Mr & Mrs C H Gaffney and Mr & Mrs G Watson

Abbotsfield Hall Nursing Home

Inspection report

Abbotsfield
Tavistock
Devon
PL19 8EZ

Tel: 01822613973

Date of inspection visit:
28 August 2018

Date of publication:
28 September 2018

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?	Good

Summary of findings

Overall summary

This comprehensive inspection of Abbotsfield Hall Nursing Home took place on 28 August 2018. The inspection was unannounced. This meant that the provider and staff did not know we were coming.

Abbotsfield Hall Nursing Home provides accommodation and nursing care for a maximum of 28 older people. There were 22 people using the service at the time of this inspection. One person was staying at the service for a period of respite (planned or emergency temporary care provided to people who require short term support), although they were in hospital at the time of our visit.
Abbotsfield Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. The service is located on the outskirts of Tavistock and is a detached period property. The home consists of three floors with the ground and first floor used for accommodation with a passenger lift providing access to the first floor. There are two large communal lounges and a large dining area. There is a large well-maintained garden which people have access to. People could choose where they spent their time.
At our last comprehensive inspection in August 2017 the service was rated requires improvement overall. We issued the provider with three requirements, which identified the following areas to be improved.
These were because:

- The provider had not ensured that care and treatment was provided in a safe way.
- They had not assessed the health and safety risks to people.
- The premises were not always safe.
- Medicines were not safely managed.
- They did not have systems and processes which were effective and established and operated effectively to assess, monitor and improve the quality and safety of the services provided.
- The provider has legal obligations to submit statutory notifications when certain events, such as a death or injury to a person occurred. These had not always been submitted.

Following the inspection, we were sent an action plan which set out the actions the provider was going to take. The provider also worked with the local authority Quality Assurance and Improvement Team (QAIT) to help support them put new processes in place. This included a service improvement plan setting out the actions required, who would undertake them and the time scales. At this inspection we found the provider had made the improvements and were no longer in breach of these regulations.
There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager had been registered with CQC on the 8 August 2017.

The registered manager had implemented several assurance systems to assure themselves the service was running safely. They had developed a service improvement plan (SIP) and were working through the actions. The providers regularly visited the service and were kept informed about the running of the service.
People said they felt safe and cared for in the home. People were protected from unsafe and unsuitable premises. Risks for people were reduced by an effective system to assess and monitor the health and safety risks at the home. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

People's needs were assessed before admission to the home by the registered manager and these were reviewed on a regular basis. Risk assessments were undertaken for all people to ensure their individual health needs were identified and met.

The provider submitted statutory notifications as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating at the service in accordance with the regulations.

There were sufficient and suitable staff to keep people safe and meet their needs. Thorough recruitment checks were carried out. New staff received an induction that gave them the skills and confidence to carry out their role and responsibilities effectively. The registered manager had been working with staff to complete the provider's mandatory training. People were protected from the risks of abuse as staff understood and knew how to report any concerns.

Improvements had been made to the medicine management at the home. A safer system to ensure the safe management of medicines at the service had been implemented. Medicines were administered by registered nurses who had been trained regarding medicine management and had their competency checked. The registered manager was working with the local GPs and pharmacist to improve the instructions of prescribed creams to guide staff.

Staff had the skills and knowledge to support people appropriately. Since our last inspection, they had received regular supervision and appraisals to support them with their performance and future development. When they started working at the service new staff undertook a thorough induction. Staff new to care were supported to complete the Care Certificate a nationally recognised qualification based on best practice. The registered manager undertook relevant professional registration checks to ensure nurses were registered with the Nursing Midwifery Council (NMC).

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Capacity assessments were undertaken and best interest decisions were being recorded. This helped to protect people's rights.

People were supported to have a balanced and variable diet. Where people had specific dietary requirements, these were catered for.

People had access to health professionals. They said they had a good working relationship with the staff and the system worked well.

Staff were caring and kind. They treated people with respect and dignity. There was a friendly atmosphere at the home and a strong ethos from all staff regarding it being a family and people's home. The registered manager and staff were committed to ensuring people experienced end of life care in an individualised and

dignified way.

There was a designated activity staff member to support people to engage in activities that they were interested in, on an individual and group basis. There were regular outings to places of interest in conjunction with a local organisation.

