arranged for a senior care worker to visit the home between 8.00 – 10.00 pm to administer evening medication and had put contingency plans in place should anyone need to have medication administered during the night.

The manager also told us that there had only been three staff on duty on Sunday 5 July 2015, instead of four. We

asked why an extra member of staff had not been brought into the home to cover the shortfall. Both the manager and general manager told us they had not been aware until afterwards that there were not enough staff on duty to cover the shift. This indicated that the manager and general manager did not have sufficient oversight of staffing levels at the home.

On 8 July 2015 we received further information of concern. The contact told us that a senior staff member was supposed to be around the lounge area at all times. This was because two or three people had a tendency to display complex behaviour and some people were known to walk without their frame when they needed one. The contact said that it was not possible for a member of staff to remain in the lounge area when there were only three staff on duty; if two care workers were assisting one person and the call bell sounded, the senior care worker had to respond to it. This meant that people in the lounge area were often left unsupervised. One person's care plan recorded that they needed supervision to protect other people who lived at the home from the risk of harm, and this was not being achieved.

We asked two members of staff if there were usually enough staff on duty, and both said that there were not enough staff members on shift. They told us that some people had to wait a long time to be assisted to get up and dressed in a morning. If people had chosen to go to bed early, there was the potential for them to be in bed from 6.00 pm until 10.30 am the next morning. This posed the risk of people developing sores and was not conducive to people remaining mobile and independent.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for two new members of staff; we asked to see the recruitment records for a third member of staff but these could not be found. These were later located at the organisation's head office and some documents were forwarded to CQC to confirm that information had been obtained to evidence the person had been recruited following the home's policies and procedures.

The records for one employee included an application form that recorded the names of two employment referees, a declaration that they did not have a criminal conviction and their employment history. The application form for the other employee could not be found. However, prior to both people commencing work at the home, checks had been undertaken to ensure that they were suitable to work as care workers, such as references, a Disclosure and Barring Service (DBS) first check and a DBS check. One person's DBS could not be found initially but was eventually located. DBS checks identify whether people have committed offences or have been referred to the DBS because they were found to be unsuitable to work with vulnerable people.

We were concerned that one person's induction documentation included this statement about communication skills: "Difficult due to not speaking clear English." This person had been interviewed and employed by the organisation and yet it was clear that there would be communication difficulties between the staff member and people who lived at the home, especially those people living with dementia. We asked the manager and general manager to send us additional documentation in respect of this person's recruitment, in particular, a record of their interview questions and responses. When we received a copy of this person's interview checklist, we noted that it included a number of comments from the interviewer, including "Would not be able to work unsupervised until spoken English improves" and "This young lady is very keen to work but is let down by her limited English. I have had to re-phrase several of my interview questions and speak slowly using simple English for her to understand." Despite these difficulties in communication identified during the recruitment process, this person was offered employment at the home.

On 8 July we spoke with a member of staff who had been 'loaned' to Amber House by another service within the organisation to cover a staff absence. Although this person could speak English,

questions had to be explained more than once to help them understand and respond to our queries. This led us to believe that they would have difficulty understanding some of the conversations with people who lived at the home.

Eleven people at the home had been diagnosed with a dementia related condition. We were concerned that staff who spoke little English were considered to be suitable to work with people who were living with dementia.

Inadequate

Is the service safe?

This was a breach of Regulation 19 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a current gas safety certificate in place, portable appliances had been tested, the passenger lift and mobility hoists had been serviced and water temperatures were being tested on a regular basis to reduce the risk of scalding. However, we did not see any evidence that bed rail checks were being carried out. The most recent fire extinguisher test had been carried out in February 2014 so was overdue. The electrical installation certificate we saw recorded that some areas were 'unsatisfactory' and the general manager told us that they would check the necessary work to make the system safe had been carried out. It transpired that the electrical installation certificates for June 2012 and September 2014 were stored together; the test had been unsatisfactory in 2012 but satisfactory in 2014. However, this created some confusion and the general manager arranged for a further electrical installation test to be carried out.

