South Coast Nursing Homes Limited

Abundant Grace Nursing Home

Inspection report

Abundant Grace House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Abundant Grace on 22 and 23 January 2018. At the previous inspection in November 2016 Abundant Grace was rated 'requires improvement'. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation to the systems and processes to assess and monitor the quality of the services provided and people's records were not always accurate and complete. We also found areas of practice that required improvement. This was because risks to people's pressure area care were not always well managed, and aspects of medicine management in relation to crushed medicines and topical creams were not clear. Also, best interest meetings had not always been completed when specific decisions were made. The service received an overall rating of 'requires improvement'. The provider sent us an action plan to tell us what they would do to meet the legal requirements in relation to these breaches.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan and confirm that the service now met legal requirements. We found improvements had been made and the provider had met the legal requirements. However, we identified some areas needed further improvement and other areas need to be fully embedded into practice. The overall rating for Abundant Grace remains requires improvement.

Abundant Grace is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Abundant Grace provides nursing and personal care and accommodates up to 67 people. At the time of the inspection there were 64 people living at the home. The home is modern and purpose-built over two floors. People who lived at the home had a range of complex health care needs which included people who have had a stroke and diabetes. People on the first floor were living with dementia and some of these also had complex healthcare needs. People required varying levels of help and support in relation to their mobility and personal care needs.

The manager registered with CQC is no longer working at the service. 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. At the time of the inspection there was a manager in post but they had not yet registered with CQC. The manager had knowledge of the service, and was being supported by the directors.

People did not always receive the person centred care they needed. One person had not received care that met their individual needs. However, other people received care and support that was personalised. They were supported to make choices and receive the care and support they required.

We found improvements were needed to ensure the quality assurance systems were consistently effective.

Staff had not received regular supervision. Although this did not impact on people it meant the provider did not have oversight of staff developmental and support needs.

People and their relatives were regularly asked for their feedback through meetings and surveys. The provider responded appropriately to resolve people's concerns and improve their experience at the home. Complaints had been recorded, investigated and responded to appropriately.

People and relatives felt people were safe. Risk assessments were in place and used to assess potential risks and to respond to them appropriately. Staff had a good understanding of the risks associated with the people they supported. The home was clean and tidy. The environment and equipment were well maintained to ensure safety.

There were enough staff on duty to meet people's needs. Appropriate checks were completed to ensure suitable staff were employed to work at the home. People were protected from the risks of harm, abuse or discrimination. Staff received regular safeguarding training and told us what actions they would take to protect people from harm.

People were cared for by staff that had received training and had the skills to meet their needs. People's health was monitored and responded to. They had access to health care services to maintain their health and well-being.

Staff had a good understanding of the Mental Capacity Act 2005. Deprivation of Liberty Safeguard and assessments had been made to determine peoples' capacity. Appropriate referrals were made to the local authority if people needed to be deprived of their liberty to ensure their safety and well-being.

People were supported by kind and caring staff who knew them well. They had a good understanding of people's needs and choices. They were able to tell us about people's personal histories and their individual interests. Visitors were made to feel welcome at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Abundant Grace was safe.

Risk assessments were in place and helped to keep people safe.

Systems were in place to ensure medicines were managed safely.

There were enough staff on duty to meet people's needs. Appropriate checks were completed to ensure suitable staff were employed to work at the service.

People were protected from the risks of harm, abuse or discrimination.

The environment and equipment was well maintained to ensure safety. Risk assessments were used to assess potential risks and to respond to them.

Is the service effective?

Good

Abundant Grace was effective.

People were cared for by staff that had received training and had the skills to meet their needs.

Staff monitored people's nutritional needs and people had food and drink that met their needs and preferences.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People's health and well-being needs were met. People were supported to have access to healthcare services when they needed them.

Is the service caring?

Good

Abundant Grace was caring.

People were supported by staff who were kind and caring.

People's privacy and dignity were respected and their independence was promoted.

People were supported to make their own decisions and choices throughout the day.

Is the service responsive?

Requires Improvement

Abundant Grace was not consistently responsive.

One person had not received care that was person centred and met their individual needs. However, other people received care and support that was personalised to their needs and choices.

Complaints had been recorded, investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

Abundant Grace was not consistently well-led.

Improvements were needed to ensure the quality assurance systems were consistently effective.

