Abbeyfield Society (The)

Abbeyfield Shandford

Inspection report

31 Station Road
Budleigh Salterton
Devon
EX9 6RS

Tel: 01395443326

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 10 and 28 June 2016. The first day of our visit was unannounced. Our second visit was announced so that arrangements could be made for us to spend time with the manager.
Abbeyfield Shandford Residential Home is a care home providing personal care to a maximum of 25 older people. The home is a detached building in the town of Budleigh Salterton in the coastal area of East Devon. On the first day of the inspection there were 23 people living at the service, which included two people staying for a short stay referred to as receiving respite support.

At the last inspection in May 2015, two breaches of regulation were found. These were because the provider had not protected people by ensuring the safety of their premises and the equipment within it. They had also not ensured staff had the required documents and understanding to apply the Mental Capacity Act 2005 (MCA) appropriately for people they supported.

The provider wrote to us in July 2015 with an action plan to say what they would do to meet the breaches of regulation by the end of September 2015. At this inspection, we found they had followed their action plan and met the legal requirements.

The service is required to have 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 resigned and left the service two weeks before our visit. They had applied to CQC to remove their registration.

The provider had appointed a new manager to run the service. They were in the process of completing their application with CQC to become the registered manager at the service. The new manager had been at the service since the end of April 2016 working alongside the previous manager. This included an induction and a handover period which had been completed on the 1 June 2016. The new manager had regular contact with people working and living at the home and undertook an active role. They were very committed to providing a good service for people in their care and demonstrated a strong supportive approach to people, their relatives and staff. They were supported by a newly appointed deputy manager who had the same visions and values.

The provider ensured there were sufficient numbers of suitable staff to keep people safe and meet their needs. There were staff vacancies at the home which the manager was actively trying to fill. The staff undertook additional shifts when necessary to ensure staff levels were maintained. When gaps were not able to be covered agency care workers who had worked at the home before were used to maintain consistency.

The manager demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act

(MCA) 2005. They understood that where people lacked capacity a mental capacity assessments needed to be completed and best interest decisions made in line with the MCA. Appropriate applications to the local authority deprivations of liberties team had been made to deprive some people of their liberties. Staff had a good understanding about giving people choice on a day to day basis and were scheduled to receive refresher MCA training to help them understand their responsibilities.

People were supported by staff who had the required recruitment checks undertaken. Staff had received an in house induction but had not always completed the required booklets to demonstrate this. Not all staff had completed the provider's mandatory training. The manager had recognised this and a programme of training was nearly completed to ensure all staff had undertaken the training and a more thorough induction. Staff were knowledgeable about the signs of abuse and how to report concerns and had completed training in safeguarding of vulnerable adults.

People were supported to eat and drink enough and maintained a balanced diet. People and a visitor were positive about the food at the service.

People said staff treated them with dignity and respect at all times and in a caring and compassionate way. People on the whole received their medicines in a safe way because they were administered appropriately by suitably qualified staff. People who chose had been assessed and were able to self-administer their medicines at the service. However improvements were needed to monitor they continued to take them safely. Where people had medicines prescribed as needed, (known as PRN), protocols were not in place about when and how they should be used. There were effective medicine procedures with regular auditing of medicines.

People had access to activities at the service. People were encouraged and supported to develop and maintain relationships with other people at the service to avoid social isolation. This was evident at mealtimes which were a sociable event. The manager recognised the importance of activities and had arranged an outing for ten people which people said they had been enjoyed. A new activity person was due to join the staff team and an event to attract volunteers to the service was also planned.

People's needs and risks were assessed before and on admission to the home. Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's routines and wishes and reflected people's changing needs. These gave staff guidance about how to support people safely. They were reviewed on a monthly basis or as people's needs changed. People were involved in making decisions and planning their own care on a day to day basis. People said they were referred to health care services when required and received on-going healthcare support.

The home had a homely atmosphere with no unpleasant odours. The manager had taken action to complete work recommended in the fire risk assessment to ensure the premises were safe. There were audits in place to monitor the environment and required checks and servicing of equipment were undertaken. Maintenance issues which were identified by staff and audits were carried out by an external contractor who visited the service weekly.

The provider had a quality assurance and monitoring system in place. This included regular audits and an annual survey carried out by an external marketing company. This enabled the provider to assess the effectiveness of the service provided. The manager actively sought the views of people and staff through regular meetings. There was a complaints procedure in place and the manager was dealing with a concern in line with the provider's policy and procedure.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

The premises and equipment were managed to keep people safe.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. They had completed training in safeguarding of vulnerable adults.

