W And J A Bishop Limited

The Abbey Residential Home

Inspection report

Town Street
Old Malton
Malton
North Yorkshire
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Tel: 01653692256

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Abbey Residential Home is situated next to the church in Old Malton. Accommodation can be provided for up to 24 people who require help with personal care; some people may be living with dementia. The service has 20 bedrooms; some can be used for shared occupancy but only one of them is currently used in this way. All of the bedrooms have en-suite facilities; 18 have an added bath and one has a shower. There are several communal rooms and seated areas for people to use.

The service had a registered manager in post as required by a condition of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We undertook this unannounced inspection on 6 and 7 July 2016. At the time of the inspection there were a total of 21 people living in The Abbey Residential Home. At the last inspection on 16 January 2014, the registered provider was compliant with all areas assessed.

We found people were provided with a safe environment. Staff knew how to safeguard people from the risk of harm and abuse and how to deal with any information of concern. Risk assessments were completed to help guide staff in how to minimise issues of concern such as falls.

Staff were recruited safely and deployed in sufficient numbers to meet people's current level of need. There was an issue raised about the tea time period, four days a week when staff felt stretched. This was mentioned to the assistant manager and they told us they would address this by ensuring one of two managers was available to help the staff team during this busy time.

We found people received their medicines as prescribed. Medicines were obtained, stored and returned to the pharmacy when no longer required. Staff recorded when medicines were received into the service and when they were administered to people. There were some minor recording issues and the need for protocols for medicines prescribed 'when required'. This was mentioned to the registered manager to address.

People's health and nutritional needs were met. We saw health professionals were involved and provided advice and treatment when required. People had their weight monitored and input from dieticians was sought when required.

People's needs were assessed and care plans formulated. These helped to guide staff in how to support people in ways they preferred. We found staff supported people to make their own decisions and choices. The registered manager was aware of the action to take and who to consult if they felt someone lacked capacity and a decision was needed about their care and treatment.

We observed staff approach was kind, patient and caring; there were very positive comments about the staff from people who used the service and their relatives. We saw staff respected people's right to privacy and treated them with dignity. The staff provided information to people so they could make choices, for example about their meals and what activities to take part in. Some people were very independent and could access the community independently; staff encouraged this and supported people to maintain the independent skills they had.

There was an activity co-ordinator who helped to plan meaningful activities; they made a record of who participated in them.

We saw staff had access to training considered essential by the registered provider and other courses which were more specific to the needs of people who used the service. The registered manager was currently completing a training analysis to see if there were any shortfalls which needed to be planned for in the coming year.

Staff told us they felt supported and we saw they received supervision and observation of their practice. This enabled staff to be developed in their role.

We found the environment was safe, warm and clean. Checks were carried out on equipment to make sure it was safe to use.

There was a quality monitoring system in place although we found this could be more structured and recording of shortfalls and actions taken to address issues could be improved. We have made a recommendation about this. The culture of the service was open which meant people felt able to raise concerns and complaints in the belief they would be addressed.

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

The service was safe.

Staff knew how to keep people safe from the risk of abuse and harm. They received training and followed guidance when required.

People received their medicines as prescribed. The medicines were managed safely and administered by staff who had received training and observations of their practice. There were some recording issues to be addressed.

Staff were recruited safely and they were employed in sufficient numbers to meet the current needs of people who used the service.

The service was clean and tidy.

Is the service effective?

Good

The service was effective.

People's health care needs were met and they were supported to access healthcare professionals when required.

People enjoyed their meals and their nutritional needs were met. The menus provided choices and alternatives.

People were supported to make choices about their care and treatment. Staff ensured they gained consent prior to carrying out care tasks. Staff were aware of best practice guidelines and current legislation when they felt someone lacked capacity to make their own decisions.

Staff had access to training, supervision and support which helped them to feel confident when supporting people.

Is the service caring?

Good

The service was caring.