There was a positive culture at the home. Work was on-going to improve and develop the service.

Abundant Grace Nursing 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.

This inspection took place on 22 and 23 January 2018 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we reviewed the records of the home. These included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' people living at the home. This is when we check that the care

detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

During the inspection, we spoke with 12 people who lived at the home, eight visitors, and 19 staff members, this included the manager and two directors. Following the inspection we contacted four health and social care professionals who visit the service for their feedback.

We spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We watched how people were being cared for by staff in communal areas and this included the lunchtime meals.

Good

Is the service safe?

Our findings

At the last inspection in November 2016, we found areas of practice that needed improvement. This was because risks to people's pressure area care were not always well managed, and aspects of medicine management in relation to crushed medicines and topical creams were not clear. At this inspection, we saw that improvements had been made.

People and their relatives told us they felt safe at Abundant Grace. One person said, "I feel safe, it's a safe place for me to live," another told us, "The staff are very good they check on me regularly so I feel safe and they always look out for me." A visitor said, "I feel he is safe here, if we have any concerns they are always sorted."

People were protected against the risk of abuse. There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm or discrimination. Records showed staff received safeguarding training and regular updates. Staff spoke with us about abuse and what actions they would take if they suspected abuse had taken place. Staff were confident that any concerns they reported to senior staff or the manager would be addressed appropriately. One staff member said, "There's nothing untoward happening here." Another staff member told us, "Anything like that we'd report straight away." We were given an example of when concerns had been reported to the local safeguarding team. Documentation showed that the provider worked openly and transparently with the safeguarding team in respect of any investigations. Staff told us they were told about any safeguarding concerns and this included what actions had been taken to ensure improvements were made and lesson's learned to prevent a reoccurrence.

There were a range of risk assessments in place and these included, pressure area risks, mobility and falls. At our last inspection improvements were needed to ensure people's pressure area care was well managed. We found improvements had been made and people received the appropriate care. Risk assessments and care plans included information about the care people needed. This included regular changes of position and the use of pressure relieving equipment such as air mattresses or cushions. Air mattresses were set in accordance with people's weights and these were regularly checked and recorded. There was guidance for staff about how to support people with their mobility such as any equipment that may be required and how many staff to provide safe care, for example when a person was moving from the chair to the bed. Throughout the inspection we saw staff supported people safely.

Appropriate action was taken following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up actions to prevent a re-occurrence. Any subsequent action was analysed and shared with staff to identify any trends or patterns.

There were a range of health and safety checks in place. Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs and the assistance required in the event of an emergency evacuation. These needed more detail about where people should exit the building. The deputy manager was aware and in the process of updating the information. Regular fire safety checks were completed. There was an ongoing maintenance program and work identified was

addressed in a timely manner. There were regular servicing contracts in place, for example the gas, electrical appliances, lifts and hoists and water temperature.

There were enough staff to support people safely. However, during the inspection the manager acknowledged the preferred staffing levels had not been met due to staff sickness. Where possible the manager arranged for regular staff to work an extra shift to cover the shortage. They explained that if necessary they would use agency staff but often it was easier to work with less staff who knew people well. Staff told us they were busy and the shortage of staff meant they were not able to spend time sitting and chatting with people. One staff member said, "We just work harder to make sure people get all their care. It is frustrating not having enough of us today but we would never let that affect people." We received mixed feedback from people about the length of time it took to answer calls bell. Comment's included, "Sometimes pretty quick, sometimes not so quick." "They come quite quickly in answer to call bell." "It depends how busy they are" and, "They answer the bell as quickly as they can." Throughout the inspection staff attended to people's support needs in a timely way. However, it was acknowledged that on occasions people had waited longer for attention. If for example, a number of call bells had rung at the same time. Where people required one to one support this was provided at all times, as staff who provided one to one support were not included in the staffing numbers. The manager told us there were changes planned for the staff team. This included the appointment of more senior care staff and one nurse would become clinical lead and work in addition to the two nurses, for support and guidance. Further recruitment had taken place to support these changes.

There were safe recruitment processes in place. Staff files included all the relevant information to ensure all staff were suitable to work in the care environment. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and each member of staff had a disclosure and barring checks (DBS) to ensure they were safe to work within the care sector. Nursing and Midwifery Council (NMC) registration information had been recorded and there were regular checks to ensure nurses had maintained their registration with the NMC which allowed them to work as a nurse.