People knew how to make a complaint if necessary. They said if they had a concern or complaint they would feel happy to raise it with the management team.

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 had improved is safe.

Potential risks to people's health and well-being had been assessed and plans put in place to keep risks to a minimum.

The premises and equipment were managed to keep people safe.

People's medicines were managed so they received them safely and as prescribed. Improvements were being made to the management of prescribed creams.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

People were protected by a safe recruitment process.

Accidents and incidents were safely managed.

There were effective infection control processes in place.

Is the service effective?

Good

The service had improved and is effective.

All staff received regular training, supervision and appraisals.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (2005) was followed so people's rights were upheld.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service remains good.

People were happy with the care they received. Relatives were welcome to visit at any time and were involved in planning their family member's care.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff treated people with dignity and promoted independence wherever possible.

Is the service responsive?

Good

The service had improved and is responsive.

Care plans contained information to help staff support people safely.

People experienced end of life care in an individualised and dignified way.

People's social needs were met and they were encouraged to follow their interests.

There were regular opportunities for people, and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Good

The service had improved and is well led.

People, relatives and staff felt the registered manager was approachable and effective, and they could raise concerns appropriately.

Staff understood their roles and responsibilities and felt supported by the registered manager.

Feedback was sought from people using the service and their relatives on a day to day basis and any issues identified were acted upon.

Staff meetings took place regularly and staff felt able to discuss any issues with the registered manager.

There were audits and surveys in place to assess the quality and safety of the service people received.

Abbotsfield Hall 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 checked 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 28 August 2018. The inspection was unannounced and carried out by an adult social care inspector, a specialist advisor who was a registered nurse and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

Abbotsfield Hall Nursing Home provides accommodation and nursing care to a maximum of 28 older people. At the time we visited, 22 people lived at the home. Ten people were having their nursing needs met by the nurses employed at the service. The remaining 12 people had residential needs and had their nursing needs met by the community nurse team.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We also sought feedback from the local authority Quality Assurance Improvement Team (QAIT) to obtain their views as they had been working with the provider to implement new processes.

We met the majority of people who lived at the service and received feedback from seven people who were able to tell us about their experiences. We also spoke with two visitors to ask for their views on the service. A few people using the service were unable to provide detailed feedback about their experience of life at the

home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia.

We spoke with eleven staff, including the registered manager, deputy manager, senior care workers, care workers, a cook, kitchen assistant, laundry assistant, housekeeper and the administrator.

We reviewed information about people's care and how the service was managed. These included six people's care records and five medicine records and the systems in place for managing and administering medicines. We also looked at three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service.

After our visit we sought feedback from health and social care professionals, commissioners and the local authority safeguarding team to obtain their views of the service provided to people. We received feedback from two professionals.

Good

Is the service safe?

Our findings

At the last inspection in August 2017, this question had been rated as requires improvement. We issued a requirement. This was because people's safety was not always protected by effective fire and environmental monitoring and practice. Medicines were not safely managed. Action had been taken by the registered manager which included regular health and safety monitoring checks and medicine audits. They were no longer in breach of this regulation and further improvements were ongoing.

The environment was safe and secure for people who used the service, visitors and staff. There were arrangements in place to maintain the premises and equipment. The maintenance person regularly monitored window openings and water temperatures. They also checked the fire extinguishers, safety lighting, fire doors, wheelchairs and flushed and cleaned shower heads to prevent legionella. The registered manager and maintenance person made us aware that there had been ongoing concerns with the boiler at the home which had been replaced. They said as part of this problem they needed to have new thermostatic mixing valves (TMVs) fitted. While this work was being undertaken staff had completed risk assessments for people who could access the sinks for personal care. This was in order to keep people safe from scalding during this work. There were also hot water warnings signs above hot water taps which were too hot.

Portable appliance testing (PAT) had taken place to ensure the portable electric equipment was safe to use. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, electrical and lift maintenance. Fire checks and drills were carried out weekly by the maintenance person in accordance with fire regulations. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

There were plans for responding to emergencies or untoward events. There were individual personal protection evacuation plans (PEEPs) which took account of people's mobility and communication needs. There was an emergency grab and go folder. This contained people's PEEPs, emergency contact numbers, for example, relatives, water and electricity and taxis. There was also emergency planning for people needing to be evacuated with details of designated places of safety. This meant, in the event of an emergency, staff and emergency services staff would be well informed and aware of the safest way to move people quickly and evacuate people safely.