Staff demonstrated a kind and caring approach. People

confirmed this in discussions with them.

Staff treated people with dignity and respect and were mindful of promoting privacy, choice and independence.

People were involved in decisions about their care and were provided with information to enable them to make choices.

Is the service responsive?

Good

The service was responsive.

People were provided with person-centred care which met their preferences and needs.

There was a range of meaningful activities for people to participate in and staff had been sensitive in responding to their needs.

The service had a complaints policy and procedure and people felt able to raise concerns in the belief they would be addressed. The recording of minor niggles would ensure there was evidence staff had responded to them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality monitoring system in place but it required more structure to ensure shortfalls were recorded and action planned. We have made a recommendation about this.

The culture of the organisation was open and transparent where people felt able to raise issues and make suggestions.

The registered manager had developed links with other agencies which enabled them to learn, share practice and training.

The Abbey Residential 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 registered 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 6 and 7 July 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

The registered provider had completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams and the local safeguarding team about their views of the service. There were no concerns expressed by these agencies. Following the inspection, we received information from one healthcare professional.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with seven people who used the service and six people who were visiting their relatives or friends. We spoke with the registered providers, the registered manager, the assistant manager, a team leader, four care workers and one member of staff who had multiple roles of activity co-ordinator, team leader and catering assistant.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 21 medication administration

records [MARs] and monitoring charts. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, minutes of meetings with staff, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the service and looked in communal rooms and bedrooms.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living there. They felt there was sufficient staff and told us they did not have long to wait when they used the nurse call to summon staff. People also told us they received their medicines on time and were not left waiting for them. Comments included, "I like it here, I don't think there is anything they can do better", "The staff are alright; yes, they do come quickly", "Yes, when I ring the bell it's okay; they come as quick as they can", "The call response is more or less quick; when you are poorly, they are there like a shot", "I could not wish for a better place", "They look after my tablets for me but I go to the doctor for an injection" and "Yes, I get my tablets when I need them."

Relatives spoken with were also positive about how well people were looked after. Comments included, "She is getting the care that she needs", "She has never complained about the staff and said they are all nice", "The home is always clean and fresh", "Staff are always there if you or your family need one" and "It's a lovely home and we know [Name] is safe here; all the family have said so."

We found staff knew how to keep people safe from the risk of harm and abuse. Most staff had completed safeguarding training although some were due for a refresher course. In discussions, staff were able to describe the different types of abuse and the signs to look out for that may alert them to concerns. They knew how to raise concerns with the registered manager or other agencies. The registered manager and assistant manager had completed safeguarding training specifically for managers and they knew how to deal with safeguarding alerts and who to contact for advice. Risk assessments were completed to help guide staff in how to minimise risk whilst at the same time ensuring people were able to make their own decisions and choices about aspects of their lives.

There was a system to manage people's personal allowance when this was deposited in the service for safe keeping. Most people managed their own monies or where assisted by their relatives. There was a lockable facility in each person's bedroom for them to store personal items if they chose. The system helped to safeguard people's monies and items from misuse.

We found there were sufficient staff on duty to meet the current needs of people who used the service. There were approximately nine to ten people who had minimal needs and only required limited assistance or supervision. Staffing rotas showed there were two care staff on duty during the day and night. Ancillary staff included catering, domestic, administration and maintenance, which meant care staff could focus on caring tasks. There was additional staff on a 9am to 2pm and 4pm to 7pm shift which multi-tasked as a care worker and catering assistant to cover busy periods and an apprentice worked several evenings a week. The registered manager and assistant manager each worked four days during the week, making sure each day was covered and doubling up three days a week; a team leader held a management role at weekends. This ensured there was always a manager or team leader on duty to supervise staff and to speak with relatives or health professionals as required. One of the team leaders worked flexible hours and completed six hours a week as a designated activity co-ordinator. They had additional time to complete staff supervisions and also facilitated some training with another team leader.