Medicines were managed safely. At our last inspection improvements were needed to ensure people received their crushed medicines safely and topical creams were consistently applied. Crushing medicines may alter the way they work and make them ineffective. We saw guidance was sought from a pharmacist before medicines were crushed. Where people required topical creams there was information in people's care plans about when and where this was required. Records showed when creams had been applied. Medicines were ordered, stored and disposed of appropriately. The nurses gave people their medicines. They received regular training and competency checks to ensure they had the appropriate knowledge and skills. Medicine administration records (MAR) charts showed the medicines people had been prescribed and when they should be taken. Medicines were given to people individually and nurses signed the MAR after the medicine had been taken. The MAR were well completed and demonstrated people had received their medicines as prescribed.

Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. One person said, "I get my medicines at 6.00am and 6.00pm; the nurse explains what they all are. If I am having trouble with my hip then I can have extra pain killers during the day." Throughout the inspection we observed people receiving their PRN medicines when they needed them. Where people receive PRN medicines individual protocols are required. These should include why the person has been prescribed the medicine, when it should be taken and what action to take if the medicine is not effective. We found the protocol for one person was not in place but this was addressed immediately. The nurse told us previously they had not written protocols for people who received

respite care however; these will be done in the future. This was confirmed by the director and manager. MAR were checked regularly to ensure they were fully completed. If any medicine errors occurred these were reported to the management team, discussed with the nurse and additional training would be provided.

People were cared for in a clean, hygienic environment. The home and its equipment were clean and well maintained. One person said, "Staff do the cleaning once a day, they do it to a good standard." Another told us, "Cleaning is excellent, they come in every day to do the bathroom and a couple of times a week to dust and clean the windows." There was an infection control policy and other related policies in place. Protective Personal Equipment (PPE) such as aprons and gloves were available. We observed that staff used PPE appropriately during our inspection. Hand sanitisers and hand-washing facilities were available throughout the home. The laundry had appropriate systems and equipment to clean any soiled washing. Regular infection control audits were completed and these showed where areas for improvement were identified then action was taken to address these. Further checks took place to ensure the work had been completed.

Good

Is the service effective?

Our findings

At the last inspection in November 2016, we found areas of practice that needed improvement because best interest meetings were not always in place when specific decisions were made. At this inspection, we saw that improvements had been made.

People were supported to receive effective care because care was delivered in line with current legislation, standards and evidence based-guidance. Staff received appropriate training and support to enable them to meet people's needs. One person said, "I am very well looked after by the excellent staff." A visitor told us, "The staff use the hoist very confidently and appear very well trained." When staff started work at the home they completed an induction which included training in relation to safeguarding, moving and handling, infection control and equality and diversity. Staff shadowed other staff and had a continuous review of their performance. They completed a workbook which was signed by the manager to demonstrate their competence to work unsupervised. Staff who were new to care completed the care certificate. This is a set of 15 standards that health and social care workers follow. It helps to ensure staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

All staff received training updates each year. These included moving and handling, health and safety, dementia and fire training. Care staff and nurses told us that in addition to the regular training further training would be provided to help them meet the needs of people who lived at the home. Staff gave us examples of having received training in relation to catheter care, syringe drivers, continence and diabetes. Nurses told us they received all the clinical support they needed to ensure they had the appropriate knowledge and skills to support people and to keep their practice current and evidence based. Staff had a good understanding of equality and diversity. They were supported by training and policies. They told us they were confident people's equality, diversity and human rights would always be protected.

There was a supervision programme in place but this had not been followed. Staff told us and records showed staff had not received regular, formal supervision. Staff told us this did not impact on them because they could always speak to someone more senior if they required support. One staff member said, "It would be quite nice to have supervision I suppose but for me it doesn't matter, there's plenty of people (staff) here you can talk to." Another staff member said, "If I have any problems I can always talk to someone. (Director) is always around." Staff gave us examples of when they had sought support and they had received it appropriately, both professionally and personally. A staff member told us, "We might not have had supervision but we're always supported. The nurses are always asking if we're alright. Just walking in the corridor and someone will ask." Staff were also confident that if they identified training requirements for themselves or colleagues they would receive the appropriate support. The director told us they had identified that supervisions had not taken place and reminders had been sent out to staff to address this.

