Amberley Lodge Care Home Limited

Amberley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 3 and 4 November 2015 and was unannounced.

Amberley Lodge Care Home is registered to provide accommodation and nursing care for up to 17 people with a variety of health care needs, including dementia. At the time of our inspection, there were 16 people living at the home. Amberley Lodge Care Home is an older style detached property close to the centre of Worthing with easy access to shops and the seafront. Communal areas include a lounge leading to a sun-lounge, a further small sitting/dining room and a rear garden with a sheltered courtyard area and seating. All rooms were single occupancy.

There was a registered manager in post. 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.

Premises were not always managed to keep people safe. Some trunking had come loose exposing loose wires in one part of the home and there was extremely poor lighting in the ground floor bathroom. There was only one bathroom available for people to have a shower. An upstairs bathroom had been decommissioned as the

Summary of findings

bath was unsuitable for people who had limited mobility. Generally, the home was clean and tidy. There were sufficient staff on duty, but they were not always deployed in a way that meant people's needs were responded to promptly. People felt safe and any risks to them were assessed and managed appropriately. Safe recruitment practices were followed. Medicines were managed safely, although competency checks for staff had not been undertaken.

Staff had received training considered essential to their work, but records were not available to confirm this. Additional training opportunities for staff were available from an external organisation, but not all staff had accessed this. Staff had received at least one supervision in the year, although the provider's policy stated that supervision meetings should occur every two months. No staff had received an annual appraisal and formal staff meetings had not been planned. However, staff communicated with each other at handover meetings. Care staff had achieved appropriate vocational or professional qualifications and new staff followed the Care Certificate, a universally recognised qualification.

Consent to care and treatment was sought in line with legislation and guidance and staff had received training in this area. However, not all staff had a thorough understanding of the legislation in relation to consent to care and treatment.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. Some people's preferences with regard to food choices were not always taken account of. Special diets were catered for. People had access to a range of healthcare professionals. Some areas of the home were warm and inviting, however, other areas were starker with narrow corridors and a lack of helpful signage for people living with dementia.

Staff knew people well and kind, caring relationships had been developed. People were encouraged to express their views and staff supported people in a caring and reassuring way. People were treated with dignity and respect. Staff knocked on people's doors before entering to promote privacy.

People did not always receive care that was personalised to meet their needs. Activities were organised for people and staff tried to involve people in these. However, some people had little mental stimulation during the day or access to meaningful activities. Care plans provided detailed information about people and were reviewed and updated every month. There was a complaints policy in place, however, this was in need of updating. No complaints had been received within the year.

People's views were obtained through informal means and the registered manager met with people every day to check on their wellbeing. People and their relatives were asked for their views in a questionnaire. However, this referenced the CQC fundamental standards and would not have been easily understood by the majority of people. Generally, people and their relatives felt the home was well-run and staff felt supported by management. There was a range of audits in place to measure the quality of care delivered, including environmental checks. However, the environmental checks were not always effective in identifying areas of concern such as cleaning and maintenance issues.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this 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?

Requires improvement

Some aspects of the service were not safe.

Premises were not always clean or properly maintained.

There were sufficient numbers of staff on duty, however, they were not always efficiently deployed to meet people's needs promptly.

People felt safe and any risks were managed appropriately to protect them from harm.

Medicines were managed safely, but competency checks were not undertaken on staff administering medicines.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

People were not always supported in their food preferences and some people's diets had been modified without a nutritional assessment.

Training was arranged for staff, but records were not available to confirm that all staff had received training considered to be essential to their role.

Staff were not adequately supervised and their performance and training needs assessed.

Staff had achieved relevant qualifications in health and social care. New staff were required to complete the Care Certificate.

Consent to care and treatment was sought in line with legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff knew people well and kind, warm relationships had been developed.

Where possible, people were encouraged to express their views and staff supported them with this.

People were treated with dignity and respect.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

People did not always received personalised care that met their needs or in line with their personal preferences.

Care plans provided comprehensive information about people and guidance to staff on how to deliver care.

Summary of findings

There was a complaints policy in place, but this was in need of updating. No complaints had been received within the last year.

Is the service well-led?

Requires improvement

Some aspects of the service were not well led.

People and their relatives were asked for their feedback about the service. However, the questionnaires were not easily accessible or understandable in their format.

Quality assurance systems in place were effective in some areas, but had not identified maintenance or cleaning issues that were found at inspection.