Because the latest electrical installation certificate provided by the registered provider did not give us assurance that people who lived and worked at the home were safe, we requested that a specialist advisor visit the premises. The specialist advisor visited Amber House on 11 August 2015 and checked the electrical installations at the home. They told us that there was a lack of evidence that the fire safety system was safe.

We contacted the fire service on 11 August 2015 and they advised that the service should have an extra member of staff on duty on each floor of the premises over a 24 hour period. The role of these additional staff members would be to patrol the floor, and to carry a torch and a device such as a horn that could be used to raise an alarm if needed. The registered provider confirmed that these arrangements would be introduced with immediate effect. The fire officer advised that fire detectors needed to be installed throughout the home. This was agreed by the registered provider.

A letter was sent to the registered provider requesting confirmation of the above details, plus details of how they would monitor these arrangements, details of when the necessary work would commence and be completed, and details of when the Commission would be provided with a copy of the updated electrical wiring certificate. This information was received from the registered provider.

On 12 August 2015 the fire officer visited the premises. He observed that there were contractors from a fire safety company already at the home carrying out the required work; this had been arranged by the registered provider. He was assured as to the safety of the system and confirmed this to CQC.

The Commission received an updated fire safety certificate from the registered provider on 13 August 2015 and an updated electrical installation certificate on 27 August 2015. The specialist advisor confirmed that the information provided in the certificate gave assurances that the electrics at the home were safe.

We observed that there was a wooden window seat in the lounge area that did not have any cushions or covering. Some areas were quite rough and sharp and this created a hazard for people if they sat on the seat. We also saw that one of the shower rooms had a broken shower screen. When we mentioned this to the general manager on the day of the inspection they told us that they were not aware of this but they would ensure the room was made safe.

There was a fire risk assessment in place that had been reviewed in March 2015 and the fire alarm system had been tested in April 2015. In addition to this, the home's handyman carried out weekly or monthly checks on door closers, the fire alarm system and emergency lighting. These checks ensured that the premises were safe from the risk of fire.

A new nurse call system had been installed and the kitchen had been refurbished. This was following the home being awarded a food hygiene rating of 3 by the local authority environmental health officer; the highest score is 5.

On 8 July 2015 we toured the premises. We observed that the stair carpet was badly fitted and that flooring had been fitted over uneven floorboards. In addition to this, there were split carpets at some door thresholds and a number of holes in other carpets. This poor maintenance of floorboards and carpets created a trip hazard for people who lived at the home.

We also saw that there was an orange coloured cable protruding through the ceiling on one of the landing areas. This was later identified by an electrician who was present on the day of the inspection as being part of the fire alarm system. However, the manager and the electrician could

Is the service safe?

confirm whether or not the cable was live. This health and safety risk could have caused harm to people who lived and worked at the home and had not been identified by staff who worked at the home or the general manager.

There was a lack of evidence therefore that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home.

This was a breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone had risk assessments in place in respect of moving and handling, tissue viability and nutrition; these were scored to identify the person's level of risk. There were also risk assessments in place for some people's specific identified risks, such as the risk of scalding, use of a mobility scooter, use of a hot water bottle, use of bed rails, smoking and the use of alcohol. Risk assessments were reviewed by staff each month which meant that staff had up to date information to follow.

All staff that administered medication at the home had undertaken appropriate training. We observed the administration of medication and saw that this was carried out safely; the senior care worker did not sign medication administration record (MAR) charts until they had seen people take their medication. People were provided with a drink of water so that they could swallow their medication, and the medication trolley was locked when not in use.

The medication trolley was stored in the medication cupboard and fastened to the wall. There was a suitable cabinet in place for the storage of controlled drugs (CDs) within the medication room and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that these balanced. Entries seen in the CD book indicated that records and medication held were audited on a regular basis to ensure accuracy. The senior care worker described the medication audits that they carried out; these included a random check on 'as and when required' (PRN) medication every seven to ten days.

There was a dedicated medication fridge where medication that required storage at a low temperature was held. We saw that the temperature of the fridge was taken and recorded regularly to ensure that it was working correctly. The temperature of the medication room was also taken to ensure medication was stored at the correct temperature.

