Abbeyfield Society (The)

Abbeyfield Care at Home (Tunbridge Wells)

Inspection report

Hale Court
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection took place on 12 February 2018 and was announced to ensure that the management team and people using the service would be available during the inspection.

Abbeyfield Care at Home (Tunbridge Wells), from here on in this report referred to as Abbeyfield Care at Home, is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and supported living homes. Abbeyfield Care at Home provides a service to older people living with dementia, mental health conditions, physical disabilities, and sensory impairments. At the time of our inspection the service was only providing a Care at Home (CAH) service to people who live at Hale Court, independent living facility.

Not everyone using Abbeyfield Care at Home receives care under a regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of our inspection six people were receiving care under the regulated activity personal care. This inspection focused on the care and support provided to the six people where they received a service registered by CQC.

At the time of our inspection there was a registered manager 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.

Risks to people had not been mitigated as risk assessments had not been updated regularly, and did not contain up to date information to enable staff to keep people safe. You can see what action we told the provider to take at the back of the full version of the report.

Care plans lacked personalised details and information needed by staff to provide people with a person centred service. You can see what action we told the provider to take at the back of the full version of the report.

A full programme of quality audits was not in place and shortfalls identified at this inspection had not been identified by the registered manager. You can see what action we told the provider to take at the back of the full version of the report.

People received their medicines when they needed them and staff were trained and competency checked to ensure they were safe to administer medicines to people. However, the recording of medicines was not always clear. We have made a recommendation about this in our report.

People were kept safe from abuse and harm and staff knew how to report concerns around abuse. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety. Staff followed

best practice guidance for reducing the risk of infection, and people were protected from these risks. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to admission. This meant that care outcomes were planned for, and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. Staff could request additional training and had been supervised effectively by the registered manager. People were supported to receive enough to eat and drink, and staff ensured people received a balanced diet.

The service worked with other professionals such as people's GPs and social workers to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals.

People were supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful, and the least restrictive option.

Staff treated people with kindness and compassion. Staff knew people's needs well and people told us they liked and valued their staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

There was a complaints policy and form, including an accessible format available to people. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. People were supported in a personalised way that reflected their individual needs.

There was an open and inclusive culture that was implemented by the management team. People and staff spoke of a friendly and homely culture that was empowering. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice, and working with other professionals and local health providers to ensure partnership working resulted in good outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Abbeyfield Care at Home was not consistently safe.

Not all risks to people had been managed safely and risk assessments did not always contain up to date information.

Medicines were managed and administered safely and people had their medicines when they needed them.

People felt safe and were protected from the risk of potential harm or abuse.

There was a sufficient number of staff to ensure that people's needs were consistently met.

The risk of infection was controlled by staff who understood good practice.

Lessons were learned when things went wrong and accidents and incidents were investigated.

Is the service effective?

Good

Abbeyfield Care at Home was effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

Staff received effective training to meet people's needs.

People were supported to eat and drink enough to maintain good health.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice.

Is the service caring?

Good

Abbeyfield Care at Home was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff supported people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Requires Improvement

Abbeyfield Care at Home was not consistently responsive.

Care plans lacked person centred information and daily notes lacked detail.

People were encouraged to take part in activities and to run some activity groups if they wanted to.

There was a complaints policy in place but no complaints had been received.

Is the service well-led?

Requires Improvement

Abbeyfield Care at Home was not consistently well led.

Effective quality monitoring systems were not in place and not all checks had been documented.

Continuous improvement and learning systems had been planned for but not implemented in practice.

There was an open friendly culture where staff were kept informed and the registered manager was a visible presence in the service.

The views of people and others were actively sought and acted on.

The service worked in partnership with other agencies.

Abbeyfield Care at Home (Tunbridge Wells)

Detailed findings

Background to this inspection

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

The inspection took place on 12 February 2018. We gave the service 48 hours' notice of the inspection visit because it is office based and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 12 February and ended on 12 February 2018. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, review of care records and policies and procedures. We visited the office location on 12 February 2018. The office was based in a supported living service where people receiving a regulated activity were living. We visited the office and the supported living service to see the manager and office staff; to review care records and policies and procedures; to speak to people, and observe the care they received.

