Methodist Homes

# Abbey Park

## Inspection report

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28 September 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 27 and 28 September 2017 and was unannounced. Abbey Park provides both nursing and 'residential' care for older people and people who live with dementia.
There are five units at the home which provide care to a maximum of 84 people as follows:

24 Residential flats (Sherbourne Suites)
15 Residential dementia rooms (The Meadows)
15 Dementia Nursing (Greyfriars)
30 General Nursing (Avon/Arden)

At the last inspection on 10 June 2015 the service was rated as Good. At this inspection we found improvements were needed to meet the required standards.

Staff knew people's needs and understood their responsibilities to protect people from harm and the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise them. However, people did not always experience care that was responsive to their needs in a timely manner. Staffing arrangements were not sufficient on some units to ensure people's needs were met. Some staff were particularly busy which restricted the time they could spend with people.

People were offered a choice of meals that were suitable for their individual dietary needs but some people on some units were not sufficiently supported during mealtimes which meant it was not a positive experience for them.

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

The provider's recruitment processes ensured staff were safe and suitable to work with people before they started working at the service. Staff completed training on an ongoing basis to develop their skills and knowledge so they could support people safely and effectively. Nurses had not received regular clinical supervision to update their nursing practice. People were involved in planning how they were cared for and supported.

Staff ensured they obtained advice and support from health professionals when needed. People were fortunate to have access to some health professionals within the home who worked with staff to maintain and improve people's health. Medicines were stored, administered and managed safely.

People told us they felt supported by staff who were caring and respectful. People across all units were positive about the staff. People were supported with some of their interests and hobbies. People felt they

could approach the staff with any concerns and complaints were investigated and responded to.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff worked to the principles of the Mental Capacity Act, and ensured people, or an appropriate representative, consented to care and treatment. DoLS applications had been made and authorised where required.

There were a range of systems to monitor and review the quality of the home to ensure the service was run effectively and in line with the provider's policies and procedures. However, these had not been consistently effective in identifying the improvements needed such as those we had found during our inspection. The management team and the provider completed regular checks to highlight any issues in the quality of the care provided, and to drive forward improvements. For example, regular checks of medicines and accidents in the home. Comprehensive health and safety checks were also carried out on a regular basis.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Staffing arrangements were not always effective to safely meet people's needs. Clinical support updates for nurses had not taken place regularly to ensure consistently safe and effective practice. Staff knew about risks related to people's care and actions to take to minimise them. Staff recruitment procedures reduced the risks of employing unsuitable staff. Medicines were managed safely by trained staff. The premises and equipment were safe for people to use.

### Is the service effective?

**Good**

The service was effective.

Staff received training on an ongoing basis to meet people's needs effectively. Staff worked to the principles of the Mental Capacity Act, and ensured people who had capacity consented to any care and treatment provided. People received a choice of meals that met their dietary needs. People had access to health professionals.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and caring in their approach and people spoke positively of the staff. Staff showed respect to people and supported people to maintain their dignity and privacy. Visitors were welcomed at any time.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Staff knew the needs of people who lived at the home and aimed to work in accordance with their preferences. However, some people did not experience care and support that met their needs. Staff were particularly busy in some units during the day which restricted the time they could spend with people when they

needed them. People had access to daily activities to support some of their interests and hobbies. Complaints were responded to and people felt staff were approachable if they had a concern.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

People and staff spoke positively of the home and the management team and were given opportunities to suggest ideas for improving the quality of care and services provided. The provider completed a range of quality monitoring checks of the service but these had not consistently identified areas needing improvement.

# Abbey Park

**Detailed findings**

## Background to this inspection

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

The inspection took place on 27 and 28 September 2017. The visit on the first day was unannounced and was undertaken by two inspectors, two experts by experience and a specialist advisor. An expert by experience is a person who has experience of using this type of service themselves or caring for someone who used this type of service. The specialist advisor was professionally qualified as a registered nurse. The second day of the inspection was announced and was undertaken by one inspector and the specialist advisor.

Before the inspection the provider completed a Provider Information Return (PIR). This 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 which included notifications they had sent us. Notifications are sent to the Care Quality Commission to inform us of events relating to the service which they must inform us of by law. We asked the local authority if they had any information to share with us about the services provided at the home. Local authorities are responsible for monitoring the quality of care for people who use the service funded by them. They made us aware of some issues that had been raised with the service including actions required relating to completion of care records. They advised people had been positive in their comments of the home.