General risk assessments had been completed. These included, security at night, electrical equipment, disposal of sharps, wheelchair usage, car park etc. These were regularly reviewed and where any changes were identified these were added. For example, the risk assessment for the car park now identified snow and ice as a risk after the winter weather at the beginning of the year.

People were protected because risks for each person were identified and managed. The registered manager recorded in the provider information return (PIR), "The residents are encouraged to take supported safe risks to enable them to live their lives as near to their normality while in the confines of a home. Staff are encouraged to learn about the preferences of each resident to enable them to be an individual." Care records contained risk assessments about each person. These contained measures taken to reduce risks as

much as possible. These included risk assessments associated with people's nutritional needs, moving and handling, pressure damage and falls. People identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included pressure relieving mattresses on their beds and cushions in their chairs. A staff member had been designated to check that pressure relieving mattresses were set at the correct setting for the person using it. We discussed with the registered manager that four mattress settings were slightly outside the correct setting for the people using it. They said that the settings knob were easily knocked by staff. They said they would implement a daily pressure mattress monitoring system to ensure they stayed at the correct setting.

People received their medicines safely and on time. Medicines were administered by registered nurses who had been trained regarding medicine management and had their competency checked. Improvements had been made regarding prescribed creams. Staff completed a cream stock record so were aware of the quantity within the home, a monthly stock control and rotated stock to ensure all prescribed creams were within date. The registered manager was working with the local GP and the pharmacist regarding prescribed creams to ensure they contained correct directions and creams no longer prescribed were not sent to the home. Staff had folders in people's rooms to guide them the type of cream, frequency and location to administer creams. The registered manager was working with staff to ensure they were correctly completed. Housekeeping staff ensured cupboards under people's sinks were tidy and no out of date cream stored.

There were safe medication administration systems in place. Medicines administered were well documented in people's Medicine Administration Records (MAR), as were any allergies or sensitivities. A review in November 2017 by the pharmacy providing medicines at the home did not raise any significant concerns.

People said they felt safe living at the home. Comments included, "My room is my home and it has always felt like home. It's very safe here" and "They're very caring here, everyone is. It feels safe." A relative said, "Been here for a number of years. I've never heard a raised voice in all that time".

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training, knew about the signs of abuse and how to report concerns. Safeguarding and whistle blowing policies were provided; they included contact details for the local authority safeguarding team and other agencies. Staff were confident any concerns raised would be investigated with actions taken to keep people safe. Since our last inspection ,there have been no safeguarding issues raised.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Accident records were detailed and showed staff had taken appropriate action.

People's individual risks were identified and the necessary risk assessment reviews were carried out to keep people safe. For example, risk assessments for falls, nutrition, skin integrity and manual handling. Where people were identified as being at risk action was taken. For example, a GP was contacted if someone had lost weight and had a reduced appetite.

People told us there were sufficient staff to meet their individual needs. They said if they used their call bell it was answered promptly. One commented, "I use the call button occasionally. Sometimes the door closes and I need it opening. I don't think I've ever had to wait a long time." Another said, "I ring the bell only occasionally but people always come." The registered manager told us how they ensure there are sufficient staff allocated on duty in the provider information return (PIR). They said they "completes monthly a dependency profile on each resident. The profile covers all aspects of the resident needs. The outcome indicates the level of support and input needed."

The staff schedule showed that there was a registered nurse on duty at all times. They were supported by five care staff in the morning and four in the afternoon and one or two care workers at night. The care staff were also supported by the administrator, the cook, kitchen assistant, laundry person, activity person, maintenance person and gardener. These staff had built up strong relationships with people and happily interacted with people as they completed their duties.

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

The home had a pleasant homely atmosphere with no unpleasant odours and was very clean throughout. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The provider had an infection control policy in place that was in line with best practice guidance. The registered manager had recognised that people did not have their own individual slings, which can be a cross infection risk. They had an action in their service improvement plan to have individual slings for all people requiring them by the 7 September 2018.