Amberley Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 3 and 4 November 2015 and was unannounced. Two inspectors and an expert by experience in dementia care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we examined the previous inspection reports and notifications we had received. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with six people living at the service and one relative. Due to the nature of people's complex needs, we did not always ask direct questions. However, we did chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider, the registered manager, two registered nurses, two care staff and the chef. We also spoke with a training consultant who provided training programmes for staff.

The service was last inspected in February 2014 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

Premises were not always managed to keep people safe. We observed some notices affixed to doors indicating that the rooms should be kept locked, for example, the laundry room and sluice room. However, we checked these doors and they were unlocked which meant anyone could gain access. We observed that some trunking had come loose outside one of the rooms on the first floor and that some wiring was exposed. We brought this to the attention of the registered manager and a repair was completed by the end of our inspection. A door stop, attached to a fire door on the first floor, had caught against the carpeting and resulted in a tear. Without repair, this tear could worsen and become a potential trip hazard. In the ground floor bathroom, we observed there was extremely poor lighting due to a low voltage light fitting. This could pose a risk to people as the artificial lighting was insufficient to enable them to navigate round the bathroom safely. The registered manager told us they were aware of this and stated they would contact an electrician to look at the light fitting. We observed that curtains and tracking had come away from the window in one person's room and the valance to curtains in another room was falling down. In one instance, this meant that the curtains could not be drawn and this could have had an impact on the person's privacy being maintained. We brought all these issues to the attention of the registered manager and the curtains were fixed when we checked later on in the inspection.

People felt that the home was clean, tidy and hygienic and a relative confirmed they had no concerns. However, we observed there was an extremely unpleasant odour in a downstairs corridor. On the second day of our inspection, the downstairs toilet where the smell appeared to emanate from had been thoroughly cleaned and the malodour had disappeared. The registered manager informed us that there were plans to widen the corridor in this area of the home and that the carpets were to be replaced. A chart in the registered manager's office showed the days of the week when people either had showers or were bathed in bed. People were bathed once a week, although the registered manager said people could be bathed more often, if they requested. One person told us, "You get a shower when they tell you". There was only one operational ground floor wet room available for approximately 13 people, that is, those who were not receiving bed baths. A bathroom upstairs had been decommissioned as staff told us that the bath was not suitable for people with limited mobility. The lack of bathing facilities meant that people could only have a shower, even though a bath might have been their preference. In addition people may not have been able to choose the frequency of their showers due to several others vying to use the shared space.

The above evidence shows that premises were not always clean or properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager informed us that there were sufficient staff to keep people safe and, based on the number of staff on duty, this was the case. Staffing levels were assessed based on people's needs and rotas were drawn up every four weeks. However, one member of staff told us, "Some days we're short of staff and the nurse will help deliver personal care". Staff were not always deployed to ensure that people were responded to in a timely fashion. For example, at lunch time there were three people who needed some support or prompts with their meals. We observed that 15 minutes elapsed before staff could support them by which time their meals would have been cold. In addition, on several occasions in the afternoon when the majority of people were downstairs, there were no staff available upstairs to attend to two people in bed who were unable to use their call bells. Whilst we were told that staff regularly checked on people who were in bed upstairs, we did not see any staff around. Late in the afternoon, one person was calling out and we had to alert a member of staff downstairs. On another occasion, we observed one person who needed support from staff. At the same time, another person started to get up out of their chair and a member of staff had to encourage them to sit back down again, as they were at risk of falling because their walking frame was not to hand. Yet another person started calling out, "He wants to spend a penny. He only tries to get up when he wants to spend a penny. Sit down [named person], sit down". After about five minutes, a visiting relative went to help and fetched the person's walking frame from their room.

We recommend that the provider looks at ways to deploy staff in a way that ensures people are responded to promptly.

People living at Amberley Lodge Care Home told us that they felt safe. One person said, "Oh yes, no-one can get in".

Requires improvement

Is the service safe?

They referred to staff and other people living at the home and said, "No, I'm not frightened, they're all nice to you". People consistently nodded and said they would speak up or somehow express any dissatisfaction to make their feelings known. For example, people would push their food away if they did not want any more to eat or could call for help, when they required support from staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. Staff confirmed they had been trained in safeguarding adults at risk and knew what action to take if they suspected abuse had taken place. This training was delivered by the registered manager.