People were supported to have enough to eat and drink. They were provided with a choice of meals which were freshly cooked each day. People's comments included, "I have breakfast in my room; the food is good you get a choice." "I generally have my dinner in my room, I have no complaints about the food it's pretty

good, I have a cooked breakfast" and, "I have most of my meals in my room but sometimes go to the dining room."

Meals were well presented to encourage people to eat and drink. Dining tables were set with napkins, condiments and people were given a choice of drink at each meal and throughout the day. Menus were displayed on each table to remind people what was available to eat. Meals were served fresh to each person and people were asked which vegetables they would like and these were served with their preference of portion size. Staff were available to support and encourage people where ever they chose to eat. Staff were not rushed, they allowed people time to eat at their own speed with the correct approach being used. For example, they sat with people, maintained eye contact and engaged with them throughout the meal. Where appropriate staff encouraged people to eat independently but observed and prompted people who required further support. People were offered a choice of hot and cold drinks and snacks throughout the day. This included, biscuits, cakes, fruit and yogurts.

Nutritional assessments were in place which ensured people received the type of diet they required, for example pureed or soft. Staff monitored people's weights and if people lost weight or had difficulty swallowing professional advice was sought and followed. Food and fluid charts were completed daily. This helped staff to identity people who were at risk of not eating or drinking enough and could ensure appropriate action was taken.

People were supported to maintain good health and received on-going healthcare support. Staff were attentive to changes in people's health. One person told us, "These last few weeks I've had the flu, now I'm feeling better the nurse suggested she made me a nice hot lemon and honey drink to help soothe my throat, nothing is too much trouble." Where needed staff ensured referrals to appropriate professionals, such as the GP, were made appropriately and in a timely way. People told us they were able to see their GP when they needed to. One staff member told us about a person who was unwell. They said the person's mood had changed and they were behaving in a different way than usual. They told us, "I knew something wasn't right but I didn't know what. I told the nurse and the doctor has visited. (Name) has got a urine infection." The nurses had a good understanding of people's health needs and how to ensure people remained healthy. For example, they knew how to support people with diabetes, they were aware of the medicines people required and the normal blood sugar range. One visitor told us, "(Name) has been rushed to hospital several times due to a drop in blood pressure, they have altered his medication and need to keep fluids up so they are now keeping a good eye on it and taking his blood pressure regularly."

Records and discussion with staff confirmed they regularly liaised with a wide variety of health care professionals. This included the speech and language therapist (SaLT) and tissue viability nurses. A team of care staff were responsible for ensuring routine and regular appointments were organised and people saw a dentist, optician and chiropodist when needed. They arranged transport for each appointment and made sure people had an appropriate escort for each appointment. One person said, "Sometimes I have to go to Eastbourne Hospital, the home organises transport and I get accompanied." Referral, feedback and information from healthcare professionals was stored in people's care plans and was available to staff for reference and information. Healthcare professionals told us they received appropriate referrals from staff. Staff listened to the advice and guidance provided and this was followed to ensure people received the support they needed.

Abundant Grace was a purpose built home over two floors. A passenger lift allowed level access. The communal walk ways were laid out in a 'racetrack' style. This meant people who liked to walk could do so without encountering barriers. The corridors were wide enough to allow and encourage this. They also allowed easy access for people who used wheelchairs. There was seating around the walk ways were people

could stop and rest as they wished. We saw these were well used. There was level access to a secure garden and people and staff told us this was well used in the summer time. One person said, "In the nice weather I go out my door and walk around the garden a couple of times to get my daily exercise. If the weather is bad I do the same only inside, I do a couple of circuits of the rooms." Bathrooms and toilets had been appropriately designed to support people to maintain their independence and allowed enough space for people who required support from staff. Bedrooms were spacious and allowed people the opportunity to spend time alone with their visitors. People chose to spend time with other people in the communal lounges. There was also an activity room, this was seen to be popular and busy, a place where people enjoyed spending their time. The provider had recognised that this room was now too small and in the future needed to be adapted to meet people's needs.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They received regular training and told us how they supported people to make their own decisions and choices. 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. Where people lacked capacity and best interest decisions were required these had been made through discussions with people, their representatives, staff and health and social care professionals. These decisions were recorded to ensure everybody was aware of how the decision had been made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. At the inspection the management team had identified when people were not able to make specific decisions around their care and treatment that could restrict their liberty. They had made appropriate applications to the local authority for a DoLS. These safeguards ensure any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring. One person said, "Staff do that bit extra, when the night staff come in they do not wake me but leave a note saying for example 'have a lovely day'." Another said, "Whatever I want I just ask and it's done." Other comments included, "I get on with all of the staff," "They certainly look after you" and "Overall I think they do the best they can."