We checked MAR charts and saw that each person also had a patient information chart that had been provided by the pharmacy; this included a photograph of the person and described the medication prescribed, the times of administration and any allergies the person had. Two staff had signed to confirm the accuracy of any hand written entries made on the MAR charts. The pharmacy had supplied a body map to identify where on the person's body cream or pain relief patches needed to be applied, and this was also recorded in the person's care plan. There were no gaps in recording in respect of tablets and medicines but a small number of gaps were seen for the administration of creams.

There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. There was a protocol in place that described a person's use of PRN medication so that this was clearly understood by staff and recorded accurately.

We noted there was an effective stock control system in place and the senior care worker told us that the date was written on liquid medication to record when it was opened and the date it expired. This was to ensure the medication was not used for longer than stated on the packaging. However, on the day of the inspection we saw that a small number of bottles / packages had not been signed by staff. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory.

People at the home told us that they were satisfied with how their medication was administered, although one person said that it was sometimes given to them a little later than prescribed.

We spoke with five people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did. One person told us, "Yes, I couldn't live on my own – I feel safe with the staff" and another said, "Of course, because there are people in the building." Staff told us how they kept people safe. One staff member said, "Keep an eye on them, keep them happy and look out for potential harm." There were three moving and handling champions at the home; it was the role of these three

Inadequate

Is the service safe?

members of staff to promote safe moving and handling techniques with the staff team. However, we noted that one person was walking with a frame and their slippers were not on their feet correctly. This created a trip hazard and was not noticed by staff.

There were safeguarding policies and procedures in place and the manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult's team and they told us they currently had no concerns about the home.

The staff who we spoke with were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they would report any concerns to the manager. Training records evidenced that most staff had completed training on safeguarding adults from abuse, although five staff had not completed this training.

Staff told us that they never used restraint to manage a person's unmet complex needs. There was information in some care plans about specific behaviours and advice for staff on how to manage these to protect the person and other people from the risk of harm. However, one person's care plan recorded that they were continually refusing to have assistance with a shower. There was no information to advise staff how to deal with this situation. This could have resulted in the person becoming unwell due to poor hygiene routines.

There were reports in people's care plans to record any accidents or incidents. Accidents and incident audits had been completed up to the end of April 2015; the audit had not been completed for May 2015. We could see that accident forms recorded whether or not medical attention had been sought, and body maps were included when appropriate. The frequency and outcome of accidents and incidents had been analysed; the report included details of how many accidents had occurred, where the accident or incident occurred and how many people had needed to attend Accident and Emergency departments as a result of their accident.

There was a satisfactory crisis management (contingency plan) in place that included advice for staff on how to deal with disruptions to power, heating and water supplies, severe weather conditions, the breakout of fire and staff disruptions. There was an evacuation plan and there were lists of staff who worked at the home, each person who lived at the home and their mobility needs, people's GPs and information about transportation. This meant that staff had procedures to follow in the event of an emergency.

Inadequate

Is the service effective?

Our findings

On 4 June 2015 we observed that there was a lack of evidence that staff had received training that would give them the skills and knowledge they needed when they were new in post. An induction checklist was seen in the folder ready for a prospective employee to complete. This recorded, "To be completed within 2 weeks of commencing employment." The checklist recorded that fire safety, the call system, orientation to the premises, the staff handbook and policies and procedures would be discussed. During week 1 the topics covered would be the control of substances hazardous to health (COSHH), infection control, the key worker system, first aid and health and safety. However, induction records could not be found for two of the three new employees whose records we checked. One of these members of staff had not worked in a care setting before so this was particularly concerning.

The staff training record could not be found on the day of the inspection. This was forwarded to us when the manager returned from annual leave. This recorded that, although most staff had completed training on safeguarding adults from abuse and some staff had attended training on MCA / DoLS and fire safety, only two members of staff had completed training on health and safety, only one person had completed training on COSHH and only four people had completed training on food hygiene and first aid. Although we had been told that some staff were 'moving and handling' champions, the training matrix recorded that nine staff had not completed this training. This meant that there was insufficient evidence that staff had completed training on topics that would give them the skills and knowledge to support people effectively and safely.