The inspection team consisted of two inspectors. We spoke with the registered manager, two senior carers, two support assistants, five people and one person's relative. We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This is the first time the service had been inspected.

Requires Improvement

Is the service safe?

Our findings

Not all risks to people had been managed safely and risk assessments did not always contain up to date information. We reviewed the risk assessments relating to the care and support provided to three people. One person had fallen, and had been taken to hospital in October 2017 returning to the service in November 2017. However, the person's health and mobility risk assessment had not been updated following the fall, and had last been reviewed in September 2017. We spoke to the registered manager about this and were told that the risk assessment should have been reviewed when the person came out of hospital. The risk assessment forms did not contain a high level of detail, and did not have clear control measures for every potential hazard that had been highlighted. For example, one risk assessment had identified considerations for helping a person to move safely, such as weakness on one side of the body. However, there was no entry recorded on the assessment for remedial action for staff members to take to keep the person safe.

The failure to ensure risks to people are mitigated is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were effective systems and processes in place to keep people safe from abuse. The service kept a safeguarding folder with a log of all recent alerts made to the local authority safeguarding adults team. The registered provider had an up to date safeguarding policy, including a flowchart for reporting any concerns and blank incident reporting forms ready for staff to use. There was a summary sheet detailing what to do when reporting concerns, such as keeping the person protected, recording information correctly and reporting to the local safeguarding team. There was a copy of the provider's safeguarding policy in a 'user friendly' poster form displayed on a noticeboard in a corridor near the dining area where people would see it. Staff members had been trained in safeguarding and were able to demonstrate that they understood how to keep people safe from abuse. One staff member told us, "We regularly monitor people and if we find any changes in behaviour we report to manager. The manager refers to the local safeguarding team and we have a policy for incident and accident reporting as well."

There were sufficient staff deployed on each shift to keep people safe and meet their needs. All people receiving a service at Abbeyfield Care at Home were privately funded and paid for their own support hours. These hours were assessed by the registered manager and agreed with people or their families. Hours provided to people were added to the service rota and tasks were clearly identified; for example, bathing or medicines support. There was a 24 hour staffing provision in the building that people receiving personal care could access if they needed, above their one to one support hours. Staff members had an electronic calendar which showed their care calls each morning and evening and what support people required. Staff could request additional support hours from the head office when they felt it was required. We saw examples of when this had happened and extra support had been provided. We checked one month of staff rotas and saw that people's assessed hours had been provided and that there were permanent staff on every shift with competent senior staff available to give medicines to people.

Safe recruitment processes had been followed and recruitment systems were robust. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to

check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS), and staff had not started working at the service until it had been established that they were suitable. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care services. The registered provider had consistently tracked the employment history of each newly recruited staff member to maintain the safety of people they are working with. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

Medicines were being stored and administered safely to people; however, we found that some recording of medicines could be clearer. The service used medicine administration record (MAR) charts, but these were not easy to follow or to track from one week to the next. The pharmacy delivered medicines every week but the MAR charts only allowed for two entries per sheet, meaning that a new chart was required every two weeks. Sometimes a new chart had been started part way through a week, so it was difficult to track any changes to people's medicines. We tracked two months of MAR charts, with the registered manager, for one person and found that all their medicines had been administered correctly, but this was difficult to audit and new staff could potentially be confused by this system. Although no errors had been made the registered manager agreed that the paperwork could be improved. Subsequent to our site visit the registered manager had sent us a copy of an updated MAR chart that would allow all medicines in a 28 day cycle to be recorded and audited on one sheet.

We recommend that the service consider current guidance on recording people's medicines and take action to update their practice accordingly.

We checked medicines in peoples' flats and found that they had been stored in lockable boxes. Tablets, where appropriate, had been pre-dispensed in blister packs and information sheets for each medicine were kept with the lockable boxes. Staff members had received effective training on the safe administration of medicines and had been competency checked to ensure they could support people to take their medicines in practice.