The housekeeping staff ensured all areas of the home were kept clean. The lead house keeper undertook a spot check audit of three bedrooms each week. The laundry room was very tidy. There was a system in place to ensure soiled items were kept separate from clean laundered items. Staff confirmed there was always a good stock of detergent available.

Good

Is the service effective?

Our findings

At the last inspection in August 2017, this question had been rated as requires improvement. This was because staff had not always received regular supervisions and appraisals. Improvements were being implemented to ensure people had a greater input into deciding the menus and having a choice. Work had taken place to address these areas.

Individual supervision meetings had been undertaken which helped staff identify further training and development needs. The registered manager had an annual appraisal planner in place which they were working through to ensure all staff were met.

People and visitors reported positively about the standard of food. One person said, "The food menu is fairly varied and when I've mentioned changes they've been incorporated into menus. I don't like dumplings and they've taken them off the menu." We discussed this with staff who confirmed the menu had not been changed but they ensured the person did not have dumplings but something they knew they preferred.

The cook said they discussed with people their likes and dislikes and had changed the menu accordingly. They asked for feedback from people about the food and recorded when people were not enjoying certain foods or had a low appetite. This information was passed on to the nurses. There was a four-week rotating menu which a minimum of two meal choices. The cook had nutrition and hydration sheets for each person informing them of people's dietary requirement. Where people had a specialist dietary requirement the staff ensured they had what was required.

The cook was very passionate about people having foods which they enjoyed. During our visit we saw there were numerous amendments to the menu to suit different people's choices.

We observed a lunchtime meal. Tables were laid with tablecloths and small silk flower displays, napkins and weekly menus. There was also a white board on the wall with the daily menu on. We discussed with the registered manager that this was not visible for people who were seated that could not read the small print menus. They said they would look at moving the white board so it was more visible.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff said they had received suitable training and had the skills required to undertake their roles. People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Staff were positive about the training they were undertaking.

Staff completed the provider's induction when they started working at the home, and were supported to refresh their training. New staff received a full induction and completed the national Care Certificate programme, to ensure had the knowledge and skills needed to care for people. They worked alongside experienced staff to get to know people's individual needs. Staff were positive about the training they had received. One commented, "The training is very good here."
At the home there were eight nurses and 31 staff, with 13 having or working towards a higher qualification

relevant to their position.

The registered manager undertook relevant professional registration checks. They had ensured all the nurses working at the service were registered with the Nursing and Midwifery Council (NMC) and were registered to practice. Help and support was given to registered nurses who needed to undergo a process known as revalidation to maintain their professional registration.

The Mental Capacity Act (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

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.

We found the home was meeting these requirements. The registered manager is a registered mental nurse and took the lead at the home regarding MCA. A nurse confirmed they consulted with the registered manager if they required any support in this area. The service improvement plan (SIP) had an action for all staff to undertake MCA training. This had been scheduled. The registered manager told us in the provider information return (PIR). They "audit that all residents have Power of Attorneys where necessary or that there is if appropriate a Deprivation of Liberty in place… that consent and capacity has been gained in whatever capacity is necessary and fit to enable a resident to remain safely at Abbotsfield and receive care." Staff demonstrated an understanding of people's right to make their own decisions and requested consent before undertaking tasks. They also as part of the provider's admission process gained people's formal consent to provider care and support and for photographs.

The registered manager understood their responsibilities in relation to DoLS and had made applications to restrict some people's liberties in line with the MCA. Applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

The provider had an on-going redecoration programme in place to improve and maintain the environment as some areas of the home were worn and tired. Since the last inspection the rear entrance off the carpark had a new reception area. The service improvements plan had identified rooms which required new carpets and areas that required painting which were scheduled to be completed.

Professionals said staff knew people's health and care needs well, contacted them appropriately and followed their advice. Staff carried out a detailed pre-assessment to discuss people's care and treatment needs with them, their relatives and relevant professionals before they came to live at the service. People confirmed they had access to health professionals if required. Comments included, "I see my doctor regularly, she thinks a lot of this place" and "I set up appointments with my GP. I use the call bell and then I can use the phone in this building."

People had regular sight tests and chiropody appointments. Any changes in health or well-being prompted a referral to the person's GP or to other health professionals. For example, the speech and language team

(SALT), physiotherapist and Parkinson's nurse.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had assessed people as requiring a special diet these meals were provided in the required consistencies for people. People at risk had their weight monitored regularly and further action was taken in response to weight loss and appropriate referrals made.

