Aitch Care Homes (London) Limited

Ambleside Lodge - Redhill

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

Overall summary

Ambleside Lodge is a care home providing accommodation and personal care for up to eight people with learning disabilities, including Autism. There were seven people living in the home at the time of our inspection.

The inspection took place on 25 August 2015 and was unannounced.

The home had a registered manager. 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.

Feedback from relatives and our observations during the day indicated that staffing levels were sufficient to meet people's needs. We did however identify that on three occasions, night staffing levels went below the home's own risk assessment for what was safe.

Summary of findings

The home lacked a sense of leadership and did not provide adequate direction to staff. Whilst staff felt supported in their roles, their skills had not been effectively appraised and practice issues had not always been identified and addressed.

The provider had a programme of training, but that did not currently include learning about people's specialist needs. For example most people living at the home did not communicate verbally and yet many staff had not received training in the use of different communication methods, such as Makaton or Picture Exchange Communication System (PECS). We saw that some staff did not interact effectively with people and some people spent large parts of the day without engagement.

Quality monitoring systems had not always been effective in identifying and ensuring improvements were made. For example, gaps in record keeping meant that it was not possible to evidence that new staff had been appropriately employed.

Some measures to keep people safe meant that other people were restricted more than necessary. For example we saw that communal toilets and kitchen cupboards were kept locked. Some people could safely access these areas, but were prevented the freedom to do so due to the needs of others.

Relatives told us that they were impressed with the quality of staff at the home. They said that staff were kind and knew their family members well. We found that staff competencies varied and that some staff were not always respectful in the way they spoke or wrote about people and their needs. We also observed that staff did not always fully protect people's privacy and dignity. For example we overheard two staff discuss private information about people in a communal area.

Care plans provided useful information about people and their needs, but this was not always reflective of the care provided. People had opportunities to participate in activities, but these were not always linked to their goals or the particular interests and cultural beliefs. For example one person liked going to the local Mosque, but they had not been supported with this activity for several months.

The environment was safely maintained and known risks were mitigated. Each person had a Personal Emergency Evacuation Plan (PEEP) which outlined how they would be supported to live the service in the event of an emergency. The home also had contingency plans to provide support in the event of a fire, flood or outbreak of infection.

People were safeguarded from harm because staff knew and understood their roles and responsibilities. Staff were able to tell us about the different types of abuse and what they would do if they ever had concerns. The culture of the home was open and staff were confident to voice concerns. People were supported effectively with behaviour that challenges and as a result incidents between people were rare.

People had the freedom to follow their own daily routines and their choices were respected. They were supported to maintain a healthy and varied diet. A library of photographs enabled people to make meaningful choices about the meals they ate.

Medicines were managed well and there were systems in place to ensure people received the right medication at the right time. The home had good links with other health care professionals and ensured that people were appropriately referred for external support or treatment when they needed it. Each person had a health action plan and their physical health and medication were reviewed with the doctor each year.

We found a number of breaches of regulations. You can see what action we asked the provider to take at the back of the full version 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 

The service was not always safe.

On three occasions staffing levels at night were insufficient to provide safe care in accordance with the home's own risk assessments.

Records available for inspection did not provide evidence that appropriate steps had been taken when new staff were employed.

There were systems in place to identify and help staff prevent the risk of avoidable harm.

People were safeguarded from the risk of abuse because staff understood their roles and responsibilities in protecting them.

Medicines were administered and managed safely.

Is the service effective?

Requires improvement 

The service was not wholly effective.

Staff did not always have the necessary skills and knowledge to support people effectively.

Staff understood the importance of gaining people's consent, but care was not always provided in the least restrictive way.

People were supported to maintain a healthy and balanced diet.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Requires improvement 

The service was not always caring.

The language used by some staff was not always respectful to the people who used the service.

People had not been adequately supported to follow their individual religious beliefs.

People's privacy and dignity was sometimes compromised by the actions of some staff.

Levels of interaction between staff and people outside of scheduled activities were poor. Some people spent long periods without any engagement or acknowledgment by staff.

People had opportunities to make choices about their care and daily routines.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

Support was not always provided in accordance with the care plans in place.

People had not been adequately supported to identify and achieve meaningful goals.

People had some opportunities to participate in activities they enjoyed.