A health care professional told us that they felt staff skills would improve if staff had training on physical health problems and how these impacted on / exacerbated underlying mental health symptoms. We saw that some courses on health problems were listed on the training matrix, such as bladder and bowel care, epilepsy, Parkinson's, diabetes and stroke but very few staff members (if any) had completed this training. One member of staff told us that they had attended training courses during the last ten months on moving and handling and end of life care.

Six care staff had completed or were in the process of completing a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3 in Health and Social Care. A senior care worker had achieved a Level 4 award and the deputy manager had enrolled on the award at Level 5.

On 4 June 2015 we asked to see an overall record of supervision or appraisal meetings for staff and this could not be found, and none were sent to us following the inspection day. The staff files we checked did not include any records of supervision meetings. One member of staff told us they had recently had a supervision meeting but they thought this was because "The management knew CQC were coming." They said they had only had one other supervision meeting during the previous two years. Supervision meetings give people the opportunity to have a one to one meeting with a manager to discuss their roles, their training needs and any concerns they have. Staff at Amber House had not been given these opportunities.

We received information of concern on 3 July 2015. The contact told us that two non-English speaking staff had recently attended a training course on Conflict and Resolution. We were told that they left half way through the course as they could not understand the trainer. We spoke with the manager on 6 July 2015 and she confirmed that this was correct. This meant that these two members of staff had not been trained in ways of reducing conflict when situations arose at the home that could cause harm to service users or others.

This was a breach of 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. No applications to deprive a person of their liberty had been submitted by the manager but they told us in the PIR document that they were in the process of considering whether any applications needed to be submitted. The training record listed that eight staff had recently attended training on MCA and DoLS and the staff who we spoke with displayed an understanding of the principles of MCA and DoLS.

Inadequate

Is the service effective?

Assessments had been carried out to record a person's capacity to make decisions. When people lacked the capacity to make decisions, we saw that best interest meetings had been held to assist them. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

The manager told us in the PIR that eleven people at the home had a dementia related condition, although there was no information available about a specific diagnosis. They told us, "Staff are presently undertaking a 'person centred planning in dementia care' course, facilitated by the deputy manager as part of a focus group run by the Bradford training group." We saw a document on the day of the inspection that recorded staff had attended training on therapeutic activities, reminiscence skills and a 'dementia friendly cascade' trainer's course. However, there were no details recorded about who had attended this training and none of these training courses were included on the home's training record. This meant there was no evidence that this training had been completed by staff. In addition to this the training record listed that only five of the 15 staff had completed training on dementia awareness. This meant that some staff who worked at the home might not have had the skills and knowledge they needed to support people who were living with dementia.

We carried out a SOFI inspection during the morning of 4 June 2015. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Our observations did not highlight any concerns about the way in which staff interacted with people who were living with dementia. We saw that staff communicated with people who had limited verbal communication by using appropriate touch, eye contact and gestures to help them understand and interact. However, we noted that there were difficulties with communication when staff needed to ask direct questions or when people living with dementia asked staff a direct question.

On 3 July 2015 we received some information of concern. The contact stated that there had been an incident when a member of staff who did not have English as their first language had been asked by a person who lived at the home if they could be assisted to put on new nightwear. The staff member had not understood this request and this had caused anxiety and a 'situation'. We spoke with the manager about this on 6 July 2015 and she told us that there had been an occasion when a non-English speaking member of staff had to find another member of staff to explain what the person had asked. The manager did not feel that this incident had caused distress to the person concerned, but it had the potential to do so.

People who we spoke with told us that they were not consulted about their care. We were concerned that the non-English speaking staff would have difficulty in obtaining people's consent to care and treatment. We observed some interactions between a member of staff who did not have English as their first language and a person who was living with dementia. Although the staff member used good non-verbal communication such as facial expressions and gestures, there was a lack of understanding when people who lived at the home asked questions. We determined that the member of staff would not have been able to ask specific questions to gain consent, such as whether the person would like to be assisted to the toilet,

However, on the day of the inspection we saw that some staff were able to encourage people to make decisions and that different choices were explained to them. A member of staff told us when we asked if people were offered choices, "Choice of when to get up and go to bed. Choice of breakfast, and choice of drinks throughout the day" and "(We) ask them and speak to them, and look at their care plan for their likes."