One member of staff said, "Sometimes it's busy but [registered managers name and assistant manager's name] will get involved in care work." We also received information which stated the time around the evening meal, four days a week was a difficult period for staff and some struggled with the work load. We discussed this with the assistant manager who had been made aware of this and they were to ensure one of the managers helped care staff during this time. A visiting health professional said, "There have always appeared to be sufficient staff numbers, with one member of staff in each 'area' and always accessible if I need to ask anything."

Staff were recruited safely with employment verification such as an application form to look for gaps, references, an interview and a disclosure and barring service (DBS) check. The recruitment process checked that people had not been barred from working with vulnerable adults and helped to ensure only appropriate staff worked within the service. We saw one new member of staff had a missing reference but the registered manager assured us they had spoken to their last employer and was awaiting the written reference to arrive. They told us that in future verbal references would be recorded until the written one arrived. They also confirmed any gaps identified on the application form were discussed during the interview but were not always recorded; the reasons for gaps in employment would be recorded in future. New staff received an induction and shadowed more experienced staff during this process. Staff new to working in care settings were enrolled on the Care Certificate. This is a nationally recognised induction course established to ensure new staff are taught the fundamental skills, knowledge, values and behaviours that are expected of them.

We found people received their medicines as required. Medicines were obtained, stored, administered and recorded appropriately. Medication administration records (MARs) showed staff signed when medicines were administered to people and when they were omitted; there were separate MARs for when people were prescribed creams and lotions to be applied. We saw medicines no longer required were returned to the supplying pharmacy. Those medicines which required stricter controls were stored in a controlled drugs cabinet or a refrigerator. Staff who administered medicines had received training. We noted some minor recording issues and a lack of guidance for when medicines had a variable dose or were to be taken 'as required'. This was mentioned to the registered manager to address. During the inspection, the assistant manager showed us a form which could be used to provide clearer guidance to staff and said they would ensure instructions were completed on it for each person and they would be held with the MARs.

We observed a member of staff administering medicines to people. This was completed in a patient way; a drink of water was offered to people and the member of staff ensured the medicines had been taken prior to signing the MAR.

The service was safe, clean and tidy with no unpleasant odours but still maintained its homely appearance. Personal protective equipment such as hand sanitiser, soap, paper towels, gloves and aprons were available. There were clinical waste bins for soiled items and the laundry was equipped with a sluice washing machine. Staff had completed training in infection prevention and control and water testing took place to rule out the presence of legionella. There were cleaning schedules for domestic staff. We saw one corridor carpet had a small area which was a potential trip hazard. It had been repaired once but the masking tape exposed a split in the carpet. We spoke with the registered provider about carpet renewals and they told us the corridors were due to be replaced in January 2017; in the meantime the carpet was re-taped to ensure it was not a hazard to people who used the service.

We found equipment used in the service was checked and maintained to ensure it was safe to use. These included electrical appliances, fire fighting equipment such as extinguishers, emergency lights and door closures, and moving and handling items such as hoists, slings and wheelchairs. The nurse call and fire

alarm systems were tested and bedrails, window restrictors and the temperature of hot water outlets were checked. The checks helped to identify any areas which needed adjustment or items which needed replacement. Fire drills and first aid training were completed to ensure staff knew what to do in cases of emergencies. The gas safety certificate had expired; the registered provider told us this had been an oversight and promptly booked an engineer to complete the check.

Good

Is the service effective?

Our findings

People who used the service told us they enjoyed the meals provided and staff contacted health professionals for them when required. They found the service easy to get about and had aids to assist them. Comments included, "The food is very satisfying and there are choices", "The food is good and they take so much trouble to see what you want and give you an alternative. The cook comes around every day about lunch the next day; she also comes to check if we've enjoyed it", "I think the food is absolutely marvellous; I don't like certain things so they give me alternatives", "Through the care that I've had, I'm 85% back to normal; since I've been here I've made a brilliant recovery", "I've not needed to have the doctor yet but they would call them", "The doctor comes and the chiropodist", "They got the doctor for me as I'm losing a bit of weight; I eat moderately well but have spells of not eating" and "When there are changes, they ring the doctor for reassurance; I just can't fault them. I see the optician and I've seen the specialist and I'm waiting to have my cataracts done."