Improvements had been made to ensure people's medicines were being managed safely. Where concerns had been identified these were being addressed.

The manager ensured staff levels were adequate to meet people's individual needs. They were actively recruiting and using agency care staff to fill the shortfall.

There were effective recruitment and selection processes in place.

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There were effective recruitment and selection processes in place.

Is the service effective?

Requires Improvement

Most aspects of the service were effective.

Not all staff had received the provider's mandatory training. The new manager had identified this and a programme of training was nearly completed to fill any training gaps.

Staff were confident they had the skills to meet people's needs.

Staff had received an induction but not all had completed the provider's induction workbook. This was being addressed by the manager.

The manager had put in place a system to ensure all staff received a regular supervision. The manager had scheduled appraisals with staff.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had been put into place to ensure people's rights were maintained.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

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

People were able to express their views and be actively involved in making decisions about their day to day care, treatment and support.

Visitors were encouraged and always given a warm welcome.

Is the service responsive?

Good

The service was responsive to people's needs.

Care plans were person centred about people's histories, wishes and social need. Improvements were being made to ensure they reflected people's changing health needs and guided staff how to appropriately meet their needs.

Plans were in place to ensure people were formally involved in reviewing their care plans.

Activities were available and people were able to access the local community.

There were regular opportunities for people and people that

matter to them to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well led.

The new manager at the service had recognised there were areas that required improvement. They had put together an action plan to address these concerns.

People, relatives and staff expressed confidence in the new manager and the changes they were making.

Staff spoke positively about communication and how the manager worked well with them.

People's and staffs views and suggestions were taken into account to improve the service.

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

Abbeyfield Shandford

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 was 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.

Abbeyfield Shandford Residential Home is a care home providing personal care to a maximum of 25 older people. The home is a detached building in the town of Budleigh Salterton in the coastal area of East Devon. On the first day of the inspection there were 23 people living at the service, which included two people staying for a short stay referred to as receiving respite support.

This inspection took place on 10 and 28 June 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which was submitted on 22 May 2016. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met most of the people who lived at the service and received feedback from seven people who were able to tell us about their experiences. 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 also spoke with a visitor to ask their views about the service.

We spoke with and sought feedback from ten staff, including the manager, deputy manager, senior care workers, the cook, administrator and housekeeper.

We reviewed information about people's care and how the service was managed. These included three people's care records and four people's medicine records, along with other records relating to the

management of the service. Such as staff training, support and employment records, quality assurance audits, and minutes of team meetings. We contacted health and social care professionals and commissioners of the service for their views; two people responded.

Good

Is the service safe?

Our findings

People said they felt safe and were happy at the home. Comments included, "I feel safe here, I certainly couldn't have gone home" and "They call the doctor if I need them I feel safe here."

At our last inspection, there was a breach of regulation. This was because the provider had not protected people by ensuring the safety of their premises and the equipment within it. At this inspection improvements had been made and this regulation was now met.

People received their medicines safely and on time. All medicines were administered by senior care workers who had received training and had their competencies checked. They had a good understanding of the medicines they were giving out. Senior care workers were seen administering medicines in a safe way. They were very patient and did not rush people. People said they were given their medication appropriately, creams were applied as necessary and they were happy with their treatment. People were able to self-administer their medicines if it was safe to do so. Staff undertook a risk assessment to assess the potential risks and consulted with the person's GP who signed their agreement. However there was not a system to monitor that people who self-administered their medicines continued to take their medicines appropriately. We discussed this with the deputy manager who said they would introduce a system to monitor that people were safe.

The deputy manager had made changes to the medicine management at the home. This included improvements to prescribed topical creams. Staff were guided regarding the life expectancy of the creams once opened and when they should be discarded. They had worked with the pharmacist to have prescribed topical creams recorded on separate medicine administration records (MARs). This was so care workers had a separate folder to record the administration of creams. This meant there was a safer system to ensure people had their topical creams applied as prescribed. All staff that administered prescribed topical creams had received training and been assessed.

Where people had medicines prescribed as needed, (known as PRN), protocols were not in place about when and how they should be used. The deputy manager said they would speak with the pharmacist and put these in place.