On 8 July we spoke with the manager. We asked if there were any difficulties when they employed people who did not have English as their first language to care for people who were living with dementia. The manager told us, "They can't understand – it's difficult for us to understand. They can't communicate with them. It's positive body language – that's about it." We spoke with an overseas worker who was employed to work at another service within the organisation but who occasionally worked at Amber House. We observed that they could speak English but questions had to be explained more than once to help them understand.

Inadequate

Is the service effective?

It was not possible therefore for the home to demonstrate that all staff would be able to obtain consent from the people who they were supporting, and that people were only receiving care or treatment that they had consented to.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The use of memory boxes was discussed at the residents meeting in September 2014. There were plans in place for memory boxes to be placed on bedroom doors to assist people to recognise their bedroom, but we were told that no progress had been made towards using these. We saw only minimal signage that was designed to assist people to find areas of the home or bathrooms and toilets. We did not see any picture menus in use and there was no pictorial information about available activities. The décor was not designed with people who were living with dementia in mind. For example, some carpets were heavily patterned and this can cause problems for people with cognitive difficulties. This had been recognised by the manager and the home's maintenance action plan recorded that work to replace some carpets would commence in June 2015. However, at the time of the inspection we saw that there were insufficient signposts available to help people orientate themselves around the home or to help them understand about meal choices and activities.

We saw there were systems in place to ensure that staff were aware of people's current care needs. A handover sheet was used to record up to date information about each person who lived at the home so this could be passed to staff on the next shift. The information shared at handover meetings ensured that all staff were clear about people's care and support needs.

Health care professionals told us that staff asked for advice appropriately and followed that advice as far as they could. One health care professional told us, "The staff do ask for advice and are willing to discuss concerns, and are also willing to attend professionals meetings." Health care professionals told us about occasions when they had asked the home to refer people to a GP as they were not receiving optimum care and that, with reminders, their advice had been followed.

There was a record of any contact people had with health care professionals; this included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs.

People's health conditions were recorded in their care plan and we saw that information leaflets had been obtained that explained these conditions. This provided useful information for staff that would help them to support the person appropriately.

We saw that people had been provided with continence aids and the equipment they needed to promote good skin integrity, such as pressure cushions and profiling beds. Positional charts were used when people needed to be moved or turned regularly to reduce the risk of pressure sores occurring.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

We observed the lunchtime experience and saw that the meal was served hot. We asked people at the home what they thought of the meals. One person told us "Good - a choice at lunchtime, I love chips and Sunday dinner" and another person said "Lovely. I like everything, but no choice of main meal for lunch, and I get sandwiches for tea." On the day of the inspection some people told us the sausages were 'tough'. Another person told us that the menu was "Repetitive". They said they had asked for bacon for breakfast the previous morning and was told there was none in the kitchen.

We did not see people being offered a choice of main course, but staff told us that people were asked about their choices earlier in the day and we saw that two different meals were served. We saw that people were offered a choice of dessert. It may be that people need to be reminded that there is a choice of meal at lunch time and tea time.

Inadequate

Is the service effective?

We saw care plans included a nutritional assessment that recorded the person's special dietary needs and risk assessments in respect of eating and drinking. These were scored to identify the person's level of risk. When nutrition had been identified as an area of concern, charts were used to monitor food and fluid intake. We noted that accurate records were kept of fluid intake and that people were also weighed as part of nutritional screening. The training matrix evidenced that no staff had completed training on nutrition; this training could enhance staff understanding of the importance of good hydration and nutrition.

Following the inspection the manager sent some information to CQC; this included a list that had been prepared for staff to identify people's special dietary requirements and the level of assistance that people required with eating and drinking. We saw staff assisted people to eat their meals appropriately and noted that this was unhurried and carried out with a caring approach. However, we did not see any special crockery or cutlery being used and people were not offered clothes protectors to promote their dignity.

There was no menu on display, either in written or pictorial format. We also noted that there was no list in the kitchen to inform the temporary cook about people's likes / dislikes and special dietary needs, so they had to ask care staff for information to ensure people's individual needs and likes / dislikes were met. This information needed to be available in the kitchen so that all staff, including temporary staff, had easy access to details of people's dietary requirements.

Requires improvement

Is the service caring?