Relatives felt their family members' health care needs were met and staff were skilled in providing the level of care required. They told us the meals were good. Comments included, "The food is really good; we've stayed here for Sunday lunch and my husband said it was as good as any restaurant meal", "She enjoys the meals that she has", "The meals are lovely", "They soon rang for a doctor when [name] needed one and the carer was brilliant with her, calming her; they are quick to act" and "Yes, I think they [care workers] are well-trained."

We found people's health care needs were met. Each person's care file had a section to record when health care professionals visited them and what advice or treatment was prescribed. We saw people had access to a range of health care professionals when required. These included GPs, district nurses, specialist nurses for palliative care, dieticians, physiotherapists, occupational therapists, speech and language therapists, opticians and chiropodists. People attended outpatients appoints to see consultants and specialist nurses when required. Comments from health care professionals included, "I am aware that The Abbey staff work closely with the district nursing teams to effectively manage any issues concerning pressure ulcer prevention. I feel that staff are always very professional and always have the best interests of the patients in high importance. The homely and welcoming feel at The Abbey is extended not only to residents but to their families and friends and visiting professionals like me."

Staff, in discussions, described how they would recognise the signs and symptoms of people becoming unwell and the action they would take. One member of staff said, "We have referred [Name] to the speech and language therapist, via her GP, last week as she was coughing when eating" and "[Name] has heart failure so we monitor their fluid intake as the GP instructed and [Name] has IBS (irritable bowel syndrome) so we keep an eye on them."

People's nutritional needs were met. Menus were arranged over a five-week period and provided people with a balanced diet. The meals for the day were on display. There were alternatives if people did not like the main meal on offer. Nutritional screening took place which helped to identify any concerns, although a nationally recognised tool which had been provided to the service was not in use. People had their weight

monitored and staff took action when required by contacting relevant health care professionals.

We observed the lunchtime experience for people; some people chose to have their meals in the main lounge, some in their bedrooms and most in the dining room. Those people who remained in the lounge were provided with over the knee tables and offered clothes protectors. The dining room was light and airy and set out with individual tables and chairs to seat four or six people at each; the meal was a social occasion. The tables were presented with table cloths, placemats, vases of fresh flowers and wine glasses. Vegetables were served in tureens so people could help themselves to the portion size they preferred. We saw the meals looked hot, appetising and were well-presented. We observed staff supported one person to eat their meal in the lounge and encouraged them in an appropriate way, sitting beside them and chatting to them. People were asked if they wanted any second helpings and the cook went around and asked people if they had enjoyed their meal.

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. The registered manager told us everyone who used the service had the capacity to make their own day to day decisions but they were aware of the actions to take, should major decisions be required for people and there was an uncertainty about their understanding of it. They said the person's capacity would be assessed and a best interest meeting would be held. Most people had made advanced planning arrangements should they become unwell in the future and had made decisions about emergency treatment. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided. They said, "We ask people. Sometimes [Name] declines care but often accepts it later with another staff" and "We ask people, talk to them so they understand what they are consenting to. The care plans are done with them and family so we know what people want."

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 saw the registered provider was working within the principles of the MCA and DoLS. They had made applications for three DoLS in the past when they thought people may meet the criteria. There were currently no people with authorised DoLS in place. The registered manager and assistant manager had completed training in MCA and DoLS and were currently sourcing this training for care staff.