The process for handling concerns and complaints did not consider the communication needs of people using the service.

Is the service well-led?

Requires improvement

The service was not always well-led.

The staff team presented as fragmented and the service required greater leadership and direction.

The provider had a range of audit tools, but these had not always been effective in improving the service.

The culture of the home was open and it was evident that feedback was listened to.

Ambleside Lodge - Redhill

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.

This inspection took place on 25 August 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we observed five people who lived at the home and interviewed four members of staff. Additional feedback was gathered from the service's locality manager, four relatives and one healthcare professional. We also reviewed a variety of documents which included the care plans for three people, three staff files, medicines records and various other documentation relevant to the management of the home.

The home was last inspected in October 2013 when we had no concerns.

Requires improvement

Is the service safe?

Our findings

In August 2015, people completed a satisfaction questionnaire for the provider and everybody said that they felt safe. Relatives told us that despite a turnover of staff, they felt that there were usually sufficient staff on duty to support their family members. One relative said that they would like it if staffing levels allowed their family member to be brought home.

There were not always enough staff on duty at night. Staff told us that staffing levels were based on people's assessed needs and that currently these required a minimum of five care staff during the day and two waking staff at night. At the time of the inspection we saw this staffing ratio in operation and this was sufficient to meet people's physical needs and support their planned activities. Staff told us that two people required 1-1 support during the day and this was always provided. We saw that these two people were allocated a member of staff on a one to one basis.

We looked at records for the previous month which showed that day time staffing levels had been maintained. We did however notice that due to staff sickness, on three occasions the home had not been staffed with two waking people at night. On one of these occasions there one staff member awake and another sleeping-in. On the other two nights, there was only one staff member in the home. Staff told us that they had attempted to cover the shift internally, but they had not been authorised to source external staff. There were mixed accounts from staff at to why this was did not happen. The home's own assessments, including the fire risk assessment stated that the home required two waking staff at night. As such the staffing level on these occasions was not safe in accordance with the home's own assessment. Feedback from staff highlighted that on the night of 23/08/15 when only one staff member was on duty, one person who required 1-1 support during the day, was awake most of the night and set off the fire alarm. This risk should have been anticipated and greater efforts made to ensure the required number of staff were on duty.

The lack of sufficient staff to meet the needs of people living at the home at night was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home could not evidence that only suitable people were recruited to work in the home. Only one of the three staff files we looked at contained the required information to show that they were suitable to work in the home. The deputy manager said this information may have been held at the head office or for one person, another home within the organisation because they had worked there previously. Audits on behalf of the provider had identified that staff files were not up to date, which indicated that this information was expected to be available in the home. It is important that the registered manager is satisfied that only appropriate people work in the home and is able to evidence how this judgement has been reached.

Medicines were handled safely and securely. Only staff that had completed training and competency assessments were permitted to administer medicine. At the current time, only the deputy manager was qualified to sign off these assessments. As such, on some occasions the deputy manager had felt compelled to attend the service when they were not on duty to either administer medicine or assess other staff as competent.

We saw that Medicine Administration Records (MAR) were completed accurately following administration of medicines. Each record contained a photograph of the person it related to, to ensure the medicine was given to the right person. Two people with different insulin regimes were monitored well and there was clear guidance in place for staff. Plans had been agreed with the dietician. Medicines were audited and accounted for regularly. There was a system for recording the receipt and disposal of medicines to ensure that they knew what medicine was in the home at any one time. Staff also carried out regular audits of people's medicines and their medicines records. This helped to ensure that any discrepancies were identified and rectified quickly.

People were kept safe because there were systems in place to ensure that the environment was safely maintained and that people were protected from the risk of avoidable harm. A range of risk assessments had been completed in respect of each person who lived at the home. These clearly identified the risks that were relevant to them and how they were mitigated. For example each person had a Personal Emergency Evacuation Plan (PEEP) that detailed how they would be evacuated in the event of an emergency situation.

Relatives told us that they had no concerns about abuse at the home, because any incident of concern was reported and investigated promptly and transparently. One relative

Requires improvement

Is the service safe?

said they had been impressed with how open the home had been with them when an incident occurred between their family member and another person who lived at the home. People were safeguarded from abuse because the home had clear policies and procedures in respect of safeguarding people, with a flow chart of who staff should contact if they suspected abuse. All staff spoken with were confident about their roles and responsibilities in respect of safeguarding and said they would not hesitate to report any concerns. A review of the records in relation to safeguarding showed that any concerns were handled quickly and appropriately.