There was a system in place to monitor the receipt and disposal of people's medicines. Medicines which required refrigeration were stored at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the senior care workers and action had been taken to ensure people had received their medicines. Regular audits of medicines were completed and records showed actions were taken to address issues identified. A senior care worker said as part of their role they checked the charts to ensure people's creams had been administered as prescribed.

The provider recorded in their provider information return (PIR); 'The home is centrally and regionally managed in regard to the maintenance of the premises and equipment. We have a maintenance

programme in place and records are kept in the health and safety folder and on line. Senior staff report any maintenance or breakdowns that may occur by email or telephone we have an out of hour emergency service in place which all seniors have understanding of how to contact.'

The manager had identified all areas of the house were not adequately clean. They were working with the housekeepers to put in place a new cleaning schedule. They had also used the services of an external cleaning company to undertake additional deep cleaning. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. There were designated mops and buckets for different areas. For example, blue for the kitchen and yellow for the dining room. This ensured there was no cross contamination. The laundry was tidy and soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

The environment was safe and secure for people who used the service and staff. Effective checks were in place to ensure the environment and equipment being used was safe. These included weekly tests of the fire alarm, visual checks of the fire extinguishers, legionella checks and monitoring the hot and cold water in the baths and showers. Window restrictors were in place as necessary. Where concerns were identified action was taken to resolve the concern. For example, when the temperature of the water coming out of a tap was too high and could put someone at risk of scalding. The relevant person in the company who oversaw repairs had been contacted and this was resolved.

A designated person from the provider's central office was responsible for ensuring the servicing of equipment. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, electrical and lift maintenance. Certificates and records of servicing and safety checks were held at the provider's head office. The manager had put in place a signing in book for external contractors so they were aware who had visited should they not be in the building. This was so they could keep a check that servicing and maintenance was being completed. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by an external contractor who visited the service weekly.

At the last inspection the area manager said they had a redecoration programme scheduled, to remodel the lounge and dining room, with new furniture, mood boards. This had not happened at the time of our inspection. However the manager said the redecoration was scheduled and they had discussed with people what they would want regarding the design.

There was a health and safety committee who met regularly to discuss issues identified and actions required. The members of this committee included a representative from housekeeping staff, care staff and a senior care worker. The manager had undertaken a health and safety audit and said they intended to present the outcomes to the next scheduled meeting which was held every three months. This was so they could put in place actions required and delegate who would be responsible.

Records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin damage, nutrition, infection control and handling assessments. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. People assessed as being at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. Each person had a 'personal risk screening tool' completed which assessed risks in areas regarding social contact and activities, health and physical wellbeing. The outcome of the assessment identified the level of risk. For example whether low, medium or high risks which was identified as green, amber or red. This meant staff

had a clear visual guide to help them assess people's risks quickly. This system supported agency staff working at the home.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken and any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures.

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff had time to meet people's individual needs. People and staff said they felt there were adequate staff levels to meet their needs. People when asked about how quickly staff responded to their call bells said, "I ring my bell and they come along"; "It depends, most of the time fairly quickly "and "I am quite happy here, they are all very nice. Sometimes they take a while to answer the bell. "The manager said they were unable to audit the call bell system at the home because the system did not have this facility at the time of our visit. However, they said when they were in the building they monitored the call bells and were happy they were answered within three to four minutes. Staff confirmed the manager had been at the service at unsociable hours so was able to make a judgment about response times at different times of the day.

The staff schedule showed a senior care worker and four care staff in the morning until 11.15 am and a senior care worker with three care staff in the afternoon, with a senior care worker and a care worker at night. Day staff were supported by the manager, an administrator, activities person, a cook, kitchen assistant and housekeeping staff.

The manager was actively recruiting to fill vacant positions. Staff undertook additional duties to fill some gaps and the provider used the services of local care agencies to cover gaps. The manager said they booked agency staff a week in advance to ensure planned gaps were covered. They had regular agency staff who people knew to maintain a consistent approach. The manager said they were trying to build up their own staff team so they did not need to rely so much on agency staff.

The staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. They were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the manager about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. The manager and deputy manager were scheduled to attend a practitioner's level safeguarding training with the local authority to have a clearer understanding of the safeguarding procedures in the local authority.