Staff had access to a range of training which was delivered in a variety of ways such as external facilitators, work books, DVDs with questionnaires and internal training sessions. Specific staff had completed 'train the trainer' courses or 'teaching adults' training courses. Training considered essential by the registered provider and accessed by staff included fire safety, moving and handling, first aid, safeguarding, health and safety, infection control, basic food hygiene and safe handling of medicines. We saw some staff completed other training such as dementia awareness, catheter care, pressure area care, end of life care, stoma care, diabetes awareness and a training course provided by a district nurse in relation to a medicine for a specific person. Staff had also completed training relevant to their roles, for example, maintenance staff had completed portable electrical appliance testing and domestic staff had completed care of substances harmful to health. Most staff had completed or were progressing through nationally recognised courses in health and social care. The registered manager was currently auditing training to ensure records were up to date. A visiting health professional said, "Currently we have a rolling rota for regular education sessions for staff within The Abbey to attend our 'introduction to palliative and end of life care' sessions."

Staff confirmed they received support, supervision and appraisal; supervision and appraisal were recorded in staff files. The supervision consisted of discussions about work and observations of their practice. For example, staff were observed delivering personal care, using the blood pressure reading machine and completing a shift handover.

The environment was suitable for people's needs. There were grab rails in corridors and bathrooms and raised seating over toilets. Bedrooms had high ceilings and were spacious. The current people who used the service were able to find their way about to their bedrooms, communal rooms and toilets; consideration should be given to signage around the service when this is required to assist people and orientate them.

Good

Is the service caring?

Our findings

People who used the service and their friends and relatives were complimentary about the staff team and their approach. They confirmed staff respected their privacy and dignity. Comments from people who used the service included, "The staff are very pleasant", "They are lovely girls", "I'm delighted with it [the home]. I have good relationships with staff and get on with all of them. I can't say a bad word about any, from management to the youngsters [care workers]", "Oh yes, they knock on the door. Sometimes I have missing clothes [following laundry] but they always turn up", "The staff are top class; they never grumble and they tell you not to worry", "I do most things for myself but the staff are very good" and "I'm settling here; it was a big decision [to enter a care service] but the staff are kind; they always knock and pop their head in to ask if you are ok."

Relatives said, "The staff are always pleasant", "They [staff] are very kind and helpful", "We talk to staff about how she is doing all the time and yes, absolutely, they keep in touch with us", "It's so homely, friendly and caring and that goes for all the staff. She is happy and cared for and the kindness shown to her has helped her settle" and "The staff are absolutely incredible; so compassionate and there is a nice ambiance."

One person, whose relative had recently died in the service, was visiting during the inspection. They said, "It is amazing care. Granny loved it here and said it was like being on holiday. She said she never washed a pot whilst she was here and loved it; she was very happy here and said the staff were kind." They also said, "In the week when she died, the family were here and were looked after very well by staff. I knew when we weren't here she was well-looked after and that made a huge difference to us; I would book myself in here."

A visiting health professional said, "I have often observed staff caring for residents in a very dignified way and always offering them a choice of what they would like to do or where they would like to go whilst maintaining their independence and privacy, and ensuring that activities are meaningful to the resident."

In discussions with staff, they described how they promoted core values such as privacy, dignity, choice and independence. They said, "We knock on doors before going in, close curtains and keep people covered during personal care as much as possible." We observed that whenever staff passed through the lounge, they would acknowledge people and stop to chat to them or ask them if they were alright. Staff spoke to people in a kind and caring way. They gave people time to answer questions and were patient with them. We saw staff gave people explanations before carrying out tasks such as using a stand aid and transferring someone from an easy chair to a wheelchair; they spoke to them throughout the process.

Each bedroom had its own en-suite facilities of sink and toilet and in all bar one room a bath or shower, which afforded people privacy. In the one bedroom which was shared, there was a privacy screen used between the two beds. There were privacy locks to bedroom and bathroom doors and each person had a lockable facility in which to store items securely if they wished to use it.