Staff knew people well and had a good understanding of people's needs. One visitor told us, "The staff know (name) well they have a good rapport with him." Another said, "The carers have made a lot of effort to get to know (name)." Throughout the day, we observed sociable conversation taking place. Staff spoke to people in a friendly and respectful manner. Throughout the inspection we saw staff stopping to speak with people, using their chosen name and acknowledging them when they entered a room. Staff gave people eye contact and spoke to them in a manner that was appropriate to each individual. They greeted people with a smile and spoke to them in a cheerful voice. This helped people to feel relaxed in the home and with the staff who were supporting them.

Peoples' equality and diversity was respected. This was based on people's choices and staff understanding of who was important to the person, their life history and where appropriate their spiritual and cultural background and sexual orientation. People told us they made their own choices throughout the day. One person said, "The staff suggest when I get up but I could lie in if I wanted." Another told us, "I quite often get up for breakfast then go back to bed for a longer lie in. I like to go to bed early, when I am tired I just ring the bell and the carers come and help me get to bed usually about six o'clock."

People were supported by staff to maintain their personal relationships. Relatives were welcomed at the home and were able to visit whenever they wished. We saw visitors were regularly at the home and visiting people throughout the inspection. People were asked about whether they would prefer male or female care staff to support them and this was respected. Staff acknowledged people's preferences changed. One staff member told us, "Some people prefer not to have male carers but sometimes when they get to know them then they change their mind."

People's privacy was respected. Throughout the inspection we saw staff knocking on people's doors before entering. One person told us, "Everybody knocks before they come in then they slowly open the door. I like my door closed, occasionally they forget to close it when they go out so I have to get up and close it myself." Another said, "They (staff) always knock before they come in." People were supported to spend time with their relatives and visitors in private if they wished. We saw some people had their doors shut and staff explained this was because they had visitors and did not want to be disturbed.

People were clean and well dressed in clothes of their own choice and style. They were supported to maintain their individuality, their personal hygiene and appearances. Staff told us how they supported and encouraged people to maintain their hygiene when they chose and this helped promote people's dignity. One person told us, "Personal care is very discreet and they always knock on the door before they come in." Another said, "I have a strip down wash every day and on Friday I have a bath with all the bubbles and

coloured lights." A further person told us, "I shower every day, the carers are always very discreet."

One staff member told us how they enabled one person to have an enjoyable bathing experience. They told us, "We use the spa bath and (name) likes to take have a cup of tea in there with them. You can see (name) lay back and really relax." People's bedrooms were personalised with their belongings such as personal photographs and mementos. This helped to make people's bedrooms individual and homely. This also provided staff with a point of reference for conversation and gave people a sense of identity.

Requires Improvement

Is the service responsive?

Our findings

Most people and their visitors told us people received care and support that was person-centred and met their individual needs. People, and where appropriate visitors, told us they were involved in decisions about their care. However, we identified one person had not always received care and support that met their individual needs and preferences. There was information in the person's care plan about their dietary preferences however; this information had not been shared with the chef. This meant, on occasions, this person had not been given the full dietary choices offered to other people. This person was unable to communicate verbally. Staff were able to communicate with the person through simple questioning and the use of body language. However, this was reliant on staff asking questions of the person. There was no communication care plan in place. Alternative means of communication had not been considered to help the person independently express their needs. From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. This had not been followed in relation to this person. We identified this to the director and manager as an area that needed to be improved. Once this had been identified immediate steps were taken to address the concern. An appointment had been made for the person and their relative to discuss dietary choices with the chef and a full care plan review was to take place. We recommend the provider reviews staff training in relation to the AIS.

Despite these concerns other people received care and support that was personalised to their needs and choices. People told us they were provided with choices in relation to their food. One person said, "There's too much food, the food is excellent. There's always a choice and they will always make you something different if you don't like the choices like an omelette." Another person told us, "The food is very good, there's a lot of variety. I have a different meal every day and the portions are good." One visitor told us they had eaten at the home over Christmas and the food was "excellent." The visitor told us their relative was offered a choice every day and alternatives were provided if they didn't like what was on the menu.

