Abbeyfield North Northumberland Extra Care Society Limited

Abbeyfield House - Alnwick

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Abbeyfield House – Alnwick provides care for up to 24 people. At the time of our inspection 20 people were accommodated at the service. This inspection took place on 27 and 29 October 2015 and was unannounced. At the last inspection of this service, in May 2014, we found the provider was meeting all of the regulations we inspected.

A registered manager was in place. 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.

People told us they felt safe living at the home. Staff were able to tell us how they would identify and respond to any safeguarding concerns. There had been no

Summary of findings

safeguarding incidents within the 12 months prior to our inspection. We saw that historic safeguarding issues had been promptly referred to the local authority for investigation.

During our inspection staff were always available within the communal areas. People, relatives and staff told us there were enough staff to meet people's needs. Recruitment procedures had been followed to ensure staff were suitable to work with vulnerable people.

Medicines were managed appropriately and the home was clean and tidy.

Staff training was up to date. Staff were given opportunities to develop their skills and understanding. An induction training package was in place to ensure new staff were competent to deliver care to people safely.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff we spoke with, including the registered manager had a good understanding of the MCA.

People told us staff were very caring and went out of their way to make them feel at home. Relatives told us they felt welcome to visit the home at any time, and were encouraged to join in with activities and events during their visits. Staff told us they enjoyed working at the home. Some of the staff had joined a fundraising group for the home, raising money for the home within their own time.

People had been asked to consider how they would like to be cared for as they approached the end of their lives. Compliments received praised the way staff had provided compassionate care to people and their relatives during the delivery of end of life care.

Care plans were not always specific or delivered as described. We found one person's pressure relieving equipment had not been used correctly putting them at risk of pressure damage. Where people used the service on a respite basis, assessments and care plans had not been completed. Records did not always reflect the care people received.

People told us they enjoyed the range of activities on offer within the home. The full time activities coordinator arranged events within the home, and regular outings to local towns and museums. People were asked to share their views on the service through regular meetings.

The provider had a quality assurance system in place, consisting of audits and checks. However, these had not been completed since June 2015. Care records audits had not identified the shortfalls in care planning and delivery which we discovered during our inspection.

People, relatives and staff spoke highly of the registered manager and told us the service was well-led.

The home had strong links with the local community.

We found two breaches of regulations. These related to the safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

People told us they felt safe and comfortable at the home. Staff were aware of the safeguarding procedures they should follow and were able to describe how they would respond to any concerns.

There were enough staff to meet people's needs. Safe recruitment procedures had been followed to ensure staff had suitable qualifications and experience to carry out their role.

Medicines were managed appropriately. The home was clean and infection control policies were followed.

Is the service effective?

Good

The service was effective.

Staff training was up to date. The manager was aware of their responsibilities under the Mental Capacity Act 2005. People's choices were respected and they were asked to consent to their care.

People told us the food on offer was appetising and plentiful. The cook was knowledgeable about people's nutritional needs.

Is the service caring?

Good

The service was caring.

People spoke very highly of the staff. Relatives and a health care professional shared examples where they thought staff had gone 'the extra mile' for people.

People told us, and we observed, that their privacy and dignity was respected.

Plans were in place to provide compassionate care as people approached the end of their lives.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care planning, delivery and recording was not consistent. We saw some people's needs were not met.

There was a wide range of activities on offer, and people told us they enjoyed the regular trips to local museums and towns which were available.

Complaints had been fully investigated and responded to, and a large number of compliments cards and letters had been received.

Summary of findings

Is the service well-led?

The service was not always well-led.

Audits in place to assess and monitor the quality of the service had not been completed since June 2015. Shortfalls in care planning and recording had not been picked up by the provider's internal monitoring systems.

People and relatives spoke highly of the registered manager. They told us she was proactive and operated the service well.

Requires improvement

Abbeyfield House - Alnwick

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.

This inspection took place on 27 and 29 October 2015 and was unannounced.

Before the inspection we reviewed all of the information we held about the service. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We reviewed information we had received from third parties. We contacted the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch team. We used the information that they provided to inform the planning of this inspection. After the inspection we spoke with two healthcare professionals who regularly visited the home.

During the inspection we spoke with six people who lived at the home and four relatives. We used 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 with us. Throughout the inspection we also spent time in the communal areas of the home observing how staff interacted with people and supported them.

We spoke with the registered manager, two senior care workers, three care workers, the activities coordinator, a hospitality assistant, a cook, and a volunteer. We reviewed five people's care records including their medicines administration records. We looked at personnel files for four staff members, in addition to a range of records related to the management of the service.

Good

Is the service safe?

Our findings

We spoke with six people who used the service who told us the home was a safe place to live. One person said, "I feel quite safe. I've had no cause for concern." Another person told us, "I'm quite happy here. I'm enjoying the change. It's not home, but at least I know I'm safe. I can get to sleep at night, and not have to think 'have I locked the front and back door? What was that noise?' I can relax here."