We saw people were encouraged to make their own choices and decisions. The registered manager told us one person didn't like the wallpaper in their bedroom so this was painted over in a plain colour of their

choice. People told us they were able to get up and go to bed when they chose to and they could receive visitors at any time. This was confirmed in discussions with friends and family who were visiting during the inspection. Visitors told us they were made to feel welcome, were offered refreshments and had stayed to have a meal with their relative on occasions. People were offered choices of meals and where to spend their time during the day. We saw people moved about independently in the service and the garden. The registered manager told us how they ensured risks were minimised when people went into the community unescorted. People who used the service said they had choices, "I go down to have my lunch but I like to have my tea in my room", "I prefer to stay in my room and watch television; I have my meals in my room. We get up and go to bed when we want" and "I fell in love with my room and I'm quite content to stay here. I'm independent and go into town on the bus."

The registered manager told us about one person, who had mentioned in their monthly review with their key worker that they would like to have more one to one time as their regular volunteer visitor had moved away. The registered manager contacted another volunteer group but they were unable to assist so an ex member of staff now visited the person and sits and has lunch with them. We saw this occurred on the day of the inspection and was an example of a caring and sensitive approach to the person's needs.

People were provided with information throughout the service. In the entrance there were leaflets describing the month's activities and who had birthdays to celebrate, there were notice boards with pictures and names of staff and there was a wipe board with the day's menu on in the dining room. We saw the cook spoke to each person and asked them what they wanted for the next day's meal. Each person who used the service was given a handbook which provided them with information about their rights and how these would be upheld by staff, what to expect regarding the care delivered and what was not included in the fee structure, for example dry cleaning and private telephone installation.

There was information about people's likes, dislikes and preferences in care files for how care should be carried out. This showed us people and their relatives had been involved in decisions about planning their care and support.

The registered manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. We found people's care files in daily use and medication administration records were held in the main office, which was locked when not in use. Staff records were held securely in lockable cupboards. The registered manager confirmed the computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held. We saw staff completed telephone conversations or meetings with health professionals or relatives in the privacy of an office to aid confidentiality.

Good

Is the service responsive?

Our findings

People who used the service said staff responded to their needs. Comments from people who used the service included, "I don't think they could do anything better", "I wouldn't attempt to change anything they do", "I used to be a nurse for 60years and I know what good care is; they couldn't improve anything for me", "I had a birthday yesterday and they made me a cake and sang happy birthday", "I would like to do more activities; I've seen the hairdresser but I'd like to have my nails done", "I just sit and watch the TV all day", "The dogs come in; I like that" and "I prefer my own company but I'm going down for the next Soroptomists' visit." The Soroptomists are a group of people who visit the service each month for an hour and a half to talk to people and help them feel connected to the local community. We mentioned the comments about one person wanting to do more activities and another stating they 'just watched TV all day' to the registered manager so they could speak with the people and find out what they would like to do.

Regarding activities, relatives said, "Yes, there is enough to do. She is not a joiner though and prefers her own company; she likes quiet time", "I've seen singers, a brass band and I've seen people baking. They are also having a summer fayre" and "I'm not sure if they have joined in activities."

A visiting health professional said, "They are well established in supporting residents to do advance care planning and know how to access further support services for out of hours."

The care files we looked at showed people had an assessment of their needs which included areas of risk such as moving and handling, falls, skin integrity, individual health concerns, nutritional screening, bathing and showering, remaining in bed, and the use of equipment such as wheelchairs and walking frames. People's care files contained their life histories and personal profiles with details about important family and friends; there was information which covered their food likes and dislikes and the social activities they preferred. There was also information about their medical history, the medicines they took, what they were for and the side effects staff needed to be aware of.