Our findings

On the day of the inspection we asked people if staff had the right approach and one person said, "Sometimes they chat to me, it depends how busy they are." Another person told us that staff were very patient with people who lived at the home. We observed that staff were caring and approached people in a sensitive and compassionate manner. Staff told us that they felt they were a good team of staff and that everyone really cared about the people who they supported. One member of staff told us, "I am here because I care about the residents. It can be very rewarding when you make a resident smile." We observed one member of staff pass a person who lived at the home in the corridor and stop to give them a cuddle and some words of reassurance.

We asked people how staff communicated with them. Comments included, "They will come and have a talk with me", "I have a bit of banter with them" and "They haven't the time." We observed some good interactions between people who lived at the home and staff on the day of the inspection. However, we were concerned that one member of staff was not able to communicate effectively with people due to language difficulties. We were concerned that people might become anxious if they asked staff a question and it was not responded to appropriately.

We asked relatives if they thought staff really cared about people. One relative told us, "Staff I have seen do – always very, very good." However, another relative told us, "70 – 80% of staff do – some don't know her and some can't speak English."

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

Relatives told us that staff at the home were good at keeping them in touch with issues concerning their relative. One person said, "Yes, they tell me how she is every day" and another told us, "Yes, they always tell us what is happening."

We asked people if they felt that they were kept informed about events at the home and they all responded negatively. None could recall being invited to attend a meeting or complete a survey. However, we saw that there had been a 'resident' meeting in September 2014 when activities, the new wet room, a bonfire party and memory boxes had been discussed. The previous meeting had been in November 2013. There was no evidence that people who lived at the home had been asked for their views in a survey or in a one to one discussion with a member of staff. This would have given people additional opportunities to express their views about the support they received and the running of the service.

All of the visitors we spoke with told us they had observed that staff respected people's privacy and dignity. A member of staff described how they maintained people's privacy and dignity. They said, "We close curtains and doors. We knock on doors before entering." A health care professional told us that people had single rooms so there were no issues about privacy in bedrooms; this also enabled people to see visitors in private if they wished to do so. They also told us they had noted care plans recorded a person's preferred term of address and on the day of the inspection we observed that these names were used by staff. On the day of the inspection we saw that one person had remained in bed and throughout the day they were wearing soiled nightwear; staff had not assisted this person to change into clean clothes to promote their dignity. However, this appeared to be an isolated incident as everyone else we saw was well-presented and was wearing clean clothing.

We noted that there was no bath available for people at the home to use. People were able to get a shower but, if they preferred a bath, this was not available. This could have resulted in people not receiving personal care in a way that suited them, and in them declining assistance. We discussed this with the general manager on the day of the inspection and they assured us that this would be addressed; there was a bathroom that was no longer in use and they would consider how this could be refurbished and brought back into use.

Staff told us that they asked people what they required assistance with and were aware of what they could manage themselves, and that this helped to promote their independence. We saw that some people went out during the day; one person on foot and two people in mobility scooters, and that people were supported by staff to do so.

Requires improvement

Is the service caring?

Risk assessments had been completed to evidence that the risks involved in these activities had been minimised. Some people told us that they visited their GP and other health care professionals independently.

No issues were raised with us prior to the inspection or on the day of the inspection about the lack of confidentiality.

We saw in the most recent staff meeting minutes that staff had been advised not to use chair protectors, as this could identify people who were not continent. The minutes of the meeting recorded, "…they may highlight residents who suffer incontinence to visitors, possibly causing prejudice." This evidenced that issues of equality and diversity had been considered.

Requires improvement

Is the service responsive?

Our findings

We asked people who lived at the home if they were aware of their care plan and if they had been involved in developing the plan. Three people told us they did not know about the plan and a fourth person said, "I have one: I don't know it and I don't see it." One visitor told us that they had some input into their relatives care plan, another said that they had been asked questions prior to their relative's admission and another told us they had no input.

We saw in care plans that people's needs had been assessed when they were first admitted to the home. Assessments had been undertaken on nutrition, tissue viability and mobility so that a person's level of dependency could be identified. This information had been used to develop care plans that reflected people's individual abilities and needs. Care plans were reviewed each month; this meant that people's care needs were continually updated to ensure they received appropriate care.