Emergency systems were in place to protect people. Fire safety assessments had been completed which identified the level of support a person would require in the event of an emergency. For example, green indicated unaided, amber required one member of staff and people assessed as red required two staff to assist them. This information was available next to the fire panel so it could be easily accessed by the emergency services. First aid boxes throughout the home were regularly checked and refilled to ensure they had the required equipment if needed. Staff undertook security checks at night to ensure windows and doors were secure to keep people safe.

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Requires Improvement

Is the service effective?

Our findings

At our last inspection, there was a breach of regulation. This was because the provider was not acting in accordance with, The Mental Capacity Act 2005 (MCA). They had not ensured staff had the required documentation and understanding to apply the MCA 2005 appropriately for people they supported. At this inspection improvements had been made and this regulation was now met.

Staff were skilled and were able to tell us how they cared for each individual to ensure they received effective care and support. They demonstrated through their conversations with people and their discussions with us that they knew the people they cared for well. For example, staff were supporting a person who had become unwell. They undertook regular checks and ensured the person was comfortable and showed concern and compassion. They demonstrated the skills required to meet this person's needs. They were also supporting a person who had a dementia diagnosis who did not recognise risks and could become distressed. They were skilled in their approach with this person explaining what they were doing and reassuring them when supporting them to undertake a task.

New staff on induction at the service worked shadow shifts with experienced care workers to enable them to build confidence and understand people's needs. The manager had recognised not all staff had completed the provider's induction workbook. They had identified staff who had not and were working to put this in place. The manager said they had not used the new Care Certificate which had been introduced in April 2015 as national training in best practice. They said they would use it for the next new and inexperienced care worker that started at the service. This was because all new staff that had started at the service since the new manager had been at the home had a higher qualification in health and social care. One care worker said, "I am part way through the booklet. I did five shadow shifts in all with the girls that knew what they were doing. I was asked if I needed more time… it was good I wasn't told just to get on with it."

Not all staff had completed the provider's mandatory training. The manager had identified that there were gaps in some staff members' training and others had not had update training. They had put in place a programme of training for all staff to ensure all staff had completed the required training. Staff were positive about the training, they said there had been a lot of training and they recognised why they needed to undertake the training. One care worker said, "The training is really good." The training included safeguarding of vulnerable adults, infection control, nutrition, dementia, first aid, fire, DoLS and MCA and food hygiene.

Two senior staff had completed evacuation chair training with the aim to cascade this training to all staff. This had been a recommendation in the fire assessment carried out in February 2016. The manager said they were looking to get a staff member trained to be a manual handler trainer to deliver regular training within the home.

The manager had recognised staff there was not a programme of regular and consistent supervision for staff. They had taken responsibility to undertake the deputy managers and senior care workers supervisions. They had designated the deputy manager and senior care workers to undertake supervisions of domestic

staff and care staff. They said supervisions would be carried out every two months. Not all staff had received a formal supervision this year but had one scheduled with their line managers. Where staff had received supervision aspects of their practice, philosophy of care and career development needs were discussed. One care worker said, "I feel you can say if you need something." Appraisals had been carried out in August 2015 and the manager said she would undertake them in August 2016. Staff said the manager was building staff confidence. For example they were working with one member of staff to develop to a more senior role within the home.

The MCA 2005 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection mental capacity assessments had not been completed to demonstrate that people did lack capacity before a best interest decision was made on their behalf. At this inspection we found the provider had implemented an MCA assessment document for staff to complete if required for each of ten identified areas of care. These included health, sleeping and night care. The manager had a good knowledge about the MCA and refresher training was scheduled for all staff at the beginning of July 2016.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The manager had made appropriate applications to the local authority deprivations of liberty team. None of these applications had yet been authorised.

It was difficult to ascertain what legal responsibilities had been appointed to relatives by the court of protection. This was because staff recorded if relatives said they held a power of attorney but they had not checked which power of attorney they had. For example whether health and welfare or finance or both. This meant people's rights were not fully protected. The manager said she would ask people's families to demonstrate the powers they had been appointed.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the visiting optician, and chiropodist. Records showed when health concerns were identified and people were visited by health care professionals. For example, staff had contacted a person's GP promptly when a person came to the service and staff recognised they were in pain. During our visit staff had contacted a GP quickly because they had concerns about a person health.

The deputy manager had been working with staff to monitor people's dietary and fluid intake. They were completing a nutrition assessment and contacting the dietician and speech and language (SALT) when they identified concerns.

Staff took action and followed health professional's advice. One health professional said, "We are contacted promptly with concerns. There appears to be a good relationship with the residents and care staff who work

hard to meet their needs which I feel are met well."