We also observed examples of good communication. One person who was not able to communicate verbally left the dining room during their meal. Staff in the dining room were busy therefore we alerted another staff member. They attended the person and asked what they wanted. The person took the staff member by the hand and led them to their bedroom where they sat in a chair. The staff member asked the person if they would prefer to eat their meal in their bedroom. The person nodded in agreement. The staff member explained the person did not like noisy situations and the dining room was noisy that day. This information had been recorded in the person's care plan.

Before moving into the home the manager or nurses completed an assessment, this ensured people's needs could be met at the home. Information from the pre-assessment was then used to develop care plans and risk assessments and these continued to be developed when people moved into the service. Care plans contained information about each person, their life story, individual personality, preferences and interests. They recorded people's healthcare needs and the support required to meet those needs. For example, care plans contained information about how to support people with diabetes. This included the medication the

person had been prescribed and regular blood sugar monitoring. Care plans contained guidance for staff on how best to support each individual. Reviews took place regularly. Care plans were being reviewed because the provider had identified not all care plans were person centred. This did not impact on people because staff knew them well and were able to tell us about each person, their care and support needs, choices and interests. Staff responded to these needs, for example, staff ensured people's positions were changed regularly to prevent them developing pressure damage, they assisted people to maintain their continence, and supported them to move safely around the home.

There was a busy activities programme with a range of activities taking place each day. People were supported to engage in activities by a dedicated activity staff team who worked each day. There was an activities room where art and crafts and various other activities took place throughout the inspection. People told us they were able to join in activities as they wished. Their comment's included. "I like to join in with as much as I can, one of the main things here is enjoying what's going on." "Each Monday I go to the lounge for armchair exercises." "The activities lady comes round and asks if I want to join in. I generally join in with bingo, scrabble, jigsaws and table tennis," and "I watch television and read and join in with the exercises, the physio comes on Monday and one of the staff does exercises with me the rest of the week." Some people chose not to join in with the group activities. One person told us, "I like to stay in my room and listen to classical music." Throughout the day we saw people reading their newspapers, doing jigsaws, knitting and generally chatting over a cup of coffee. Some people chose not to and others were unable to join in with group activities. Therefore they were supported to enjoy one to one activities.

A recent survey and resident meeting had identified some people were not happy with the amount of one to one activities provided. As a result of this there had been a change to activity staff roles, with one activity staff member being responsible for one to one activities each day. There were records to show when people had engaged in one to one activities. However, the manager and director acknowledged this would take longer to become fully embedded into practice and ensure everybody had the opportunity to take part in what they enjoyed.

People and their representatives were regularly asked for their feedback about the service. There were regular resident meetings which relatives could attend if they chose. People were able to raise any issues and were also given information about changes at the home, such as the manager change and review of previous identified issues. There were also regular feedback surveys to identify people's wishes or concerns. We saw action was taken to address these. There was a complaints policy in place. The manager had identified that on occasions people would raise concerns. Although these were not formal complaints and action was taken they had not been recorded. Therefore she had introduced a system to record these concerns and give an overview of issues raised. This would help prevent concerns escalating to formal complaints and also provide an overview of issues raised which could be used to improve and develop the service. There was a complaints policy in place and people told us they knew how to make a complaint if they needed to. One person told us about a complaint they had made and how they had been involved in the resolution of the matter. People told us they were happy to raise any concerns. One person said, "I would be happy to complain if I needed to, I would complain to matron (the manager)." Another person told us, "If I'm not happy about anything I go to the relevant person and tell them and it is sorted straight away." A visitor said, "The staff are all very approachable so I would have no problem if I had to make a complaint."

Some people required end of life care and staff supported them to maintain a comfortable, dignified and pain free death. Staff were aware of changes to people's health and comfort. Appropriate support and treatment was sought in a timely way when needed. People's medication was regularly reviewed to ensure each person was comfortable. Staff were aware of people's spiritual and cultural needs at the time of their death and these were respected. Care plans reflected the person's wishes were and were completed as far

as possible with people and their families. However, staff were mindful of people's wishes if they chose not to discuss this.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2016 the provider had failed to ensure there were effective systems and processes to assess and monitor the quality of the services provided and, had failed to ensure people's records were secure, accurate and complete. At this inspection we found some improvements had been made however, further improvements are required to ensure these are fully embedded into practice.