We spoke with 17 people and five relatives across all units within the home about their experiences of using the service. We spoke with the registered manager, deputy manager, five nurses, ten care staff, the music therapist, the cook and two maintenance people.

Some people were not able to communicate their experiences of care at the home due to their healthcare needs. We therefore spend a period of time of each of the units observing how people were cared for and

supported. This included the use of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at seven care plans to understand how people's care needs were supported and how risks associated with their care were managed. We reviewed records related to medicine management, staff training, clinical supervision of nurses and accident and incidents. We looked at recruitment records, complaints records, health and safety records and records of quality monitoring including actions taken to improve the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

People told us that staffing arrangements in the home did not always meet their needs. Two people spoken with on the nursing units said staff took too long to respond to call bells. One told us, "I find it hard to be independent now as I was never waited on before …..as for my buzzer it might take three quarters of an hour to get them if I need something. When the staff do come we have a laugh." Another said, "Staff always check on me overnight but call bells take a while to be answered."

A relative on one of the nursing units told us, "I do feel [person] is safe here. My only worry is the staff changes. Staff are leaving and then they use agency staff who don't know [person]."

Abbey Park has five units, each supporting people with differing needs. People had varying experiences of there being staff around to support them. One person told us, "As for staffing it's sometimes a bit short. It's not as efficient as when I first came here."

We asked staff if they felt there were enough of them to meet people's needs safely. One staff member commented that the staffing arrangements sometimes meant they could not respond to people in ways they would like in an emergency situation. They told us, "You feel you need another carer on when you have so many emergencies like one falling or someone sick in another room." Another told us, "I think on Avon and Greyfriars there are times when it can be really hectic. If that is the case we have [staff member)] helping us, she is normally in the office." We were told this staff member was a volunteer co-ordinator and sometimes worked as a member of care staff. The staff member went on to tell us, "We always have somebody in the lounge" and stated sometimes the nurse stayed in the lounge if care staff were in rooms supporting people. They said, "We have to communicate where everybody is." Other staff said there were usually enough staff on the units to meet people's needs but this was dependant on people's changing needs which could fluctuate each day.

We found staffing arrangements were not always sufficient to meet people's needs. There were periods of the day when staff were not around for short periods of time in some of the lounges. This meant those people who should be closely monitored were vulnerable to the risk of harm. For example, one person on a dementia unit approached a person asleep in the lounge, sat on them, kissed them and woke them. Although the person did not object and it did not appear to have a negative impact on them, it could have. This was not witnessed by staff. When we spoke with staff, they suggested there should always be a staff presence in the lounges.

We found at mealtimes staffing arrangements were not effective. A relative told us, "I often have to clean [person] up as the food can be all over the place." At lunchtime on a nursing unit, four people chose to have their meals in the lounge dining area, and the rest, in their rooms. A staff member told us all people in their rooms were able to eat independently. However, we found several people needed support. In one room a person had slid down their bed resulting in their bed table being too high for them to see their food properly. We had to ask a staff member to assist the person so they could eat. Another person had their meal on a bed table that was placed too far away from their bed so they had to stretch their arms to reach it. The

person was leaning sideways out of bed to eat which placed them at risk of falling. A considerable amount of their food was on the floor. When we returned 45 minutes later the person was asleep and the food remained on the floor. Another person was seated in bed with a full plate of uneaten food on their bed table which was still there when we checked some time later.

In the lounge on this unit, one person had been given their meal but was unable to eat it unaided. They waited twenty minutes to be assisted which meant it was likely the food was cold. On another nursing unit, people were seated at tables waiting for their meals for half an hour when others had already been given their meal. This did not support a positive mealtime experience for them. We saw one person had fallen asleep at the table while they had been waiting. A staff member on the nursing units told us they found the staffing arrangements over lunch presented a challenge to them because there were so many people needing assistance or prompting to eat.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

We asked care staff if there were sufficient nurses to support them and ensure people were kept safe. One staff member told us, "Generally they (nurses) are supportive. Sometimes you feel you don't want to contact them too much if they are busy." They explained that whenever nurses were free, they helped to assist people to eat and attend to their personal care. Night staff told us there were enough of them to manage people's needs and to carry out their duties safely and effectively.