We saw care plans were produced from the assessments. The registered manager told us they were in the process of transferring information from one format of care plans into another; they showed us examples of the work completed so far which separated areas of people's needs on to individual pages so the information was more detailed and provided guidance for staff in how to care for people. The new style covered more personalised information although there was scope for this to be enhanced even further. We spoke with care staff and it was clear they knew people's needs very well and provided person-centred care to them even though some personalised information was not always included in the care plans. The registered manager told us they would speak with key workers when writing the care plans to ensure all the small personal details were included in them. We saw staff recorded in daily notes what care was provided to people and also completed monitoring charts for a small number of people. These included their food and fluid intake, although we saw some staff were more vigilant than others when completing them. This was mentioned to the registered manager to address with staff and to ensure it was included in the audit programme.

The service had an environment which responded to people's differing needs such as communal lounges, quiet areas, the facility for companion bedrooms, a study, a bar, a hairdresser's room, a telephone booth, an outside seating area and garden, and aids and equipment. Bedrooms were personalised and people were able to bring in their own furniture, pictures and ornaments to make it more homely; some people had their own telephones installed so they could keep in touch with friends and relatives. The registered manager told us about one person who wanted to bring in their sofa and chairs but their bedroom could not accommodate all the furniture. Instead the lounge was rearranged to fit in their excess chairs which they preferred to use. Similarly a new potential user of the service was concerned about where to keep their motorised wheelchair. The registered manager invited the person for a visit and showed them where it could be housed and recharged and the person was happy to come for respite stays.

We spoke with a member of staff about the activities provided for people who used the service. These included nail care, one to one chats, planting vegetables and flowers, crosswords, DVD games for groups to join in, baking, shopping, reading newspapers and magazines, church services, and outings to local cafes and pubs. Some people also participated in occupations such as setting tables, cleaning silver, folding napkins, peeling vegetables, dusting and polishing items in their bedroom. We saw 'pat a pet' visited weekly, the Women's Voluntary Service visited each fortnight to exchange library books, entertainers visited each month for sing-a-longs and there was occasional live music sessions. People's birthdays were celebrated. The service had a study with a computer for people who used the service to keep in touch with friends and family via email and skype. We spoke with the member of staff to see if people's participation in activities could be recorded in an 'at a glance format' which would easily identify those who declined so the programme of events could be further explored with them and perhaps tailored for their needs.

There was a complaints procedure on display and this was also provided to people in a 'resident's handbook'. The policy and procedure described timescales for investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. They told us they tried to sort out issues straight away before it developed into a complaint. There was also an accessible comments book for people or their relatives to write in any suggestions. People who used the service said they felt able to raise concerns. One person told us they had mentioned missing laundry to staff but this had not been documented anywhere as a niggle or complaint so it was difficult to audit if it had been or was currently being addressed by staff. The registered manager told us they would address this and ensure minor niggles would in future be documented to show they have been attended to. Another person confirmed that a complaint they had raised was sorted out quickly for them. Relatives told us they felt able to raise concerns and said, "Yes, absolutely I would complain; I would speak with the manager", "I feel I could raise concerns if I need to" and "If I want anything, I talk to the girls; nothing is too much trouble."

Requires Improvement

Is the service well-led?

Our findings

People told us they would be able to speak with the registered manager if they needed to. Comments included, "The manager is very good. The boss who owns it comes to see us and chats to us; he comes to tease and have a joke." During the inspection, we observed the registered provider sitting and chatting to people who used the service.

Relatives spoken with all knew the registered manager's name. They said, "Management is spot on and very caring. It's a lovely friendly place" and "The manager would listen to us."

A visiting health professional said, "The Abbey appears to be very well-led, with senior management always present and aware of the day to day changes that occur with the residents or their families. The management appear to be very focused and are very good advocates for their residents."