Good

Is the service caring?

Our findings

The service continued to be caring. People were supported by staff who provided person centred, kind and compassionate care. People's comments included, "All the nurses are very nice here, in fact everybody here is very nice", "It's very nice. People are nice, food is nice" and "People (staff) here are lovely." Visitor's comments included, "(Person) is happy here. She does get anxious over things though. The care here is good, I get the impression that the people working here do genuinely care for (person)" and "(person) gets excellent care here, you can see his face light up when people come in."

Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and joking. We observed staff transferring a person in a wheelchair. The staff were chatting with the person throughout.

The provider's statement of purpose stated, "It is important that residents are empowered to be as independent as they can, to have a voice, be involved in their care or to have a person who can stand by them and help support them if their memory is failing. To be given choices." We saw staff involved people in their care and supported them to make daily choices. For example, people chose where they spent their day and the clothes they wore. People said they were given a choice about how they spent their day. One person said, "(People) can do what they like now. If they want to stay in bed they can, if they want to have lunch in their room they can. We can get up late if we want."

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. One care worker told us about a person who had recently lost a loved one and it was taking them time to get back into a routine again. They explained that was why the person was having a late breakfast. They were also knowledgeable about the medicines the person had been prescribed and the hoped-for outcome.

People said staff treated them with dignity and respect when helping them with daily living tasks. The registered manager in the provider information return (PIR) said, "Staff have training on dignity, respect, being non-judgemental, equality and autonomy." People confirmed they had been asked what they preferred to be called and staff had respected that. One person commented, "They do ask how we want to be addressed. I like that as not everyone wants to be called by their first name."

Staff ensured they maintained people's privacy and dignity. Staff were seen knocking on people's door and waiting for a response before entering. On each door was a sign which staff could turn around when providing personal care in someone's bedroom, 'care in progress'. This ensured staff or visitors did not enter this room unless needed.

Staff all said there was a family atmosphere at the service in relation to people, their families and the staff team. They ensured people's relatives and friends were able to visit without being unnecessarily restricted. People and relatives said they were made to feel welcome when they visited the home.

The atmosphere at the home was calm and welcoming with people living there appearing 'at home'. The staff were aware that it was people's home and did not rush around carrying out tasks. People's rooms were personalised with their personal possessions, photographs and furniture. The provider's statement of purpose confirmed they encouraged this, "We encourage residents to bring in familiar items of their own from home to help them settle to be around familiar items."

Good

Is the service responsive?

Our findings

At the last inspection in August 2017, this question had been rated as requires improvement. This was because care plans were not always updated in a timely way to guide staff. Not all staff could use the computerised system. Therefore, they could not add information about people's changing needs. At this inspection we found action had been taken to transfer the information from the computerised care records onto a paper based system. This meant that staff could access these folders easily and add and make changes when needed.

A comprehensive pre- admission assessment of need was completed prior to people coming to live at the service. The registered manager explained in the provider's information return (PIR) the admission process of people coming into the home. "Robust assessment completed prior to admission to ensure that home can meet the needs of the potential resident and the placement is appropriate… this enables the assessors to have the needs and wishes of the resident to enable them to make a better decision on admission. Following admission more detailed preferences are taken to enable the Staff to make a more detailed care plan ensuring that the care plans are person centred and unique to that person. This ensures that a person can live their lives as close to normal as possible for them." We found care files contained people's choices and preferences.

Care plans reflected people's needs. Each care plan started by assessing the person's need regarding specific areas. For example, care plans looked at the support a person needed regarding their continence with the level of need was assessed, from no care needs up to a severe need. Care plans were in place for continence, psychological/emotional, mental health and cognition, oral, physical health, medication, mobility activity and social, sleep, skin condition, hearing and eye sight. The care plans guided staff how to support people. For example, communication care plans guided staff how to support people with their communication needs. Where one person had a hearing difficulty staff were guided that they needed to speak clearly and slowly. Nurses and senior care workers work in teams and had designated people. They reviewed people's care plans and risk assessments monthly and more regularly if people had a change in their needs.