People were being kept safe from the risk of infection by the prevention and control of infection hazards. Infection control training had been provided for all staff and this training was competency checked. The communal areas of the accommodation were clean and hygienic during our inspection. People's individual flats were cleaned on a rota basis and they told us that they liked having a cleaner come round once a week to assist with cleaning. The service was following good practice around infection control and had colour coded mops for different uses. There was a dishwasher in the dining room and all plates and cutlery were cleaned using a steriliser. There was an appropriate supply of personal protective equipment available to staff, and we saw that they used this as needed. All staff had food hygiene training in place, and the cook was using the Food Standards Agency 'Safer Food Better Business' scheme to ensure food safety.

Staff understood their responsibilities to raise concerns and report incidents. Accidents and incidents had been recorded and reviewed by the registered manager. We reviewed two incidents were people had fallen in their own flats. In each instance the fall had been recorded and responded to appropriately. People were provided with call bells in their rooms and following a fall one person had been given a pendant call bell so that they could keep it with them at all times. Emergency call bells were connected to a handset that staff keep with them during their shift so that they could respond quickly to any emergencies. Another person had fallen in their flat and were hospitalised. The registered manager visited the person in hospital to find out how the fall had occurred and to assess what could be done to prevent it in the future.

Good

Is the service effective?

Our findings

People told us that they felt the service was effective in meeting their needs. They told us staff had the necessary skills to provide the care they needed and supported them to access health services as needed. One person said, "The staff are so nice and they know how to treat people well." Another person commented "Most of the staff have worked in other care homes for a long time and so yes we feel that they are knowledgeable and capable." A relative told us, "Yes, generally (name) does their own thing and is quite independent but they [staff] seem to be very helpful and (name) sings their praises."

People's needs were assessed and their care planned in a way that meets their needs. There were assessments of people's needs prior to a service being provided. We reviewed these documents and they were detailed and covered multiple areas of people's needs to give a holistic profile. The assessments looked at areas including, communication, continence, involvement in domestic tasks, routines during different times of the day and activities. People were asked what their preferred name was and cultural and religious needs were assessed. One person was assessed as enjoying church services and bible studies and this had been carried through to their care plan. People's mobility was assessed at the initial assessment and any issues were highlighted so that staff were aware. Each assessment ended with a list of services required, broken down in to time slots. For example, half an hour to wash and dress and half an hour to prepare lunch. We saw that people had received their assessed support at the correct times.

Staff had the skills, knowledge and experience to deliver effective care to people. Staff members had received training in order to help them carry out their roles. A list of training dates had been recorded that showed all staff had training on relevant core courses, such as fire awareness, moving and handling people, food hygiene and equality and diversity, amongst others. Where there were gaps in staff training, or a need had arisen for new training to be provided, refresher courses had been booked, and planned for, in the coming months. One staff member told us, "When we start we get induction training and all the basic courses like infection control and we have online training as well. I recently had an email from head office reminding me to complete my new training updates." Staff had been able to use their training in areas such as infection control to keep people safe and their living environments clean. Staff members had formal supervision as well as observed supervision. Staff had an annual appraisal of their performance where they were asked to rate areas of performance and identify any areas for improvement. This was facilitated by a line manager who gave positive critical input to staff member's performance and set targets for the following year. New staff were inducted to the service using the Care Certificate. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care services are expected to uphold.

People were supported to eat and drink enough to maintain good health. People received a meal at lunch time as part of their housing provision and were supported, if they needed assistance to prepare an evening meal or breakfast. One person required assistance with their food so that it was cut up prior to serving it to them. The risks associated with this had been assessed. During lunch observation we saw that this person's food had been prepared in the correct way. Although no one had needs around their malnutrition or dehydration the registered manager was able to explain to us how this would be managed if the need arose.

Staff were aware of people's abilities and needs around food and drinking and were able to document any changes and refer people for assistance if needed.