The registered manager told us the number of agency staff that worked at the home was minimal as they had successfully recruited to nurse vacancies in recent months. They told us agency staff had been "block booked" when needed to minimise disruption to the service and help provide people with consistent care. The registered manager also subsequently advised us that call bell response times were monitored to check people were not left for unacceptable long periods of time before they were supported. They had not identified any recent concerns and stated nobody had been left for long periods of time.

People told us they felt safe at the home and with staff. One person told us, "I do like living here and I feel safe because everyone is always helpful. They do a really good job. There seems to be enough staff. I have no real worries or fears." Another told us, "I feel safe and if I need anything then I press my buzzer and they come pretty quick."

Staff had completed training in safeguarding people and understood their responsibilities to keep people safe and protect them from harm. Staff knew to report any concerns such as potential abuse to their manager. When we gave staff scenarios and asked them how they would respond they gave appropriate answers. The registered manager had referred safeguarding concerns to the Local Authority and the CQC in accordance with the required procedure.

The registered manager told us an assessment of people's needs was undertaken before they came to Abbey Park which identified any potential risks to providing their support. For example, some people needed specialist equipment because they were not able to move around safely. Others needed special equipment because of the potential risk of them developing sore skin and skin damage. We saw several people used specialist chairs. These were people who could not use ordinary chairs as they were not safe for them due to their healthcare needs. The specialist chairs meant they could sit safely with others in the communal areas.

Staff knew people's risks and how to manage them. For example, one person had been sitting on a dining

room chair for some time, a care staff member went to the person and said, "Do you not want to sit in a comfy chair? You're falling asleep there, it is a hard chair, it might hurt your bottom." Those people at risk of developing sore skin due to sitting for long periods of time were seen to be sitting on pressure cushions and people in specialist chairs were repositioned regularly by tilting them to prevent the risk of skin breakdown. We saw two staff assisted a person to move from their chair safely and in accordance with information in the person's care plan to ensure they were moved safely.

We noted that the bottom of some of the specialist chairs had rips in the upholstery. The registered manager told us this had already been identified and there were plans to raise funds for them to be replaced. They told us the infection control risks were minimised as these were below touching level of people when seated.

People received their prescribed medicines by suitably trained staff although one person felt their prescribed medicine had not been obtained promptly. They told us, "I have a nose and throat problem and saw a GP recently but I am still waiting for a spray to appear." When we checked the medicine records we found the medicine had now been received. However there had been delays in staff following this up so the person received it in a timely manner. We were told this was because the medicine had been prescribed in the middle of the medicine cycle. Repeat medicines were usually ordered and received monthly.

A nurse told us it was very time consuming ordering and checking medicines during a busy shift, and felt that improvements could be made by requesting this to be a separately allocated task to their shift. They felt it was difficult to meet people's needs effectively on these occasions.

Medicine records were signed to show when medicines had been given as required. Medicines given through a PEG (feeding tube) had been recorded on fluid charts as well as medicine records so it was clear they had been given safely. Medicines that required extra checks were checked by two nurses as well as the deputy manager. Where people had been prescribed medicines to be given PRN (as required) there were clear instructions stating how the medicine should be managed to minimise the risk of too much being administered.

Staff told us they were not allowed to start work until their recruitment checks had been completed which minimised risks to people's safety and welfare. Records showed staff were recruited safely and included Disclosure and Barring Service (DBS) checks and written references. Checks had been made that nurses were registered by checking their personal identification numbers (PIN) allocated to them when registered.

The provider had taken measures to minimise the impact of unexpected events such as fire risks. Each person had a personal evacuation plan on their file so that it was clear how they would need to be supported. There was an evacuation plan kept in the registered manager's office and in the reception area of the home so this was accessible to staff and the emergency services in the event of an emergency. Safety checks of the premises and equipment used were carried out by two maintenance men employed by the service. They managed any environmental risks and equipment concerns and checked equipment such as specialist mattresses and beds to make sure they were in good working order. Any faulty equipment was reported to the relevant supplier and where appropriate removed.