People confirmed they had been seen by health professionals. One person commented, "Very good care frankly, the drop of a pin you get medical attention. You get care whether you like it or not, they check things out." A visitor commented, "What they are very good at is informing me if there is a problem."

We observed a handover held between shifts. Staff were engaged in the discussions, they were asked when they were last on duty. They were given the information they required to ensure they knew people's changed needs and requirements. Because the lift was out of action staff were reminded to undertake care and comfort rounds to ensure people had been offered drinks, support to the toilet and reassurances that staff were available.

People were supported to eat and drink enough and maintain a balanced diet. Everyone was complimentary about the meals at the home. Their comments included, "The food here is wonderful, I wouldn't get anything like this at home"; "Very nice food"; "Food is not so bad" and "The food is very good, I am very happy here."

There was a four week menu with a choice of two main meal options and one dessert. The cook said people could have the option of yogurt, fruit, ice-cream or jelly as an alternative if they did not like the dessert on offer. It was evident that people had made choices by the different meals they were eating.

On the first day of our visit the lift was not in use so the majority of people on the first floor chose to eat their meals in their room. Care staff ensured everyone received their meals and had the condiments they required. We visited people in their rooms and they said they had enjoyed their meals. During the lunchtime period on the second day of our visit there was a happy atmosphere in the dining room with people chatting sociably. Tables were laid up with place mats and salt and pepper was available where appropriate and a menu on each table room with the weeks menu choices. Staff were attentive to people's needs and went around offering a choice of drinks and support.

People who required a special diet were catered for. The cook had clear guidance about people's needs and who required a special diet. For example, people requiring a sugar free diet. They could differentiate between Speech and language (SALT) recommended consistencies of puree and fork mashable consistencies. Speech and language therapists provide treatment and support for people who have difficulties with communication, or with eating, drinking and swallowing. This meant people who required a specialist diet recommended by SALT had the appropriate meal consistency to meet their needs safely.

Good

Is the service caring?

Our findings

Staff were kind and friendly towards people and were seen positively interacting with them, chatting, laughing and joking. People said staff listened to them. People's comments included, "Staff are very obliging, I can't complain"; "Some very nice staff and some are still learning but they are getting there" and "I don't think we could have been more fortunate to land here. The girls in general are very good, very helpful."

Care workers told us people received good care. Comments included, "I feel the residents are well supported… because of the team of people who works here they are all so nice"; "They care and are understanding they all treat residents as we would want our mums to be treated.. we can have a bit of fun with them but always thinks about their dignity."

Staff talked with us about individuals in the home in a compassionate and caring way. They said they spent time getting to know the person and demonstrated a good knowledge of people's needs likes and dislikes. Care plans were focused on the person and their individual choices and preferences and contained personal histories. This enabled staff to have a good knowledge of people's past and people and events special to them.

Staff were considerate and caring in their manner with people and knew people's needs well. They were friendly and supportive when assisting people. They treated them with dignity and respect when helping with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people when supporting them with personal care and gained consent before providing care. Staff were seen supporting people to the dining room in a kind manner. They did not rush them and took time to help them to sit down and when they had finished to stand up. Staff were heard telling a person with deteriorating eye sight what the dessert in front of her was and waited for the person to acknowledge they understood.

On the first day of our visit the lift had broken down and they were awaiting a part to fix the problem. This meant some people were unable to go downstairs to the main communal areas. People had been kept informed about the issues and the manager had written a letter to people to ensure people knew what was happening. Where one person had needed to change rooms because they could not access their room upstairs the manager had brought flowers for them as a thank you. Staff were busy as the lift being out of action had increased their work load. However they happily chatted to people and there was a pleasant atmosphere at the home.

People's consent for day to day care and treatment was sought. Staff gained people's consent before they assisted people to move and they explained what they were doing and involved the person. They listened to people's opinions and acted upon them. For example, where they wanted to spend their time and if they required further refreshments.

Staff involved people in their care and supported them to make daily choices. For example, staff were heard asking people if they wanted to use the temporary dining area set up on the first floor. Another person had

asked to stay in bed which they did. The deputy manager has run sessions with staff to improve writing in care records and giving people choices. For example, we were told, if someone wants to stay in bed they can. Staff said they would ensure they have a drink and a bell but it is their choice. One care worker said when talking about the changes at the home, "More laughter in the house, much more about them…before there was not much choice now there is."