Staff worked together to ensure that people received a consistent and person-centred support when they were moved from or were referred to the service. When people moved from another care provider the registered manager would complete an assessment to find out what the persons needs were by speaking to the person, staff, and the persons family. The registered manager described how they would contact any other agencies involved. Where a person had no network the registered manager told us they would seek support from social services and if necessary involve an advocate on the person's behalf.

People had been supported to live healthy lives and had access to health and social care professionals. Records confirmed that people had access to a GP, dentist, and optician and could attend medical appointments when required. Care plans demonstrated that a wide range of professionals were involved in people's care. For example, one person had been supported to attend a specialist clinic around diabetes. People had a profile in their care plans listing all the medical and healthcare professionals involved in their care. Although no one currently receiving a service required accessible information, the registered manager explained how they would provide easy read versions of health information, such as screening procedures. People had access to a GP surgery very close to the service and were offered the chance to register at this practice when they moved in.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. People's right to make decisions was promoted and the principles of the MCA were adhered to. People were supported to make decisions and to give their consent to their support. People had signed consent forms to agree to their care and support. People that were supported with taking their medicines had given explicit consent for staff to do this. Although nobody currently receiving a service lacked capacity to make a specific decision, the registered manager showed us how they would ensure that best interest's decisions were made in accordance with legislation. The provider's MCA policy set out how lawful decisions were to be made and explained the correct process for determining best interest decisions for complex and day to day decisions. Staff members had received training in the MCA; they understood the principles behind the law and knew how to apply it to the people they supported. One staff member told us, "People have capacity to make decisions, and before we do anything we seek their consent and they are able to express their feelings and tell us their priorities."

Good

Is the service caring?

Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "The staff are extremely caring. They make me a cup of tea and a sandwich when I get up and it's lovely." Another person said, "…overall the staff are brilliant; they do their very best." One relative commented, "I think the staff are caring. When (name) first moved in I met, and chatted to the staff, and they are great; they are really lovely."

People were treated with kindness and compassion in their day to day care. Care workers had built positive and caring relationships with people they were supporting. When one staff member forgot to serve one part of the afternoon meal to a person they came back and made a joke whilst serving the meal. People at the table enjoyed this joke and the atmosphere during lunch was jovial and conducive to a positive experience. This reflected the overall atmosphere within the service that we observed during our inspection.

Staff knew and respected the people they were caring for, including their backgrounds, preferences and were attentive to people's needs. During lunch one person was looking at the salad on the table. One staff member noticed this and walked over to the person to offer the salad. The staff member knew the person liked grated cheese on their salad and offered this before the person needed to ask for it. The person commented how nice it was that their salad was the way they liked it. Another person wanted garlic butter, instead of plain butter, with their jacket potato and staff went to the kitchen to obtain it for the person. People were at ease in requesting from staff what they wanted and were clearly used to staff members supporting them in a considerate way. One person had gradually moved their chair away from the table and a staff member offered to help them to move back, closer to their food. As the staff member had their arm on the chair, to help the person to move, the person leaned in and gave the staff member a hug. The staff member responded in a caring way by gently rubbing the person's back and accepting the person's affection. This action appeared to bring comfort to the person who looked more relaxed at the table afterwards.

Staff knew how to communicate with different people and where people had a communication need this was explained in their care plan. People were very natural with their support staff and sat and talked as equals. One staff member joked with one person about putting part of their meal in their pocket for later. Although this could have been an inappropriate remark for another person, staff knew this person enjoyed a joke and the person sharing the joke laughed and made a humorous remark back to the staff member. Staff were mindful that they were working in people's homes and sought their permission before doing anything or supporting people. Staff members checked whether people had finished eating, or whether they wanted more food or drink, before taking their plate away.

People were supported to express their views and be actively involved in making decisions about their care and support. People had reviews of their care and were able to invite their family and other significant people to the review. We reviewed notes from one person's review and saw that the person had been involved and put at the centre of the review process. Any decisions about their care, or changes to their support were discussed, with the person's views being central to any decisions made. The person gave their

overall opinion of the care at home service: that they were happy with the service they received and the staff delivering it. At the initial assessment people were asked what support they needed and could decide which times they would like support from staff.