Good

# Is the service effective?

## Our findings

People felt that overall staff had the skills required to meet their needs and our observations throughout the day showed most staff knew how to support people's needs appropriately. For example, staff explained to people what was about to happen when they hoisted them into chairs from wheelchairs. They made sure people sat on pressure cushions to prevent skin breakdown. They also wore protective clothing such as aprons when supporting people to help prevent the spread of infection within the home. This demonstrated their learning.

Staff completed training so they could meet people's needs effectively. Staff told us when they were recruited they went through an induction process and shadowed (worked alongside) other more experienced staff to prepare them for their role. New staff completed induction training which also included their competency being assessed. Records showed training for care staff was based on the 'Care Certificate'. The Care Certificate helps new staff members to develop and demonstrate they have the key skills they need to provide quality care. Ongoing training was planned and delivered to support staff development and this was ongoing. Overall staff felt the training provided was sufficient and helpful. A nurse, however, told us they would value more training on dementia care.

Staff told us they had attended supervision meetings with their manager to discuss their role and any training development needs. We identified the nursing staff had not received regular clinical supervision to ensure their nursing practice was updated and they worked to best practice. The 'Nursing and Midwifery Council' recommend clinical supervision at least every three months. One nurse told us, "I have not had clinical supervision for months." However they told us they would go to the senior nurse in charge if they needed advice and said, "I know she will support me.'' The registered manager acknowledged clinical supervision had fallen behind and planned to address this before the end of the year.

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

The registered manager understood their responsibility to comply with the requirements of the MCA. Staff had received training in the MCA and aimed to work within the principles of the Act. Staff understood the importance of supporting people to make as many decisions of their own as they were able to. We saw them ask for people's consent before delivering care.

The MCA and Deprivation of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. Applications had been submitted where potential restrictions on people's liberty had been identified, and there were systems to ensure that DoLS

applications were resubmitted prior to the DoLS expiry date to ensure the home continued to deprive people of their liberty legally. Staff understood the importance of the MCA and how this impacted on people. For example, one staff member told us, "It's when we sometimes have to take away someone's rights due to mental capacity." They went on to tell us about a person who needed a daily shower which they sometimes didn't want but explained how a decision had been made for them to have a shower as this was in their best interests. They told us, "They are okay when sitting down, it's just the going to the bathroom."

People had a choice of meals and were able to choose if they had their meals in the lounge, dining area or their bedroom. One person told us, "I only have toast and marmalade (for breakfast), I could have a full English breakfast every morning but choose toast." Another told us, "The food is brilliant. I have different meals every day and a good fried breakfast every day." A relative told us the food was "adequate" for their family member's needs.

The provider told us people were involved in making decisions about meals provided. We saw 'resident' meeting notes that confirmed people were asked about menu choices. People said they could choose where to eat their meals. We saw people had access to drinks and snacks during the day and we saw drinks in people's rooms on bedside tables.

People with specific dietary needs had their needs met. The advice of health professionals such as the Speech and Language Therapist (SALT) or dietician was sought when there were concerns around people's nutrition. For example, one person had lost weight, and an appropriate referral had been made to the dietician and high calorie milkshakes had been prescribed to help them gain weight. A vegetarian had a vegetarian menu made available to them. The catering manager told us staff informed them of people's specialist needs and when a new person came to the home their nutritional needs were discussed so they could accommodate them. The catering manager knew about people's allergies and cultural needs and ensured these were taken into account when preparing menus.

Staff knew those people who needed their food made soft or pureed so that it was easy to swallow to reduce the risk of them choking. We saw advice sought was followed. Thickening agents were used in drinks for those people who had difficulty in swallowing. Where people were assisted by staff they were not rushed. Some people had spouted beakers to assist them to drink and plate guards to hold the food on the plate so they could eat independently.

People were able to see health professionals when there were changes to their health that required their advice. Care plans confirmed people saw chiropodists, opticians and GP's. The registered manager told us a GP regularly visited the home to see people who had health problems.

Good

# Is the service caring?

## Our findings

People we told us they felt supported by staff who were caring. People across all units were positive about the staff. One person told us, "I am definitely very happy here. They are lovely people (staff). They'll do anything for you." Another told us, "They are all very nice and they are always nice to us all."