Risks to people were managed so that they were protected from harm. Personal Emergency Evacuation Plans had been drawn up so that, in the event of an emergency, staff knew who to contact to support people to be evacuated safely. Accidents and incidents were reported and action taken to mitigate the risk of future occurrences. The registered manager said, "Recording of falls gives me a good overview. I monitor infection as well". They explained how they looked at the correlation between people suffering, for example, from a chest infection or urinary tract infection, and how this might link to an increase in falls. When people sustained a fall, they were automatically identified as being at high risk for three months afterwards and their risk was closely monitored during this time.

People's risks were identified, assessed and managed appropriately. Risk assessments provided information, advice and guidance to staff on how to manage and mitigate people's risks. One care plan showed that the person had been identified as being at high risk of developing pressure ulcers, through the use of Waterlow, which is a tool developed specifically for this purpose The same person had been assessed as being at low risk of falls as they had extremely limited mobility and were cared for in bed. People were supported to be as independent as possible. One person had restricted mobility following a hip operation, but was supported by staff to recover their mobility through the use of a walking frame. This was recorded in their care plan. We observed several occasions when staff supported people safely whilst being hoisted from an armchair to a wheelchair or vice versa. These transitions were completed safely, competently and with kindness from staff. We heard staff explaining to people what they were doing, checking with them that they were all right, holding the person's hand and singing with them to relax and reassure them.

The service followed safe recruitment practices. Before new staff commenced employment, the provider obtained two references and checked their suitability to work in a care setting through the Disclosure and Barring Service. Registered nurses submitted their PIN numbers to show they were registered with a professional body and their registration was up to date.

People's medicines were managed so they received them safely. We observed medicines being administered by a registered nurse who said to one person, "It's your 2.30 medication time now, you have these two at this time. Can you open your mouth and I'll pass you a drink". Only nursing staff administered people's medicines. However, the registered manager told us that no competency checks had been undertaken to ensure registered nurses continued to administer medicines safely.

We recommend that the provider seeks guidance about refresher training in the administration of medicines and implementing competency checks for staff from a professional body, such as the Nursing and Midwifery Council.

The registered manager told us that the supplying pharmacy undertook annual audits and records confirmed this. We checked the stock levels of medicines and the Medication Administration Records (MAR) and these were in order. Controlled drugs were stored and dispensed safely in line with legislation. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated regulations.

Requires improvement

Is the service effective?

Our findings

The provider had arranged for an organisation to deliver additional training to staff and a training programme was in place for 2015. However, not all staff had attended the training sessions on offer. Training was available on a wide range of topics including diabetes, mental capacity, food safety, health and safety, challenging behaviour, nutrition and health, infection control, moving and handling and person-centred care. A training plan to indicate which staff had completed training in specific areas had not been completed for 2015, so it was not clear whether staff had received all the training considered essential for their role. Staff did not receive any specific training on end of life care. A member of care staff told us about their experience of the sensitive care and support they provided to one person who had recently passed away. The registered manager told us that if staff did not attend training, then they would read the associated information on the training topic and this would be discussed with them later.

Staff had supervision meetings with either a registered nurse or the registered manager. The registered manager told us that they aimed for supervisions to be held for each staff member every two months. However, records of supervision meetings showed that not all staff had received such regular supervision. The registered manager acknowledged this and said that all staff had attended a supervision meeting at least once this year, although records could not be produced to confirm this in every case. They added that they thought six supervisions per year was an unrealistic target and that this would be changed to three supervisions annually in the future. Where supervision meetings had taken place, these recorded the discussions and that the supervisor and supervisee had agreed any actions arising. These were then taken forward and addressed at the next supervision meeting. The registered manager said that no staff annual appraisals had occurred within the last year, but that they were, "Looking into it". In addition, no staff meetings had been held in the year, as the registered manager said they were going to complete all training with staff first. This meant that staff did not always receive effective support, supervision, appraisal and training to enable them to carry out their role and responsibilities effectively.