People's relatives and friends were able to visit when they liked. People and a relative said they were made to feel welcome when they visited the home. One person commented, "People can come and see you any time day or night, they treat it like it's your own home it is open seven days a week."

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. People confirmed the daily routines were flexible and they were able to make decisions about how they received their care, spent their days and what activities they participated in. People said staff were responsive to their needs. One person said ''They are lovely whatever we need we get."

Before people came into the service the manager would undertake a pre-admission assessment to ensure the service could meet their needs. They met with people and their families and discussed their care needs and what was important to them. This information was then used to generate care plans to guide staff to know how to provide the care they required. This ensured people's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. The care plans covered people's health and physical wellbeing, psychological and mental health, nutritional needs, communication, continence, sleep, mobility and personal hygiene. There was also care plans in place to guide staff about needs and choices and social contact. For example one person's plan recorded, 'I have a telephone in my room, I have lunch in the dining room with the other residents. What staff need to do to support me. I require assistance from one carer to bring me down in the lift so I can come into the dining room/lounge... I normally know what events are taking place but occasionally I need reminding.'

People's care plans reflected people's changing care needs. They gave staff details about people's preferred routines and what care and support they required when they become unwell. Staff were made aware of the needs of new people at the service at handovers and were also encouraged to read people's care plans. Care plans had not always been reviewed in a timely way. The deputy manager said they had implemented a monthly care plan review and changes would be added as they occurred. The manager said they were supporting staff to build up their confidence with writing people's records.

People's care folder included personal information and identified the relevant people involved in their care, such as their GP, optician and chiropodist. They also included information about people's history, likes and dislikes. There was a 'preferred priorities checklist' completed. This included people's religious preferences, funeral decisions, their will arrangements and who (family and/or friends) they wished to be present in the event of them dying or their death. This meant that when staff were assisting people they knew their choices, wishes, likes and dislikes and provided appropriate care and support. The care files were presented in an orderly and easy to follow format. Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. The manager was putting in place that senior care workers involved people formally in reviewing their care plans.

The manager recognised activities were an important part of people's lives. Previously there had been a committee at the service who arranged activities and fund raising events. They had stopped their involvement with the service in February 2016. Members of the committee had visited the home each week to have a chat with people and go and get shopping they required. One care worker had recognised people had missed this arrangement and had set up a shop (referred to as the tuck shop) supported by the manager. This had been very well received by people. There was a designated activity person employed by

the service. At the time of the inspection they were leaving and the manager had recruited a new activity person who was scheduled to start subject to the appropriate employment checks. The manager said in the interim period care staff would take on the responsibilities of ensuring there were activities going on at the home. This included looking at newspapers and discussing current events and news and listening to music. There was art work displayed on the wall in the dining room completed by people in April 2016. A coffee morning had been arranged at the home to encourage volunteers to visit the home. The manager had arranged a community bus to take ten people on a mystery outing which the manager said people had appeared to have enjoyed. Two further outings had been arranged. The Abbeyfield society has celebrated their 60th anniversary this year and a garden party was held at the home to celebrate, with the mayor and an external entertainer attending. The manager had also reinstated the monthly newsletter to keep people informed of events and things happening at the service.

Written information about how to raise concerns or complaints was available in the main entrance and easily accessible for people, relatives and visitors to use. People said they would feel happy to raise a concern and knew how to. Comments included, "I would go to the manager she is very approachable. I haven't needed to yet, touch wood…have been exceedingly kind to me" and "There is no way either of us could complain as we both have been treated exceedingly well." The manager had received one complaint regarding a person's laundry. They had responded to the complainant in line with the provider's policy. The manager was still in discussions with the complainant to resolve the concern and put in place new ways of working to reduce the risk of it reoccurring in the future. As an outcome of these concerns the manager was looking to change the routine with bedding being laundered in the morning with people's personal clothing in the afternoons-change to take place in August. The manager said there was a message book where senior staff recorded messages and concerns. This was used to ensure the manager was kept informed so she could deal with issues and concerns before they became a complaint.

Good

Is the service well-led?