People were supported to maintain relationships with those who were important to them and made choices about who visited them at the home. Relatives told us they were welcomed into the home and we saw them visiting people during the day. Relatives were positive about the staff. One told us, "Generally I am very pleased (with the care)," they went on to say they were made to feel, "Very welcome in the home." Another relative told us, "The cleaner is excellent, she'll come and speak to [person] in her lunchbreak." Another relative told us, all their family members were made to feel welcome when they visited.

Staff were caring and supportive towards people and we saw all staff warmly interact with people. One care staff member who was making a drink for a person used the opportunity to have a conversation with them. The staff member pointed out the autumn colours on the trees and said how the temperature was cooling now that Autumn had arrived. This helped to orientate the person who was living with dementia to the time of year. We saw smiles and laughter shared with people on several occasions when staff sat next to various people and had a quick chat.

On the Meadows unit there was a relaxed homely feel. Interactions between people and staff were natural, familiar, warm and compassionate and each resident appeared to feel valued. The staff team on this unit had rapport and a strong sense of team work. Staff knew people well, one staff member noted a lady's perfume and asked her if it was a particular one this generated discussion and a genuine interest in the person.

A person in one of the dementia units indicated they were unhappy with their clothing. The staff member knew the person well and understood they wanted to change out of their trousers into a dress or skirt. The staff member saw there wasn't one in the person's bedroom so they went to the laundry and came back with two skirts. The person smiled at the staff member and pointed at a skirt they wanted to wear.

People's privacy and dignity was respected and staff knew how to ensure this was maintained. One person told us, "They usually knock, and I usually say 'come in' they shut the doors and curtains so people can't see (when delivering personal care)." We saw this happened. We also saw they when staff were going to assist a person with their personal care they took the time to get everything prepared before they did this so the person was not kept waiting unnecessarily during care. They told the person what they were going to do before they hoisted them so they were prepared and this did not make them anxious.

People had chosen how they wanted their rooms to be arranged and had personal belongings around them such as photographs and ornaments to make their rooms more homely.

The provider recognised important cultural events such as Diwali and we were told this occasion was

usually celebrated at the home with meals and entertainment. We saw the wishes of one person, who as part of their religion, wished to follow a restricted diet for a period of time. A request had been made this person only have vegetables for their meals. We saw the person was provided with these and they told us they were happy with this.

People had developed positive relationships with care staff and the activity organiser. The activity organiser knew people well and was able to speak with people about items of interest to them. People's birthdays were recognised and celebrated. Staff treated people with respect when supporting them with care.

We saw people seated in specialist chairs were asked if they wanted to join other people in the dining area at lunch time and furniture was moved around so they did not feel excluded and felt part of the lunchtime experience.

Requires Improvement

# Is the service responsive?

## Our findings

People gave differing views about staff responding to and meeting their needs dependant on which unit they were on. Whilst people's comments about staff skills and abilities on the Meadows and Sherbourne units were positive, comments about the nursing units were not always the case. One person told us, "The staff think they know what to do. I have continual nightmares. I rang for help recently but [staff member] didn't know what to do." A relative told us, "They are good here. The girls have been good but they need to anticipate [person's] needs a bit better." They went on to tell us how the person didn't like one particular drink which was frequently given to them because they would always choose the first option given to them. They went on to say, "Some staff know [person] but definitely not the agency staff." Another relative told us they were asked to be involved in their family member's care but their views were not always listened to. They told us, "Some take notice and some don't."

One person told us, "The staff are all very nice but I cannot have my [drink] no longer at night and they have renewed my care plan with it taken off just in case I have a toilet problem in the night." I haven't a good appetite so the various choices of food doesn't tempt me." Another person who was encouraged to sit at the dining room table told us they would like to sit with people who they could talk to. They said people they were seated with had limited abilities to communicate.

Relatives did not feel health appointments were always promptly arranged. One relative told us their family member had arthritis and they had considered physiotherapy could help but they had not received any support with this from the home. Another relative told us, their family member had a urine infection and it had been them who had identified this and "pushed" for a doctor appointment.

Some staff had a good knowledge of people's needs but some told us they did not. One staff member told us, ''This is a big home and we have to swop around a lot between units sometimes, so we don't always know the residents very well.''