The above evidence shows that staff did not always receive appropriate support, training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative felt that staff were competent, skilled and knowledgeable in their role. Care staff explained their induction, supervision and training they had completed since commencing employment. A member of care staff told us they had achieved a National Vocational Qualification (NVQ) at Level 2 in health and social care and, more recently, a Level 3 diploma, as well as completing essential training. The same staff member informed us that they had completed the Care Certificate and that they supported new care staff to achieve this. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Care staff confirmed they had received training in moving and handling, fire safety, food hygiene, infection control and safeguarding. Face to face training for staff took place and the majority of training was delivered by the registered manager who was qualified to deliver this. Staff said they received regular training and one said, "It makes me feel confident and helps me get better to help others". Another member of staff felt training promoted, "Good communication, which is better for the residents". The registered manager told us that they used the standards under the Care Certificate as a guide to training staff. A registered nurse enjoyed working at the home. They told us, "It's teamwork. [Named registered manager] is very supportive. We can call him any time".

Care staff explained how they handed over between each shift and discussed people's care. The night staff hand over to morning staff at 7.50am and this handover meeting lasted for 20 minutes. A handover meeting was observed during our inspection between the registered nurses. Details on each person living at the home was uploaded onto the internal computer system from the daily notes completed. Each person was discussed with regard to their food and fluid intake and their personal care. The registered manager told us that they also used handover meetings as an opportunity to provide training updates to

Is the service effective?

staff. However, since these meetings were only of 20 minutes' duration on average, it was difficult to see how these training updates could be done in a meaningful or detailed way.

Care staff said that if they noticed a change with any person they would discuss this with one of the registered nurses or the registered manager. The person's GP would be contacted if required and a home visit arranged. People had access to, and support from, a range of healthcare professionals. For example, one person was reviewed by a community nurse from the living with dementia team and this included a nutritional review. People felt that medical attention would be sought and a relative confirmed this: "I know they do get the doctor whenever it's needed". People had access to a chiropodist and a hairdresser. One relative said, "They've got [named family member] hearing aids sorted out, so it's much better".

Consent to care and treatment was sought in line with legislation 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care staff were asked about their understanding of the MCA and DoLS. Care staff confirmed the MCA training was provided as part of their safeguarding training, but was not a 'stand-alone' topic. One member of staff explained that all people had the right to choice including, "What food they eat, where they go and where they live". The same member of staff provided an example when the DoLS team had been into the home and reviewed one person's care and treatment who had been assessed as lacking capacity. When asked about their understanding of the MCA, a registered nurse appeared unsure and referred to challenging behaviour and, "How dementia affects their quality of life and how the brain works". The registered manager informed us that one DoLS had been authorised and was in place and that they were still in the process of completing four applications. Where necessary, best interest meetings were held. A best interest meeting had taken place for one person to decide whether their medicines should be administered covertly as they refused to take their medicine. A best interest meeting is where a decision is made by the person's relatives, staff and professionals on the person's behalf and in their best interests.

We recommend that the provider looks at further training on MCA and DoLS to enable all care staff to have a better understanding of these topics and to put what they learn into practice.

When care staff were asked about the safe use of restraint within the home, they informed us that this was not currently required. We asked staff how they managed people with behaviour that might challenge. One member of staff referred to one person and explained how they would offer reassurance, encourage them to a safe place and offer them something to eat or a drink. This guidance was recorded in the person's care plan. A registered nurse told us, "We leave her to settle down. Some people [referring to staff] relate better to her than others".

People were supported to have sufficient to eat, drink and maintain a balanced diet. People had small bowls of grapes or oranges during the morning, as well as biscuits or savoury nibbles that were offered. During the morning, people had drinks in mugs, cups and beakers which reflected their needs and preferences. Staff understood the importance of caring and supporting people to ensure they had enough to eat and drink. People were offered fluids and food in the main lounge/dining area throughout the day. Apart from two people who stayed in bed in their rooms, everyone else had their meals at individual tables downstairs. We did not hear anyone being asked where they would like to eat and two small dining tables in separate areas were not available to use; people stayed where they had been sat during the morning. One person, however, sat alone all day in a separate small room away from everyone else and ate at an individual table there. Staff explained that this was the person's preference.