Staff recorded the support they gave people on daily records. The registered manager was working with staff to make their entries more person centred, about how the person presented and was feeling. Since our last inspection, the registered manager had also implemented a new role of senior care workers at the home. They said in the provider's information return (PIR) "Now that there are senior health care assistants (HCAs) they can be more proactive in the way writing some of the sections in the care plans, as they are more hands on and aware of the more personal details that residents want and need."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people had their hearing aids in place and had their

glasses cleaned. A care worker said, "I like to make sure that (person) special hearing aids are correctly positioned, otherwise he can't hear properly." The registered manager said they ensured people had information in accessible formats where needed, to help them understand the care and support available to them.

The registered manager and staff were committed to ensuring people experienced end of life care in an individualised and dignified way. There was nobody receiving end of life care at the time of our inspection. The registered manager and a nurse had completed the six steps end of life programme to further improve end of life care at the service. The six steps programme is a national end of life qualification that aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. Relatives had sent thank you cards to the team for the care the staff had given their loved one. One of these said "Thank you all for the wonderful care given to (person) It was a huge comfort to know that he was well looked after and kept comfortable. Also thank you for the continuing care and support given to (relative) and the rest of us."

The provider recognised the importance of social activities and understood meaningful activities formed an important part of people's lives. People's social needs were being met. The registered manager recorded in the PIR, "Part of the admission process is to research resident's life history. This will include asking questions about hobbies, interests, jobs and careers that a resident may have had. It will include any ongoing interest they have. From this Staff can help support them in any interest that they would like to continue with. The home has been on six trips already and a further six have been requested."

There was a designated activity person who worked 18 hours a week supporting people with activities. They were very passionate about delivering activities and were looking to further develop the activities at the service. The provider used the services of external entertainers to regularly visit the home to entertain people. One of these did gentle exercises every two weeks.

People and relatives were happy with the activities that were offered at the home and spoke highly about the activity person. Comments included, "We go out on trips quite a lot. We were out last week and in two weeks' time we're off to Looe in Cornwall", "People also come in and play the piano for us, and an accordion." In the corridor there was a photo gallery of the activities people had enjoyed The registered manager said, "These are changed as events take place. the photos are kept in an album."

The activity person allocated time to visit people who chose not to or couldn't leave their rooms because of a health issue. They read books, had a chat, undertook nail care and anything the person would like. The registered manager was working with the activity person to record these visits so they had a clear overview that everybody at the home had meaningful activities.

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included the local government ombudsman, local authority and The Care Quality Commission (CQC).

People and relatives said they would feel happy to raise a concern and knew how to. The registered manager had dealt with concerns and complaints in the same manner and in line with the provider's policy and had made changes as a result. They had undertaken an investigation and responded to the complainants to let them know the outcome of their findings and the actions they were taking. For example, one concern was regarding cigarette ash by the front door and that at one meal time there was not a relish

of choice for one person because they had run out. A record was kept to show what action had been taken to address these concerns and to show complaints were taken seriously.

Good

Is the service well-led?

Our findings

At the last inspection in August 2017 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The first breach was because the provider did not have robust quality assurance procedures in place to ensure the safe running of the service. The provider sent us a comprehensive action plan which said they would be introducing auditing systems to ensure they were fully compliant. The registered manager had worked with the local authority quality assurance team (QAIT) to put in place processes and develop a service improvement plan (SIP) which set out the actions required, by whom and the time scales. The registered manager and staff had prioritised the actions in the SIP and had made great progress working through these.

The second breach was because the provider had not submitted statutory notifications. The provider has legal obligations to submit statutory notifications when certain events, such as a death or if injury to a person had occurred. The provider sent us an action plan following the inspection which said all notifications to the local safeguarding authority will include a notification to The Care Quality Commission (CQC). Since our last inspection, the registered manager and provider were meeting their legal obligations. They notified the CQC as required, providing additional information promptly when requested. The provider had displayed the previous CQC inspection rating at the service in accordance with the regulations.

At this inspection we found the provider had taken the actions set out in their action plan and had met the requirements. They said at the beginning of the inspection we would see a lot of changes but recognised there was still work to be undertaken as set out in their SIP.