People's care plans included their life history, religion, culture, family relationships, what jobs they did and what their interests were. Care plans had been regularly reviewed and updated to ensure information they contained was accurate. Care staff told us information in care plans helped them to understand the person and to get to know them as individuals. However, we found that sometimes people were not always closely monitored when there were concerns related to their care. For example, a nurse on the dementia unit had identified a person had behaviours that challenged and frequently shouted out but did not respond to staff intervention. The person was taking medicines that could impact on their behaviour. Their behaviour was not monitored or recorded to try and identify the reasons for this. Following our discussion with the nurse, action was taken to make contact with a mental health professional and they were requested to visit and review the person's medicines.

During our visit we saw a person was seriously unwell and the nurse in charge had not acted appropriately to meet their deteriorating needs to provide relief for their symptoms. We discussed this with the registered manager so they could take the necessary action to minimise the risk of this happening again.

On Avon and Arden units most people were cared for in bed. Staff told us they made regular checks of people to manage their personal care and pressure relief so they didn't develop skin damage. Prior to our inspection we had received concerns about a person's continence needs and nutritional needs not being met. During our visit, we found concerns in both these areas. When we walked around one of the nursing units during the lunchtime period it was evident some people in their rooms were in need of personal care and eating support.

The dementia care unit had limited resources available for people with dementia to touch, hold or investigate. There was one doll and a pram that could be used for doll therapy for those that responded to this, but nothing else was visibly present for people. We saw two people walking around the unit with nothing to occupy their time, staff did not distract or guide them to activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person Centred Care

People told us when they first moved in to the home, they were involved in discussing and agreeing how they were cared for and supported. One person told us, "I understand about my Care Plan and are involved." Relatives confirmed they also had some involvement in care planning. One told us, "We are asked for our views quite often and they review the care plan with me every six months."

On the Meadows unit we saw people's appearance was very smart. Their clothes were colour coordinated and clean in appearance. The gentlemen were clean shaven and some of the ladies wore perfume and nail varnish in accordance with their choices.

The registered manager told us they planned activities for people at different stages of their dementia and tried to have something for everyone. They told us, "We have to try and cater for both sides residential and dementia sides." They went on to tell us about plans to improve the environment within the Greyfriars unit. They explained, "We are trying to capture the Meadows environment within Greyfriars (nursing dementia care unit)." We noted the 'social care facilitator' completed some care tasks because of staff sickness. When staff were around, they responded to people's needs when they could.

The provider employed their own music therapists at the home after they had identified the effectiveness of music therapy for people living with dementia. We were told several one-to-one therapy sessions took place with people in addition to group sessions which had resulted in positive outcomes for people. At 11am, we saw a music therapist engaged people in a music activity on one of the units. People were seen enjoying the songs and using the instruments. One person was tapping their feet, two were playing instruments in time with the beat and another had a big smile on their face as the music was played suggesting they were enjoying it.

We saw action had been taken to pursue people's interests when this was possible. The registered manager showed us scrap books that had been put together to mark social occasions individual people had enjoyed across the units. For example, one person used to work in a post office sorting office. Memories of this were put into a scrapbook to share with the person. There were pictures of where the person used to work, their colleagues and little envelopes pasted into the book to remind them. Another person who worked at Cadbury's was taken there to celebrate their birthday. There were pictures of Cadburys many years ago and pictures of their visit as well as chocolate wrappers pasted into a book.

A chaplain at the home supported families when people were coming to the end of their life. The registered manager told us, "We have wakes at the home. She will conduct the funeral and wake." They told us a

"spouse group" had been developed by the chaplain to support families who had relatives in the home with dementia as some relatives experienced grieving as a result of their family members health deteriorating. The group was an opportunity for relatives to get together to share their experiences.

Church services and catholic mass were planned to support people's needs. Contact had also been established with a Hindu temple and support arranged for people to attend if this is was their wish.

People knew how to raise a complaint if they needed to and information was available in the home about how to do this. One person told us, "If I had a complaint I am sure they would listen." A relative told us, "I haven't had cause to complain but I would feel able to if I wanted to." Another stated, "They (staff) are very approachable," if they needed to raise a concern.

Prior to our inspection we received information from a member of the public that their family member's needs were not being sufficiently met and action to address their concerns was not being managed in a satisfactory way. These concerns related to a person having the right support and equipment to manage their healthcare needs as the person had developed skin damage. We found investigations into these concerns were ongoing at the time of our visit and the registered manager was co-operating with all agencies involved to ensure the issues of concern were addressed and responded to.