On the day of our inspection, the food choices for that day were not on any of the menus displayed on the noticeboard. This would have been confusing for people

Is the service effective?

living with dementia. We heard staff telling people before lunch that the main choice was meatballs. There were no visual menus or tools to assist people to make choices. We were informed that people were offered food choices and then the chef prepared the menu, with two choices on offer for lunch that day. Care plans did not include people's preferences and it was not clear during the inspection how daily choices were made by those who might have difficulty in communicating verbally or who changed their minds. One person indicated clearly that they did not like sweetcorn the moment the meal was served. This seemed to indicate that their choice or preference had not been checked and taken account of. One person was known to prefer sandwiches for lunch and their relative said, "However they always just try and offer a main meal first and then provide sandwiches if [named family member] won't eat it". We observed this was the case. Two people did not like the meal they were offered, but were not offered an alternative. Despite people stating they did not like the food, they were still then encouraged to eat it. A member of staff said, "Oh, you don't like it? We'll try a bit more, two more mouthfuls". The person being fed the meal had sat for 15 minutes with no help or support and the meal had grown cold. A notice in the kitchen did have a list of people's likes and dislikes and food preferences, as well as any allergies people suffered from. People were not asked whether they wanted to wear clothes protectors, but staff put these on in a kind way and explained what they were doing.

Meals were served directly to people at their individual tables and all the portion sizes looked similar. Meals were presented in different ways, for example, with plate guards or softer, pureed food was separated into food groups. The pudding on offer was rice pudding and each pudding was of a similar size and all had jam on them, whether people wanted this or not. One person commented, "These portions are too big. Can I have a smaller one next time, it's too much". This was acknowledged by a member of staff who responded, "That's fine [named person]. I'll tell the chef for next time". We observed some staff standing over people throughout the day, when giving fluids or assisting people with their food. However, three people had a positive meal experience, with staff members giving them their full attention, giving good eye contact and checking to see if they were ready for their next mouthful. Fluids were offered intermittently and staff were gentle and unhurried in their manner. We heard some lovely conversations over the mealtime, for example, baking cakes like mum used to and how to make rice pudding.

For the most part, people had drinks available, were able to reach them and where needed, staff offered support. However, one person upstairs alone in their room with the door closed was not able to reach their drink. Special diets were catered for, for people with diabetes or for people who required their food to be pureed. A note displayed in the kitchen showed who required a special diet and any allergies. People's risk of malnourishment had been assessed and care records confirmed this. Risks had been assessed using the Malnutrition Universal Screening Tool, which is specifically designed for this purpose. Care staff knew which people required a different diet and why this might be needed, including some associated risks. Care plans recorded this information too, however, it was not clear what professional dietary advice had been sought for people. The registered manager told us that many people were already on a pureed diet when he started his employment at the home. However, a review of people's dietary needs, together with the involvement of relevant professionals, would ensure that people's nutritional needs were assessed and arrangements that were in place remained appropriate.

The above evidence shows that people's preferences in relation to food choices were not always taken account of and some people had not been assessed as needing a specific diet. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the main entrance area to the home was bright and inviting, the environment in many areas was stark, with narrow corridors and a lack of consistent, helpful signage for people living with dementia. Some areas were dark and lacked hand rails, however, some narrow corridors were not suitable for hand rails to be fitted. There was an operational lift, but this was noisy and cold and similar to a goods lift, with big, thick concertinaed grill doors. The registered manager explained that the lift had been recently updated, serviced and was safe to use. Some people's rooms were homely and personalised with memorabilia and items of personal furniture. Each was decorated differently in various colours. However, in

Requires improvement

Is the service effective?

contrast, other rooms were stark, uninviting and unkempt with curtains and curtain tracks hanging off. All rooms had overhead tracking to assist staff in moving and handling people.

We recommend that the provider undertakes regular checks around the home to ensure the premises are properly maintained and suitable for the purpose for which they are being used. For example, people's dementia care needs.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Staff had a caring approach and were patient and kind. They smiled with people and looked approachable, however, a registered nurse on duty during the morning had a noticeably different approach. They were serious, stood over people on occasions and did not present with the same warmth that the other staff had. People confirmed that staff overall were kind and helpful. One person said, "I'm happy and I've no complaints about them". A relative referred to staff and said, "They are very caring. They always dress [named family member] appropriately, regard her wishes and know her back history. The physio involvement is also very good. They know her preferences". Comments overheard from staff to people illustrated their caring attitude. For example, "Where would you like to sit?", "Hello [named person]. How are you? Can I make you more comfortable and give you a wash?" and, "Would you like to come outside with me today?"