Requires improvement

Is the service effective?

Our findings

Relatives told us that they thought staff knew their family members well. Two relatives commented that staff managed complex behaviours well. A visiting professional told us that they believed staff to be competent in their roles.

Not all staff had the necessary skills and experience to meet people's needs. We observed staff throughout the day and noticed a significant difference in their competencies and how they engaged with people. We saw that some staff had an excellent knowledge of people and how to support them, but others did not communicate with or support people appropriately. For example, we observed that two members of staff repeatedly spent time with people who were unable to communicate verbally without engaging with them.

Staff told us that they had access to computer based learning which they completed regularly in areas such as fire safety, infection control and medication. No staff had received appraisals to date and it was not clear how staff were monitored to ensure that they were effective in their roles. The service's locality manager said that the organisation were in the process of introducing a staff appraisal system, but to date these had not occurred.

People had complex needs, including living with autism and non-verbal communication. Many staff had not received training in either of these areas. We read that some people's care plans referred to specialist communication methods such as Makaton or the use of pictorial aids and yet found that these were not routinely being used by staff. For example, the behavioural support plan for one person stated that staff should use a Picture Exchange Communication System (PECS) at all times. Staff spoken with had not been trained in the use of PECS and the deputy manager told us this was not currently being used. It was not clear how staff engaged with people who could not communicate verbally to understand their needs, choices and concerns.

The failing to provide staff with training to enable them to perform their duties is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had received regular supervision. A supervision is a 1-1 meeting between a staff member and their senior to discuss practice and training requirements. We saw the minutes for some of these meetings. Staff told us that they felt well supported by the management team and felt confident to raise any issues with them.

People's legal rights were not fully protected because their care was not delivered in the least restrictive way. Staff had a basic knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw evidence that the home had made DoLS applications for some of the people who lived at the home. The application for one person had been granted and the registered manager had completed monthly monitoring in line with a condition of the authorisation. Whilst staff were aware that these were in place, they were not aware of the principle of providing support in the least restrictive way. We observed restrictions around the home and whilst these had been considered in respect of health and safety risks, they had not been assessed in respect of the MCA. For example, kitchen cupboards were locked due to the identified needs of some of the people who lived at the home. For other people, they did not require this restriction and yet they had to ask staff for access. Similarly, communal toilets were kept locked because access to hand soap was a risk for one person. When discussed with management it was agreed that a less restrictive way of managing this risk was available.

This restriction or people's liberty was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the importance of gaining people's consent and we read that best interests processes had been followed where it was believed that a person lacked the capacity to make a decision for themselves. For example, where a person needed medical treatment. A best interests decision is where other relevant persons are consulted with in order to reach a conclusion as to whether the decision being made is right for the person who can decide for themselves.

People received a good range of food and drinks. We joined people in the dining room for lunch. The meal of Spanish omelette looked appetising and people enjoyed the food they were served. Staff told us that menus were drawn up weekly with each person making the choices for one day. We saw a file with an extensive library of photographs which staff explained were given to people so that they could make actively make choices about the meals they

Requires improvement

Is the service effective?

wished to have. The menu for the week was then displayed in the kitchen although it was noted that this was in a written format and as such it was not clear how meaningful this would be for the people living at the home.

Staff had a good knowledge of people's food and drink preferences, including their dietary and cultural needs. For one person we saw that efforts had been made to ensure that their choice not to eat certain meats was respected. We also read that these were documented in the care plans, along with details of any support people needed to eat and drink. Throughout the day we saw that people had access to drinks and snacks as they wished. People's weights were monitored and they received appropriate support to maintain a healthy lifestyle.

Staff ensured that people had access to external healthcare professionals and received the healthcare support that they required. We heard that people regularly attended health checks with their doctors, dentists, opticians and chiropodists, although records of these appointments were not always fully documented. We also found information in care records to show that where a professional had given specific advice, such from the dietician for a person with diabetes, this had been discussed with the person and incorporated into a support plan for them.

Requires improvement

Is the service caring?