Requires Improvement

# Is the service well-led?

## Our findings

People were mostly positive about living at Abbey Park. Comments included, "All in all this is a brilliant place. I know the manager but I often see the chaplain who is lovely." Another said, "I have a good time here. It is good and I would recommend it to anyone." However, our inspection identified some people did not experience person centred care that met their needs. This suggested that audit processes were not consistently effective in identifying and responding to people's individual needs.

Quality monitoring processes had not been fully effective in identifying areas for improvement. For example, the staffing arrangements for the home were not always sufficient on some units to ensure people's needs were met safely and effectively. The registered manager told us the activity organiser and kitchen staff were able to help on units during the lunch period but following our observations, action would be taken to monitor staffing arrangements more closely.

People spoke positively of the registered manager and staff. One person told us, "I know who the manager is and I do see her. It is great living here and they all care and are very good to me."

People had access an in-house chaplain, activity organiser, music therapist and an occupational therapist to support their needs. The music therapist worked with people living with dementia to see if music had a positive effect on them and could be used to support their needs.

People were able to participate in monthly 'resident and relative' meetings where they could discuss issues related to the running of the home such as social activities and food preferences. This meant people were involved in some decisions that affected their everyday lives. The registered manager said they tried to accommodate requests as much as possible and gave examples of requests people had made that were addressed.

We saw notes of a 'resident and relative' meeting in July that showed a discussion had taken place about a "Dementia Friends Group". This group had been organised by the provider so people and relatives could share information about dementia and support their understanding of how this impacted on people.

People were asked to give feedback about the care and support they received through annual quality monitoring surveys. The survey carried out in 2016 showed 39 people had responded with 100% stating they were happy living at Abbey Park and 95% stating overall satisfaction of the service. Comments people had written were positive and included, "I'm fine here, it's like home, I'm treated well." And, "Everyone I meet is kind and loving."

Audit checks were completed by management staff and to check the quality of the service people received. These included checks on the number of people who had fallen each month, people who had experienced weight loss and people with skin damage. This information was analysed to identify trends such as the time of day and location so that any required actions to minimise risks could be taken. A quality assessment was also completed by a member of the management team to check the provider's policies and procedures

were being followed. This included audits of medicines, mental capacity assessments and care plans to identify if there were any areas which required improvement. The provider attended quality improvement meetings each month where information about each of the homes within the organisation were shared and discussed in detail to continually drive improvement across all services.

There was a clear management structure at the home and the provider had ensured the registered manager was supported by a management team. This included an area manager, two area support managers and a quality business partner. In addition there was a deputy manager, an administrative manager, senior care staff and nurses to help ensure the home was managed effectively.

The registered manager felt well supported by the senior management team. They told us, "They physically come in and say 'what do you want me to do what do you need help with'. They do more actions than highlighting areas for improvement."

Staff understood their roles and told us they felt supported by management staff. One staff member told us, "She (registered manager) is accessible when we need her and she will listen to our grievances. She has been really helpful." Staff told us a short meeting took place each day with a member of the management team and one staff member from each unit. This was so they could share and discuss any issues or concerns they had identified. We saw the deputy manager walked around the home during the morning to also check if there were any concerns to report from the units. This included, falls or any hospital admissions so these could be communicated to the registered manager and any follow up issues dealt with. This demonstrated systems were in place to support effective communication across the home and ensure any risks were managed.

The registered manager understood their responsibilities of registration and notified us of the important events as required. This included serious accidents and incidents involving people in the home.

Comprehensive health and safety checks were carried out on a regular basis. This included checks relating to water temperatures in people's rooms, electricity, fire and equipment used by people. Records confirmed any areas identified as needing attention were addressed in a timely manner.

Community links had been established by the provider including links with a local school where children had visited the home. A volunteer was seen working at the home supporting people with a trolley service where they could purchase sweets and toiletries. The provider employed a reflexologist (reflexology is a massage therapy to feet and hands) and people were able to utilise the service of a local hairdresser and chiropodist on site. Advocacy services were advertised within the home if people needed their support due to not having family members or people who could represent them and or act in their best interests, for example, in relation to their finances.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always experience care and treatment to meet their needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of staff were not always available to support people's care needs to maintain their health and safety. |