It was clear that the registered manager and care staff knew people well, including their histories such as past employment and their interests. The registered manager said, "We try to keep it like a home and keep the residents at the heart of what we do". They added that people were encouraged to express their views and they spoke with people on an individual basis. Staff spoke with people using their preferred names and with a sense of compassion. This was evidenced in the way they transferred people and singing was encouraged and enjoyed by all. When one person became upset, staff were able to identify the cause and said, "Aah [named person]. What's the matter, you're crying? Is it [referred to spouse]? They will be coming to see you soon. They haven't abandoned you, don't worry". We observed care staff telling people what was happening next in terms of food, drinks or in relation to personal care. Staff reassured people who were distressed, confused or anxious. This included appropriate touch such as holding people by the hand and talking to them calmly. When care staff approached people they bent down to their level which enabled people to see who was talking to them.

Care staff talked enthusiastically about people, their preferences and how they could tell that a person was happy with the care they were receiving. An example was given of a person who enjoyed hand cream being rubbed into their hands as it seemed to help them relax. The same staff member talked about the importance of upholding the wellbeing of people who lived at the home.

One member of staff provided an example of how they promoted privacy and dignity when supporting people with personal care. This included asking and explaining to the person what was going to happen, shutting curtains and closing doors behind them. This was observed throughout the day when staff were offering reassurance to people with any personal care or support being given. Staff knocked on people's doors before entering.

Requires improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. One person was washed and dressed and ready to go downstairs at 11.15am. Staff told us that this person was usually taken downstairs just before lunch as it was difficult for them to sit comfortably in the lounge. As the staff member opened the door, they switched the light straight on and the person was wide awake, fully dressed and had their head resting on the bed rail. They looked as though they wanted to get out of bed and were leaning over. This person was lying in complete darkness as the curtains were drawn together. After this, the lights were left on, the door was propped open and the person was brought downstairs to the lounge. We observed some people who had little mental stimulation and were at risk of social isolation and another person who was noticeably more capable and wanted to be more active. They told us, "I've always been busy you see and I want to walk more".

The lounge area did not afford much space and some people were sat close up to a large screen television, whilst others sat in a line along the side wall. There was also a conservatory where three people sat and another small room, where one person sat alone for the whole day. When this person had spilled their mug of tea, staff were not aware of this. After 10 minutes, a member of staff came in and sat at the table eating their lunch. They did not speak or make eye contact with the person. A radio was left on and music was playing. We asked the registered manager about this. They told us that staff should communicate with the person in this small room, but that this person preferred to be by themselves. We looked at this person's care record which stated, 'A goal for [named person] is to provide activities to vary the days'. During the inspection, no variation to that person's activity was observed. They sat in the same chair all day with a newspaper that appeared to be of little interest to them. The registered manager said that this person had been creative in the past, but the knowledge of this person's history was not reflected in any activities arranged for them. People's needs and personal preferences were not always taken account of and some people were at risk of social isolation.

Pop music was played on radios throughout the day in communal areas and in some people's bedrooms. However, when listening to people singing throughout the day, the music on the radio did not appear to match their preferences. One care plan stated one person's preferred type of music, but this was not playing when we inspected. Some people were interested in looking at pictures of celebrities or members of the royal family, but others required staff support to engage with this activity in a meaningful way. There were also some percussion instruments and some ball throwing, but this only lasted for about 20 minutes before lunch and really engaging people was limited due to a lack of time.

There was no evidence to show that families were involved or included in any decision making about people's care. When asked whether people were involved in decisions, one relative told us, "We are involved in care plans of a sort, but you'd have to ask my daughter about that". In addition, there was no evidence to show that care staff had read and understood people's care plans, although our observations indicated that care staff knew people well and provided care and support to people in an individualised way.

The above evidence shows that people did not always receive care that was personalised to meet their needs or reflected their preferences. This is a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative thought that staff were responsive to their family member and said, "They notice if [named family member] is a bit sleepy and might ask if they want to go to bed early, so they go with how [named family member] is feeling".

The registered manager told us that they worked closely with social services and with the dementia crisis team. They gave an example of one person who liked art and that they did a little bit of painting. They had tried involving this person in some structured activities, but that these had not been successful, so they had bought some paints which the person enjoyed using.

A person came in to organise singing with people on a monthly basis and a church service was also held regularly, if people wished to attend. On the first day of our inspection, people were given reminiscence cards, newspapers and colouring sheets to do at their tables and a couple of people started singing. On the second day of our inspection, we observed staff engaging with two people and playing ball with them. A lively discussion ensued about netball. People said they liked to go out into the garden and the garden had bird feeders which

Requires improvement

Is the service responsive?

attracted a variety of birds, squirrels and a passing cat. One person said, "I love to walk and that's the only problem here that I can't walk as much as I'd like to. When it's nice I go out into the garden. They used to take us out, but that doesn't seem to happen anymore".