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. One staff member told us, "We always try and discuss things in people's room and if we do personal care we pull the curtains. We ask permission and what they want e.g. male or female carer, how they want their personal care, and we always try and respect their wishes. We never discuss personal things in communal areas." People and their relatives told us that staff were respectful towards them and we observed this to be the case on the day of our inspection. People had locks and door numbers on their doors and staff treated these doors as the front door to the person's home. We observed staff members knock on people's doors and wait for permission to enter before going in to people's flats.

People were supported to maintain their independence and be as self-reliant as they wished. The service operated an ethos of supporting people to do the things they wanted to, even if there was a risk element. People's capacity to make decisions for themselves was assumed, unless there was clear evidence otherwise. One person told us that they were very hard of hearing. The person had requested that staff wrote any questions they had on a pad to assist with their hearing loss. They were pleased that the staff team respected their wishes. The person told us, "From what I have seen [the service] covers people's needs for living independently. Staff are supportive and friendly and I would give this a very favourable rating." People were encouraged to manage their own health appointments and support had been offered to people to collect emergency prescriptions on occasion. One person told us, "I have a bad back and it gives me some pain but I am still able to do a fair bit for myself here." The service was meeting the accessible information standard and had key policies and health information in accessible information for people who required it. The accessible information standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss.

Requires Improvement

Is the service responsive?

Our findings

Care plans lacked person centred detail and daily notes of care lacked personalised detail. People's care plans did not have the necessary detail to describe to staff how they should achieve care tasks. For example, one person was assessed as requiring assistance with personal care. However, the needs assessment only noted that assistance was needed, and not how to assist, for example whether they prefer a bath or shower, which products to use and what level of support is required. The care plan for this person did not contain sufficient detail on how to achieve the stated outcome of assisting with personal care. Although the person could tell staff how they wanted support it had not been recorded anywhere so new staff would not be aware, or the person's wishes would not be recorded if their condition deteriorated.

Another person had a hospital passport in place. A hospital passport is a document designed to provide hospital staff with important information about the person and their health when they are admitted to hospital. The hospital passport had not been updated to indicate the person no longer managed their own medicines and required support with this task. The same person had recently had a reduction in their mobility and this had also not been updated in their care plan or hospital passport. Other care tasks such as evening support merely stated what to do; for example, get person ready for bed, without saying how the person wanted this to be done. Some assessments also lacked personalised detail such as one assessment of need that listed dietary requirements as 'gluten free, diabetic' but did not give further instruction around the persons preferences when offering alternatives. Daily notes that recorded the care and support people received were often repetitive and did not contain detailed information about the support that staff had given to people, just a brief summary of tasks completed.

The failure to ensure that care and treatment met people's needs and reflects their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were supported to attend a range of activities that were tailored to their needs. One person was supported to attend piano lessons after they moved in to the service. Another person was supported to engage with their church and maintain contact through attendance at church coffee mornings. Some people attended group activities such as an afternoon, 'knit and natter' social group. Several activity groups had been set up such as board games and exercise and people could chose to attend these if they wished. One person ran a relaxation class, another person sometimes held sing-alongs with other people. On Friday afternoon there is a quiz that is popular with people and the questions are written out in advance for people who are hard of hearing but still want to participate. The registered provider had introduced a 'resident as volunteer' scheme, which encourages people to take a lead in running different activities. Some people had signed up and were running a scrabble group, and another person had been supported to request funds for a craft group to be set up.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service kept a complaints file with a copy of the complaints policy, which set out the steps on how to respond to and resolve the complaint. The policy made reference to the local government ombudsman if people were not happy with the complaints' resolution. When people moved in to the service they were

presented with a pack of information and a copy of the complaints policy is included. The complaints log had recorded no complaints since the service had opened. People and their relatives all told us that they were aware of how to complain and who they could complain to if the need arose. Staff members were aware of the complaints policy and the procedure for dealing with complaints, including how to support people to complain. One staff member told us, "All complaints go to the manager and they get sent to the head office. All residents and families are given phone numbers on how to complain and if there is anything to learn from the mistakes we would talk about it at staff meetings."