Our findings

Relatives told us that they thought staff were caring and treated their family members with kindness. One relative commented "Staff are very caring and [person's name] seems genuinely settled here." Relatives said they could visit at any time and were always made to feel welcome.

However we found that people did not always experience support in a caring way. We observed some very compassionate care, but also saw several examples of poor practice in which staff were not respectful in the way they engaged with or talked about people. For example, one member of staff repeatedly used language which indicated a "them and us" culture. When discussing continence issues or supporting people to be more independent they described people as "Lazy" and made comments such as "The thing about these people is they're lazy, if you do things for them they'll let you." Similarly, written records were not always respectful about people. In one person's daily notes we read "[person's name] urinates on the floor if he can't get what he wants". There was no recording about what the person wanted or how they were supported in relation to this unmet need.

During the day we observed long periods of time when people received little engagement or acknowledgement from staff. One person spent a large amount of time during the morning looking out of the dining room window. Whilst it was recognised that the person liked to watch the birds, staff were in and out of the room but did not engage with the person about their occupation. At lunchtime, only the deputy manager spoke with people and encouraged them to interact. Staff ate with people, but once they had finished their meals, they got up without a word and left the table. One person was left alone to finish their meal. As the last member of staff got up, they placed a jug of drink next to the person still eating and walked out of the room without speaking. It was not until another staff member re-entered the room five minutes later and prompted the person to help themselves to the drink that they poured themselves a glass.

Some staff did not always promote people's privacy and dignity. For example, we overheard an exchange about a person's continence taking place between two staff in the communal lounge where other people were present. By contrast we observed another staff member actively protecting a person's privacy when they were in state of undress.

Failing to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we saw that people's religious beliefs had been explored, staff had not always made adequate attempts to support them to attend a chosen place of worship. For example, the care plan for one person identified that they enjoyed visiting the local Mosque on a Friday for weekly prayers, but had not done so for a long period of time. Staff confirmed they were aware of this and that the person used to attend with a former member of staff that was also a practising Muslim. The person's father had offered to accompany the person with a staff member, but this had never happened. Staff were not able to tell us why this had not occurred.

We also saw some good practices and the music session held by staff in the morning was highly interactive and staff worked hard to get everyone involved. Another person also displayed some behaviours that challenged the staff member supporting them and this was handled calmly and sensitively to the person's needs.

Care records showed that the home had a system for providing 1-1 meetings with people and their key worker. A key worker is a named person that is allocated to support a person and oversee the person's care on a regular basis. The notes from these meetings however showed that these had not been consistently completed for people this year. The provider had identified the gaps in one of their audits, but improvements in the recording of these sessions had not yet occurred. Due to the complex communication needs of people, these individual sessions were an important way of involving them in discussions about their care.

Each person had their own room and people had been supported to personalise their space as they wished. We saw that bedrooms reflected people's individual interests. Staff said that people were supported to keep their own rooms clean and tidy. We observed this to be the case for

Requires improvement

Is the service caring?

one person who was assisted to clean their room during our visit. One relative commented that they thought their family member may benefit from additional support in this area.

Staff told is that people were free to get up and go to bed as they wished. We saw that people were enabled to follow their own routines during the day. We also noticed that if a person expressed a wish not to participate in a particular activity then this was respected by staff.

Requires improvement

Is the service responsive?

Our findings

Relatives told us that they thought their family members were kept occupied and that overall received the support they needed. Staff spoken with said that they thought some people got bored and that more work was needed on finding meaningful activities.

People did not always have access to activities that were meaningful to them. Despite people having opportunities to participate in trips out and in-house sessions, activities were not wholly person-centred and based upon people's known interests and goals. For example, the lists of likes and dislikes detailed in people's care plans did not match the activities people actually did. For one person, their care plan stated that they enjoyed going to the Mosque and water sports. During the inspection we observed this person watching the lunch being prepared from outside the kitchen for a period of 80 minutes. The recorded activities for this person during August were listed as 24 local walks, personal shopping, meal at McDonalds, house shopping, bus to Crawley and a bus ride. Staff said they found it difficult to engage the person in other activities, but there was no evidence that other things had been attempted. Similarly, another person's care plan included a list of activities they enjoyed, such as visiting the leisure centre, bowling, cinema, walks on the farm and a wet shave at the barbers. With the exception of bowling, there was no record of the activities having recently occurred. Staff told us they thought people's access to meaningful activities could be improved.