The registered manager told us that they reviewed and updated people's care plans every month and records confirmed this. The registered manager also showed a separate review that had been undertaken to identify people who were at high risk of falls. A similar format was adopted for each care plan which provided details of the needs of the person concerned. Pre-admission assessments showed people's daytime and night time routines. In addition, there was information about their health needs, skin integrity, psychological care and personal preferences. Each person was allocated a member of care staff who was their keyworker. This member of staff co-ordinated all aspects of the person's care.

There was a complaints policy in place, however, this was not easily accessible to people or their relatives. The policy stated that any complaint received would be resolved within seven working days. The registered manager said that there was a copy of the complaints policy in each person's service user guide. The complaints policy was out of date and showed a CQC contact address in Maidstone, which is no longer current. We brought this to the registered manager's attention and they acknowledged that the policy required updating. They also told us that no formal complaints had been received within the last year and that if anyone had any complaints, they usually were raised and resolved informally.

Requires improvement

Is the service well-led?

Our findings

The registered manager understood the concept of person-centred care, that people should be treated as individuals and that Amberley Lodge Care Home was people's home. The registered manager told us, "We try and keep the resident at the heart of everything we do. We try and keep it like a home. When people walk in, it should feel like someone's home, that's the main aim". Some staff demonstrated a personalised approach in the way they cared and supported people, but it was not clear how these values were embedded and practised by all staff across the service.

Residents' meetings had been held in the past, but the registered manager said that these had not been a successful way of obtaining people's views and feedback. Instead, more informal get-together meetings were held with people and their relatives and these were annual events. In October 2015, a food tasting evening had been organised and a variety of foods were on offer for people to try, such as oriental pork, vegetable lasagne, Eton mess and spotted dick. This event enabled people to have a say about which meals they would like to see served at the home and how often. Twenty-three forms had been completed which showed that the oriental pork dish was popular and spotted dick the least liked. One relative had commented, 'All really lovely. I'll be round three times a week!" The registered manager met with people on a daily basis to obtain their feedback and address any concerns.

A questionnaire had been sent to people and their relatives in 2015. This questionnaire referenced the CQC fundamental standards under the headings of 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led'. However, with no explanation to people of what these standards meant, it was difficult to ascertain whether the feedback received accurately reflected people's views about the home. People and a relative said they thought Amberley Lodge was a well-run home and one said, "They always ring us and let us know about things". Another person said, "You can speak to them anytime and you feel like they listen to you". A relative said, "I'm always made welcome yes and they pay attention to what the visitors say". Four people, a relative and an external professional all said they would recommend the home.

Staff felt supported by the registered manager and the provider. One member of staff enjoyed their work and said, "Quite rewarding and I get praise from people". The provider visited the home weekly and undertook informal audits. They told us that they looked at rooms and chatted with people, adding that they regularly spoke with staff, people and family members. A registered nurse told us, "It's a really nice home and very understanding".

Accidents and incidents were analysed and any patterns or trends were identified and acted upon. Records showed that an infection prevention and control audit had been undertaken in October 2015 and fire evacuation and emergency plans had been recently updated. An audit of care plans was undertaken to ensure that all necessary information about people had been included in their care plans. A medicines audit was undertaken by the provider's pharmacy in 2015. This showed that action had been taken against issues identified as a result of the audit. People's rooms were checked for cleanliness every day and cleaning audits were completed. However, these checks were not always effective and had not identified the areas of concern that we found on the day of our inspection. We recommend that the provider looks at putting more efficient systems in place to measure and monitor all aspects of the service and to drive continuous improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met: The premises were not always clean, suitable for the purpose for which they were being used and properly maintained.** **Regulation 15 (1)(a)(c)(e)**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met: Staff did not always receive such appropriate support, training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform.** **Regulation 18 (2)(a)**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met: People did not always receive care and treatment that met their needs or reflected their preferences.** **Regulation 9(1)(b)(c)**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People's preferences were not always taken account of with regard to their food choices. People had not been assessed as needing a specific diet.

Regulation 14(4)(a)(b)