Information about a person's life history had been recorded in a document called "My Life Story". However, we noted that some of these were stored at the back of care plans and so there was a possibility that they had not been read by staff. The general manager told us that these would be moved to the front of care plans so they were easily accessible.

The manager told us in the PIR that life story books had been completed. None of these were seen on the day of the inspection and no-one who lived at the home or staff member mentioned them. These would have helped staff to understand the person, to know more about their previous lifestyle and to enhance the relationship between them.

In discussion with staff on the second inspection day we were told about one person who lived at the home who could be verbally and physically challenging towards staff and other people who lived at the home. We checked this person's care plan. There were behaviour charts in place to monitor their mood and behaviour throughout the day. In February 2015 a community psychiatric nurse wrote in this person's care plan, "Amber House to continue to implement management plan akin to delivering personal care adequately and effectively when needed." The person's risk assessment stated, "If aggressive, keep distance from (the person) whilst ensuring their safety. Offer drink – cup of tea. Record any incident and report to manager."

We spoke with a member of staff on duty and they confirmed that they were aware of this risk assessment and that this was how they usually de-escalated the person's behaviour so that they were able to assist them with personal care. However, we saw that the care plan did not include a specific behaviour management plan or guidelines on how to manage further escalation in behaviour, and no explanation for the use of behaviour charts and when and how these would be reviewed.

We were also told by care staff that the communal areas of the home were not always supervised as there were insufficient numbers of staff deployed to enable a member of staff to remain in communal areas throughout the day. This meant that this person's individual care and support needs were not being consistently met, and this also left other people who lived at the home at risk of harm.

This was a breach of Regulation 9 (3)(d) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

We saw that staff supported people to keep regular contact with relatives, and relatives and friends told us that they were able to visit the home at any time of the day. A member of staff told us, "Some of the residents have mobile phones, and we encourage visitors to come in." Two people had mobility scooters and went out into the local community. Another person went out on a regular basis to meet their spouse. There was an enclosed garden that allowed people to sit and walk outside in a safe environment. The home's action plan recorded that a sensory garden would be created in the enclosed area and it was hoped that this would be completed by September 2015.

People told us that the hairdresser visited the home each Wednesday and one person told us that a member of staff encouraged them to take part in exercises, but apart from that there were few activities to keep people occupied. We did not see any activities taking place on the day of the inspection and people who we spoke with told us that there was a lack of activities and stimulation within the home. We saw that staff tried to spend time with people but they were too busy to spend much one to one time

Requires improvement

Is the service responsive?

with them. One member of staff told us, "We don't get a lot of time to speak to people individually" and another said, "There is a book shelf and some games. Not a lot of time to do this – we used to have outside companies to come in and do this but this has stopped." A visitor told us that they thought their relative watched a film on a Sunday but they were not aware of any other activities.

Although there were some activities taking place, staff did not appear to have the time to spend with people undertaking meaningful activities.

We saw that there was no comments book in use or suggestion box available for people to leave comments anonymously. This would have provided an effective way of gaining feedback from people who lived, worked at or visited the home.

We saw that the complaints procedure was displayed in various areas of the home. We checked the complaints procedure and saw that it included the contact details for the Care Quality Commission should someone wish to take their concerns further. The manager told us in the PIR that no formal complaints had been received during the previous twelve months and we saw that there were none recorded in the complaints log. People who lived at the home told us they had not needed to make any complaints, but were able to tell us who they would speak to if they wished to raise a concern or make a complaint. One person said, "I would tell seniors, but I have not had to" and another told us, "I would tell one of my relatives who visits, but no complaints."

Relatives told us that they would not hesitate to speak to the manager, although one person said that they had complained and the situation had improved, but then they had to complain about the same issue again.

We asked staff if people's complaints were listened to. We were told that people were listened to, but that action was not always taken to resolve people's complaints.

On 8 July 2015 we received information of concern; we were told that some complaints had been received by the home but they had not been recorded or dealt with in a satisfactory manner. We had already discussed this with the general manager on 4 June 2015 and they told us that they were not aware of any concerns or complaints raised by people that had not been addressed.