Our findings

Staff spoke positively about the manager and said they had made significant changes and improvements at the home. Staff comments about the manager included, "The new manager is ace and is implementing change, she has ordered new hand gels, new flannels the basics we need to do our job. There are red bags in the rooms and all of the training is being done, it is brilliant"; "The new manager is very approachable, she has only been here a short time actually but has put in place things that needed to be done. She knows her job quite well. I am really impressed with her" and "We have gone to the manager about getting stuff and it is here by the next day." A senior care worker commented, "The change is positive... staff morale has gone up. Most of the carers have given me good feedback. By this time next year I believe you will see a big difference."

People were also positive about the new manager and providers. Comments included, "The new manageress seems very nice, very helpful, very approachable" and "(The manager) is very approachable if you need anything she listens."

The manager was in day to day control at the service supported by a newly appointed deputy manager. One care worker said, "(The deputy manager) is a good support as likes things well done." They were supported by senior care workers who worked alongside staff. The provider's business manager also visited the home. The manager said they were supportive and backed the changes they were making and was available at the end of the phone to support her.

The manager had looked at the issues raised at the Care Quality Commission's (CQC) last inspection. They had been working to address the main areas of concern. They said their main priority was ensuring staff levels met people's needs and was keen to build on the current team. They had identified training had fallen behind and had put in place a training programme. They had identified areas which had not been acted upon. These included floor boards creaking in the dining room so had this resolved. A fire risk assessment undertaken in February 2016 recommended an addressable fire panel. The manager was currently looking at getting quotes. The risk assessment also raised concerns regarding the safety of some fire doors at the home. On the second day of our visit there were outside contractors in the home undertaking changes to the fire doors as recommended in the fire risk assessment.

People's views and suggestions were taken into account to improve the service. The manager recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. They had held a meeting to introduce themselves to people and ask their views. One person said, "We have meetings once a month sometimes more frequently. The manageress is here, office manager, nursing staff all here …anybody can raise anything they like." Topics discussed included staff levels, activities and people being able to make choices about their day to day activities. For example, coming down to the dining room for breakfast. The deputy manager reminded people that they could speak to her or the manager if they had any worries.

People had been asked to complete a questionnaire in October 2015 about the service by an external

market research organisation on behalf of the provider. They had received 15 responses from people. The survey asked people's views about the staff and care they received, the home and comfort, choice and having a say and quality of life. The area that came out the lowest was about choice. The manager had prioritised this and had been working with staff and people to change this at the service. They spoke with people at a residents' meeting and staff were being guided to ensure people were offered choice.

Staff were consulted and involved in decisions making about the service through regular staff meetings. Staff said they felt informed and listened to. The manager said, "I had a staff meeting to try and increase staff morale and pride in working for the service." The manager had held two staff meetings and discussed changes being made. They said they were keen that staff were involved with changes being made. For example, staff agreed to have polo shirts as their new uniforms, although not all had agreed on the colours they wanted. A meeting with senior care workers had discussed care plans allocation, delegating responsibilities, discussed the survey and the need to increase choice.

The manager had held a team building session with staff. They had been placed in pairs and were asked to discuss the most embarrassing thing that had happened to them. The manager was very positive about the outcome of this session and said it had been well received by staff and it had help improve staff morale as people got to know one another.

A range of quality monitoring systems were in use which were used to continually review and improve the service. The manager had implemented an action plan identifying the areas they had identified which required improvement. An example recorded in the action plan dated 6 May 2016 included, training to be scheduled and completed, quarterly health and safety meetings, infection control audit, programme of regular supervision to commence and care plans to be up to date. They had started undertaking these tasks. The infection control audit had identified some cleanliness issues in the home. They had already had an external commercial cleaning company to undertake a deep clean of the kitchen. They were due to return to undertake a deep clean of the shower rooms, ensuite and communal toilets and bathrooms. The manager said the cleaning schedule needed improving and was working with the housekeepers.

The service worked with other health and social care professionals in line with people's specific care needs. People and staff commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GPs, speech and language therapist, district nurses and physiotherapists.

In June 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored four with the highest rating being five. This confirmed good standards and record keeping in relation to food hygiene had been maintained. Where they had made recommendations these had been acted upon.

There were accident and incident reporting systems in place at the service. Accidents were recorded by staff and followed up by senior care workers. The manager saw all of the accident records and had to sign each one to demonstrate she was happy with the actions and outcomes. The manager said every month they looked at trends and patterns of incidents and was aware on a day to day basis of concerns.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as when a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested and working in line with their registration.

The provider had displayed the previous Care Quality Commission (CQC) inspection rating in the main

entrance of the home and on the provider's website.