There was no registered manager at the service. The previous registered manager had left in September 2017, since that time there had been managers in post who were supported by the directors. These managers had also left the service. A new manager and deputy manager had recently been appointed. They already worked for the provider and knew the home, having worked there previously. The manager had been working at Abundant Grace for two weeks prior to the inspection.

The provider had identified in September 2017 that staff supervisions had not taken place regularly. A memo had been sent to staff to remind them of their responsibilities. Some supervision had taken place as a result but not every staff member who needed supervision had received it. The provider had changed the supervision process and forms to complete. We found the policy had not been updated to reflect this and staff had not received the appropriate training to either deliver or receive supervision. Staff told us this did not impact on them because they felt supported by their colleagues, the managers who had been in post and the directors. However, this meant the provider had not fully identified the training and support needs of staff because supervision was not in place. We saw a supervision record where issues had been identified. This had been discussed with the staff member but had not been followed up. The director told us of actions they had taken and conversations held to address the issue but this had not been recorded.
We saw there were sensor mats throughout the home. Some of these were in place for people who were at risk of falls and appropriate assessments were in place. However, we were told some were in place to alert staff if another person entered their bedroom. Although there was no evidence of any impact these could present a trip hazard. In addition there was no rationale for why these were used and no evidence alternative options had been explored. We recommend the provider review the appropriateness of these systems. We identified these as areas that need to be improved.

The director had commenced an audit of the care plans and identified work was needed to ensure the care plans were person centred. Therefore they had stopped the audit and concentrated on reviewing all the care plans in depth. However, the audit had failed to identify one person did not have a care plan for all their needs. We discussed this with the manager as an area that needed to be improved.

The provider had introduced an electronic care planning system and all care plans were now recorded this way. Staff had access to care plans via a hand held device and recorded the care and support provided using this. These were secure and staff had varying layers of access dependant on their role. This meant staff only had access to information that was relevant to them. The directors told us the process had been time consuming and further time was needed to ensure all information was recorded in a consistent way. Work was on-going to promote and develop staff learning in relation to the system.

People, visitors and staff spoke highly of the manager. One person said, "I like the manager, I'm glad she is back, we had a good old talk yesterday." A visitor told us, "There's great communication, (manager) always answer any questions we might have." A member of staff added, "She is such a popular lady I think we're all glad she is back." Staff told us in the absence of a permanent manager they were always able to talk with a director. One staff member said, "(Name) is easy to talk to and always gets things done." Healthcare professionals gave positive feedback about the service. One said, "I am always happy to recommend Abundant Grace and confident that they are providing a very good service."

There was a positive culture at the home. Staff were open and honest and spoke to us freely. They were committed to proving good care and support and developing the service. One staff member told us they worked hard to ensure people received the care they needed. They said, "I go home every night, fulfilled." A visitor told us, "If (relative) is happy then we are happy, I leave each day in confidence." The manager recognised that staff had been through a period of change and the team needed to develop and grow. Changes had been made to the staff team which included two senior care staff on each floor each shift and a clinical lead nurse who would work to support the nurses on duty. Clear roles and responsibilities were being developed.

Staff told us they felt valued and involved in the home. They said they were often thanked for their hard work during handover and staff meetings opened with a 'thank you'. Staff meeting minutes demonstrated they were involved in the ongoing changes and development of the home. However, some staff told us they had felt unsettled by the lack of consistent management but were looking forward to positive changes. The manager was developing good oversight of the service. They were aware of most issues we raised with them and committed to improving the service and developing their own support networks within the wider community. For example, developing relationships with visiting healthcare professionals in order to share information and learning around local issues and best practice in care delivery.

There were a number of quality systems were in place and these included a variety of audits. These included medicine audits, health and safety audits and infection control audits. These were used to improve practice. For example, a recent infection control audit was completed and action points identified. The electronic care planning system allowed the audit process to be developed further in the future to identify trends and patterns. Provider audits took place three monthly. An action plan was in place to address any identified concerns with timescales for completion.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. We had been informed of significant events appropriately. The manager was aware of their responsibilities under the Duty of Candour. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong. The Duty of Candour is a regulation that all providers must adhere to.