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were not effective in monitoring the level of service provided to people. A full programme of quality audits were not in place, and shortfalls identified at this inspection had not been identified by the registered manager. For example, risk assessments being updated and care plans being updated and reflecting peoples individual needs. We asked the registered manager for copies of any audits that had been completed and were told that there was only a medicines audit that had been recorded. The registered manager told us, "Most of the checks are observational but at this point we are not recording them. This is something on my action plan to record the checks."

Continuous improvement plans and systems for learning had been planned but were not in place. The registered manager told us that they were planning to create an action plan and put processes in place. For example, there were plans to archive old documents from files and review medicine administration charts. The registered manager told us, "Because it is a new service there is a lot we need to look at. Recruitment is a big area. I need to introduce things like care plan auditing, and recording observations with staff. I will also be looking at personal development with staff members.

The failure to ensure there were systems in place to assess, monitor and improve the quality of service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an open and inclusive culture in the service. The service was empowering and each person was supported to maintain their independence. There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. People and staff spoke to us about the friendly and homely feel of the service and we observed this during our inspection. The service had a clear vision to provide a homely environment and a set of values that included 'caring, openness, respect and honesty'. The registered manager ensured these were effectively embedded into practice by discussing these values with staff members in appraisal where staff were asked to show how they have demonstrated each value. The provider promoted equality and inclusion within the staff team. There were policies in place for equality, diversity and human rights and staff were trained in equality and diversity. The registered manager explained how they promoted equality of opportunity, "It's about encouraging people from all faiths and protected characteristics to come in and be part of Abbeyfield." There were effective systems in place to ensure recruitment was carried out in line with The Equality Act 2010.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour. The registered manager was given good support from a senior business manager who supervised and appraised their performance and visited regularly.

People, their families and staff members were involved in the service and regular feedback was sought through questionnaires and feedback forms. Families were encouraged to visit the service and to be involved in people's lives. Strong links had been developed with local communities. There were events held by the service where the local community had been invited. During the recent official opening of the service the towns' mayor and deputy mayor attended with a celebrity. The event was also attended by neighbours, volunteers, staff members and families. There had been a summer garden party where relatives and friends had been invited to come and get to know the service. The registered manager was working with local schools who have attended to put on dance shows and sing carols at Christmas. One school arranged for girls to come and do gardening, have lunch with people and play scrabble. A local electrical products retailer visited to do a technology event and brought virtual reality headsets for people to try.

The registered manager was receiving safety alerts from the head office for potentially faulty equipment and reviewed these when they came in for things such as wheelchairs or hand rails. The service was effectively using information technology systems to monitor the service delivered. There was an IT system in place used by the registered provider and an intranet that allowed staff to access policies and procedures. The registered provider had recently signed a contract with an IT company to provide a software package to help manage the service. Call bells were in place for people and they were linked to a handset carried by staff on duty. People told us that they felt reassured knowing they could call for help within the building.

The registered manager had a good working relationship with the local health and social services. The service worked closely with The Alzheimer's Society and had connections with them through forums that the registered manager had attended. The registered manager had also made contact with Kent Association for the Blind who had visited the service to make contact and offer assistance to people. The registered manager had attended an older people's forum in Tonbridge and had made connections with theatres and an organisation in Tunbridge Wells offering people small groups and events in different areas of interest.

Abbeyfield Care at Home had linked with specialist services for people with dementia and ensured best interests decisions were reached with the specialist input for one person who used to use the service. Another person had a specialist occupational therapist and private funded social worker who the service liaises with closely. The service had been sharing appropriate information with other relevant agencies for the benefit of people who use the service. The registered manager was aware of changes to data protection coming in to force in the near future. The registered manager told us, "We establish if people have the right to the information, and if residents confirm they are happy to share the data, we make sure it is sent via secure email."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that care and treatment met people's needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that risks to people had been mitigated.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that there were systems in place to assess, monitor and improve the quality of service.