Requires improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with the Care Quality Commission (CQC). The manager told us that they had submitted an application to CQC. However, they had not checked on the progress of this application and it transpired that it had not actually been received by the Commission. This meant that the manager had been in post for almost a year but no application for registration had been received by CQC.

We asked staff to describe the culture of the home. They told us, "There is a good team and a good vibe about the place. We are able to voice our concerns." Staff also told us that they would not hesitate to use the whistle blowing policy if they had any concerns. However, they added that "Things could be organised better. Seniors are always complaining that things are not being done."

We asked people who lived at the home if they felt able to speak with the manager. Two people told us that they were able to speak with them, but another two people said they were not sure who the manager was. Relatives told us that they could approach the manager or staff and they felt they received truthful responses.

A health care professional said that staff telephoned them to ask for advice and usually acted on advice. They said that they were willing to discuss potential clients and would advise if they felt unable to meet their needs.

There were three moving and handling 'champions' at the home; it was the role of these three members of staff to promote safe moving and handling techniques. There were no 'champions' for other aspects of care such as dignity, end of life care or dementia so there was no-one promoting good practice on these topics to other staff members.

The manager had carried out an audit on the prevention and control of infection in April 2015. The audit recorded many areas for improvement in the 'comments' column. For example, fly screens needed to be replaced in the kitchen and carpets were not always cleaned every three months. The action plan recorded, "We are in the process of addressing the issues documented - work in progress." However, there was no record to identify whether any of the actions had been completed. The senior care worker carried out a satisfactory medication audit. We did not see any evidence of care plan audits but we only had minor concerns about the content of care plans.

We did not see any evidence of audits being carried out by senior managers within the organisation to monitor whether the home was being managed effectively.

We saw that there had been a staff survey in March 2015. The action plan recorded, "The manager recognises that the induction has been lacking. As a company we are in the process of updating our induction programme. Any new starters will have access to the new induction." We saw that one new staff member had completed induction training, but the induction records for the other two new members of staff whose records we reviewed could not be found. The action plan also recorded, "The training matrix has been updated, and staff training needs identified through discussion and supervision." There was little evidence that staff had been offered appropriate training opportunities to bring their skill levels up to date or that they had attended a supervision meeting.

Although staff told us that staff meetings were now held on a more regular basis, we only saw the minutes of one meeting. The minutes indicated that staff were able to make suggestions and have input into the meeting. The previous meeting had been in June 2014.

We were told in the PIR that resident / relative meetings were held but we could not find any minutes to support this. When we asked visitors to the home if they were asked for their views and opinions, one person said, "Never, never asked. They are too busy to ask", another said, "No, they did say there would be some (meetings) but never had" and a third person said, "I have attended two and they were no use."

No recent surveys had been carried out with people who lived at the home, relatives or health and social care professionals. This meant that there was a lack of opportunity for people to express their views about the service being provided by the home.

There were insufficient opportunities for people who lived at the home, staff, relatives / friends and health and social care professionals to give feedback about the way in which the home was operated, and that would lead to improvements in the service.

Requires improvement

Is the service well-led?

On 8 July 2015 we carried out a tour of the premises at Amber House. We observed that, on the stairs to the left of the premises, the stair carpet was badly fitted, that there were split carpets at some door thresholds and a number of holes in other carpets. In addition to this, some floors in the upstairs corridors were uneven. This poor maintenance of floors and carpets created a trip hazard for people who lived and worked at the home. No health and safety audit had been carried out at the home. An audit would have identified that carpets in various areas of the home had holes or gaps that created a trip hazard. This health and safety breach could have caused harm to people who lived and worked at the home.

This was a breach of Regulation 17 (2)(a)(b) 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 legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. You had not ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The premises and equipment used by the service provider were not suitable for the purpose for which they were being used, or being properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people who lived at the home.

This section is primarily information for the provider

Enforcement actions

The staff employed had not received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they were employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Persons you had employed for the purposes of carrying on a regulated activity did not have the qualifications, competence, skills and experience which were necessary for the work to be performed by them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care You had not enabled and supported relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent As a registered provider you had not ensured that care and treatment of service users had only been provided with the consent of the relevant person.