The registered manager had put in place a system to undertake regular supervisions and appraisals of all staff. They had put in place regular health and safety checks which included hot water temperatures being monitored weekly. They completed regular audits which included infection control, the environment, care plans and medicines. The registered manager had reviewed the policies and procedures at the home to ensure they were appropriate and reflected current legislation and best practice. They had reviewed the statement of purpose to ensure it reflected what the service offered to people. All incidents and accidents were monitored monthly by a designated nurse who looked at the description and the action taken. The registered manager checked for patterns and any problems and if everything had been put into place.

Leadership at the home was very visible. The registered manager was in day to day charge supported by the administrator who was also the HR (human resources) manager, nurses and senior care staff. There was also a head housekeeper and lead cook who oversaw their staff and kept the registered manager aware of any concerns. The registered manager recorded in the provider information return (PIR), "Lead by example by being professional in approach and being positive."

Staff said they felt supported through supervision, staff meetings and working alongside the management team. They were positive about the changes that the registered manager had put into place. One staff member commented, "Where it was and where it is now is much better, everyone has worked very hard. (Registered manager) has done a good job getting things in place." Another said, "The registered manager,

nurses and (office manager) are brilliant. Any problems we can go to them." The providers visited the service regularly. They met with the registered manager to give support and discussed concerns and plans.

People living at Abbotsfield Hall and their relatives were positive about the management of the service. Comments included "It's family run. (Provider's) come in every now and again and (one provider) plays the piano for us", "(Registered manager) comes in for a chat. She always asks if everything is alright" and "I think our new manager is very good. I get down at times, she's trained in that sort of thing and she's helped me. She can be firm though (this was said in a positive way."

The staff had a clear understanding of their roles and responsibilities. There was a management pyramid which defined staff roles and responsibility. Nurses referred people appropriately to outside healthcare professionals when required.

Since our last inspection the registered manager had put in place a new role of senior care workers. They recorded in the provider information return (PIR) "They (senior care workers) have been chosen due to the experience and the qualities each of them offer. They are currently completing the NVQ level three and have completed their levels for the care certificate. They are also completing the … Pharmacy course which will enable them to help with medications." A new senior care worker had a clear understanding of their role. They said, "It is a developing role, taking more responsibility day to day, organising staff teams and work as a bridge between the nurses and care staff." People were also positive about this new role at the home. One person said, "There's always a trained sister (nurse) on duty and now we have four seniors. It's better this way as I can ask any of the seniors to get my medication. I appreciate the system as its better for me. I think the seniors was (registered manager's) idea. She looked to promote people but if they haven't got the qualifications they have to do the NVQs."

The registered manager did not hold resident's meetings. However, they said and people confirmed they regularly spoke with people. They also sent out a newsletter to keep people informed about changes. The newsletter also reminded people and relatives to put forward ideas and suggestions. An example of a suggestion was one relative suggested a mat by the front door; this had been put into place. There was a suggestion box in the main entrance where people and relative can leave any comments. One relative said, "Suggestion book is good here. I wrote something in it about the gardens and it was done the next time I came." The registered manager told us about a successful cheese and wine evening they had in February 2018 where they made time to chat to people and families.

Staff were actively involved in developing the service. The registered manager worked alongside staff and had an open-door policy for staff to speak to them if needed. They recorded in the PIR, "Regular Staff meetings are done which I feel is important for the staff as they feel they have a voice and that their opinions are valued." Full staff meetings were held every 12 weeks. Records of these meetings showed staff were able to express their views.

The registered manager said they had not sent out questionnaires to staff, relative and professionals. Instead, they were placed clearly on display in the main entrance for anyone to complete as they chose.

There was a handover meeting at the changeover of each shift where key information about each person's care was shared and any issues brought forward. The nurse and senior care worker attend and then information was filtered to care staff. There were also communication books for the care staff and nurses. A white board in the nurse's office contained information for the nurses which included who was taking antibiotics, needed regular weighing and catheter changes. The PIR stated, "Staff have a communication book which is vital for information to be handed over whether it is a clinical matter or personal to a resident

matter. The sisters (nurse) have one in the office for more clinical issues as well as the diary, the HCAs (health care assistants) have a file and a diary which highlights any issues." This ensured information was passed on and staff were informed of changes.

In January 2018 the service was inspected by an Environmental Health Officer to assess food hygiene and safety. The service had scored the highest rating of five. This confirmed good standards and record keeping in relation to food hygiene had been maintained.