One person went out for breakfast with a staff member which they reportedly enjoyed. On their return to the home however, they were left for the remainder of the morning with limited interaction from staff.

We saw for one person that they had a very structured activity timetable. From the information recorded about this person and feedback from their relative and staff about the person's needs, it was evident that this worked well. We also saw that the person had a visual aid to assist their understanding of when certain activities would happen. The person had 1-1 support and was occupied throughout our visit.

People's needs had been assessed, but information was not always used to provide support that was person centred. Each person had a detailed plan of care which outlined their support needs and the support they needed from staff. Care records provided a lot of information to staff about what was important to people, their likes, dislikes and daily routines. Information had been regularly reviewed and updated. It was however identified that information was recorded in different places and as such some parts of the care plan contradicted other records. For example, the morning routine for one person provided different information to that contained in their behavioural support plan. Health care plans did not tally with the medication care plans. Staff did not follow communication care plans and staff gave different views as to whether it was the care plans that were wrong or that they weren't followed because people had not been trained to use the systems in place.

People had a list of goals recorded, some of which were recent, others which had not been updated for several months. In each case, goals were not being effectively monitored and staff were not aware of what they were or how to support people to achieve them.

These gaps in providing person centred care that is responsive to people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that staff managed people's complex behaviours well and the low number of incidents between people supported this view. We saw that each person had comprehensive behavioural support plans. During the inspection, we saw that these guidelines were used effectively and behaviours that caused challenge were de-escalated quickly.

Relatives told us that they hadn't needed to complain, but that they would feel confident to raise any concerns if necessary. The home had a complaints policy and procedure and we saw that any complaints had been acknowledged and investigated in accordance with it. No complaints had been received from people who lived at the home. Staff said that they could tell if people were unhappy about anything and took action at the time to deal with this. We discussed with the management team whether the complaints procedure in its current format was sufficiently accessible to the people who used the service.

Requires improvement

Is the service well-led?

Our findings

Relatives spoke highly of the management team and said that they were kept well informed about their family member.

We saw examples of good and poor practice during our visit and what was apparent was that there was a lack of overall leadership and direction within the home. The quality of care provided appeared to be dependent on individual staff, rather than a definite steer from the registered manager. We also saw a difference between the information recorded about people and the support that was actually being provided.

Whilst staff felt that they were provided with training and support to do their jobs, their conduct and performance were not always being effectively monitored by the registered manager to ensure they delivered care in line with the organisation's values.

The provider had a range of audit tools, but due to some changes within the organisation, these had not always adequately led to actions being checked. Audits had identified gaps in record keeping, but these had not yet translated through to improvements being made. For example, gaps in staff recruitment records had been highlighted, but the information had still not been made available in the home. Similarly, provider audits had recognised that keyworker meetings had not occurred monthly in line with the organisation's policy and yet these were still not being fully completed at this frequency. In some areas such as privacy and dignity, the management oversight of the home had not identified these concerns.

The lack of effective governance systems was were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture of the home was open and there were systems for people, relatives and staff to provide feedback. Relatives said they were contacted regularly and always invited to their family member's care reviews. We saw that residents' meetings had been held in which people had raised issues such as activities, maintenance and holidays. As a result of this feedback, a day trip to a theme park had been organised and new flooring had been agreed.

People had also recently completed a satisfaction survey and the provider was in the process of setting up a 'People's Parliament' which would look at the issues raised within the survey and provide a platform for feeding back to people on the actions taken. A representative from Ambleside Lodge had already been identified to sit on this group.

Staff had opportunities to provide their feedback, both individually through the supervision system and also collectively at staff meetings. We saw that staff meetings were recorded and discussed topics relevant to people's roles. The locality manager said that the provider was in the process of implementing the appraisal system. The registered manager and deputy manager have recently completed training to enable them to complete assessments for new staff undertaking the Care Certificate.

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 for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not always ensured that there were sufficient numbers of staff on duty to keep them safe at night.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to provide staff with the necessary training to perform their roles effectively.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had placed unnecessary restrictions on people's liberty of movement.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person had failed to ensure that all staff treated people with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not ensured that care and treatment was delivered in a person centred way to meet people's needs.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not effectively used its quality assurance systems to monitor and improve the quality of care provided.