We spoke with the registered manager about the culture and values of the organisation. They described an open culture and told us the service was like one big family and stressed the importance of involving people in decisions and being firm but fair with staff. They said, "Here, the residents come first." We observed there was an open-door policy with people who used the service, their relatives and staff entering the registered manager's office to talk to them about issues or to pass on information. The registered providers were very 'hands on' and visited on a regular basis and talked to people, their relatives and staff. The registered manager told us training was very important and they had completed a City and Guilds advanced management in care course and management skills in a care environment certificate. Both the registered manager and assistant manager had obtained a national vocational qualification (NVQ) at level four for registered managers. The registered providers had both completed an NVQ at level two in health and social care to evidence their commitment to the important of a skilled workforce. The services' statement of purpose focussed on the rights of people who used the service and ensuring they were provided with a quality service that met their individual needs. We saw this was reflected in practice.

Staff told us they enjoyed coming to work and felt supported by the management structure. Comments included, "It's rewarding and more like a family", "It's really nice here; each day is never the same", "The manager is alright; there is always an open-door", "Yes, I do feel supported" and "It is a good home; I would have my relative here." Staff confirmed there was a system to cascade information such as shift handovers, a communication book, meetings, one to one discussions and the open-door policy. Staff had a portable communication system with which to speak to each other and request assistance. This was important given the layout of the building.

The registered manager was aware of their responsibilities in regard to notifying the Care Quality Commission about incidents which affected the health and welfare of people who used the service. These were sent in a timely way in order for them to be assessed and any action taken.

We saw there was quality monitoring in place but this wasn't structured in a systematic way. The registered provider completed visits to the service and had meetings with the registered manager but these were not

recorded so it was difficult to audit if they had raised any issues and how they had been dealt with. There were some audits completed, for example, medicines stock and people's medication administration records were checked each month but we were unable to see any action plans to address any shortfalls that had been identified. The registered manager said any shortfalls would just be addressed with staff but not recording them in an action plan made it difficult to see how issues were rectified, lessons learned and monitored the following month. In the past, there had been audits of accidents and analysis of information but these had not been completed for several months so it was difficult to see what action had been taken to minimise them. The registered manager told us they would complete this analysis quickly. An audit of service records had not been completed which if it had would have picked up an out of date gas safety certificate; this was rectified straight away. Staff training took place but it was difficult to audit if it included up to date information. There was no system of checking if monitoring charts were completed fully; we found some staff were more vigilant than others when recording the food and fluid specific people had each day. Key workers held monthly reviews with people who used the service to discuss care and one person had now been allocated the task of making changes to care plans as a result of them to aid consistency; there had been some gaps in checking updates in the past and this should rectify it.

We saw questionnaires had been completed in 2015 for people who used the service and their relatives, and comments had been collated. These had been analysed and an action column formulated. There had not been any questionnaires in 2016 yet and we could not see any staff surveys or visiting health professionals to obtain their views. The registered manager told us new surveys for visiting professionals had just been produced in a simpler format and would be sent out to them soon.

Although there was a quality monitoring system in place we recommend a more structured approach to quality assurance, which records the shortfalls and action taken to address them.

We saw some areas of the environment were looking tired and in need of refurbishment. The registered providers had produced an action plan with timescales for completion of work to be carried out. This included the refurbishment of two downstairs toilets to make them more accessible to people.

There were no 'residents meetings' held but the registered manager told us they spoke to people on a daily basis and any issues raised were addressed. They gave examples of how they had listened to people. These included, adding items to the menus, obtaining more tables and lap trays for people who preferred to eat their evening meal in the lounge and providing a more substantial supper. They also told us they had purchased a perching stool for some people who liked to sit in the kitchen and prepare vegetables.

We found the service had developed links with other agencies such as the local district nursing team and hospice service team. A visiting health professional confirmed this and said, "Staff are always very engaged with the hospice services and communicate any deterioration or any concerns that they have with us and the local primary care team to work together to provide streamlined, safe and effective care. The managers have good attendance at our regular forums and also have specified 'link palliative care workers' who attended our special 'link worker event' here at the hospice. The registered manager told us they had built up relationships with a local domiciliary care service in order to share training opportunities. They also attended independent care provider's group meetings to share good practice and information.