All of the staff we spoke with were able to confidentially describe the process they would follow if they had any concerns that a person was at risk of abuse. Staff knew about the different types of abuse and were able to tell us some signs and indicators which would prompt them to take action. Whilst all of the staff we spoke with told us they felt comfortable reporting any concerns to the manager, they were also aware of how they could contact the local authority safeguarding team in her absence. There had been no safeguarding issues within the 12 months prior to our inspection, but historic records showed concerns had been reported promptly to the relevant safeguarding team.

Risks to people using the service, staff and visitors to the home had been assessed and plans put in place to mitigate these risks as much as possible. External contractors had carried out testing to assess if the building posed an asbestos risk and if any action was needed to be taken to minimise the risk of legionella bacteria developing in the water supplies. Electrical installations assessments showed the electrics within the home were in a satisfactory condition. Electrical items had been listed and were PAT tested once a year to ensure they were in good working order.

Maintenance records showed tests were carried out to ensure the premises and equipment within the home were safe. Fire alarms, fire doors and call bells were checked regularly to make sure these worked as they should. Records showed the boiler and hoists had been serviced regularly.

Contingency plans were in place to address any unforeseen circumstances such as staff shortages due to poor weather or sickness. The manager explained that most staff lived locally which meant they were able to walk to the home if necessary. The manager lived on site and so was available to provide support to staff outside of normal working hours if necessary. The manager told us that whilst there had been no use of agency staff within the previous 12 months, she could arrange agency cover if required.

The home was open plan with all of the communal areas such as the lounge, dining area and conservatory linked together. We saw this area always had at least one member of staff present to support people if they needed any help. People told us staff responded promptly if they used their call bells. One person said, "I just need to ring my bell and they'll come straight away". We noted during our inspection that when the call bell alarm was heard, it was responded to very quickly. Staff told us there were enough staff to carry out their roles. One member of staff said, "There are definitely enough staff here. I've worked in other places and it hasn't been the same. We've been rushed off our feet with no time to talk to people. That's not the case here at all. There are enough staff to get things done, and make sure we can be there to sit down and talk to people and provide that care too."

Safe recruitment practices had been followed and a number of checks had been undertaken before staff began working in the service. Personnel records included proof of staff identification, completed application forms detailing their previous employment and any gaps in their employment history, and records of the interview they had attended. Recruitment policies had been followed and references had been received. Disclosure and Barring Service (DBS) checks had been carried out and the results obtained before staff had started to work at the home. The provider had ensured staff were suitably qualified and fit to work with vulnerable people.

A number of volunteers visited the home to provide social stimulation and community links for people who used the service. A policy for approving volunteers was in place which included requesting references to check volunteers were of good character. Each volunteer role was assessed as to whether a DBS check should be undertaken. The manager explained that whilst none of the current volunteers had DBS checks in place, they did not carry out any personal care and were never left alone with people who used the service. Staff we spoke with confirmed this.

Staff who administered medicines had received training in how to do so safely. Records showed they were subject to competency assessments, including answering questions and being observed administering medicines ensure they

Good

Is the service safe?

were competent to do so safely. Medicine Administration Records (MARs) had been fully completed without any gaps. Codes had been used to record if people had refused their medicines and the reasons why. This clear recording meant it was easy to tell what medicines people had taken. We watched staff administer medicines, and saw they followed the medicines policy. Staff washed their hands before handling medicines, explained to people what their medicines were, and provided a drink of their choice. Staff did not rush people, but stayed with them until they had swallowed their medicines so they could record whether it had been taken. Medicines care plans were in place which described to staff how individual medicines should be administered and the reasons they had been prescribed. This meant staff had information available to them to provide consistent care. Medicines were stored securely and processes were in place to dispose of any medicines which had not been used.

The home was clean and free from any unpleasant odours. The service employed domestic workers who cleaned all areas of the home and washed people's laundry. Staff used personal protective equipment when they were delivering personal care to minimise the risk of spreading infection.

Good

Is the service effective?

Our findings

People and their relatives told us staff carried out their roles well. One person said "I think the staff are well trained. They certainly seem to know what they are doing." A relative told us, "The staff are competent. Anything I've asked they've been able to give a satisfactory response."

Staff had undertaken a range of care and safety related training in areas such as moving and handling, infection control and health and safety. Training completion and expiry dates were recorded in individual staff files, and discussed during supervision sessions as to when staff training needed to be renewed. All staff had received training in dementia awareness, mental capacity and end of life care.

New staff received a training induction package, which included training and shadowing more experienced staff. Staff worked towards completing the range of training identified as mandatory by the provider, and in line with the new Care Certificate in the first twelve weeks of their employment. The Care Certificate is a framework for induction which outlines what care workers should know and be able to deliver in their daily jobs. On completion staff were asked to provide feedback on their induction, what they had found useful, and if there were any areas where it could be improved upon. The manager told us the induction process was under review, as improvements to training and documentation were planned.

Staff were supported to develop their skills and knowledge. They told us the training they received had adequately prepared them for their roles. One staff member said, "I'm up to date with my training. You can never have too much, or say you are done with it. But I've definitely been given enough to do my job properly." All of the care staff had been awarded a diploma in Health and Social Care or the previous NVQ equivalent, most staff had Level 2 or 3, but two staff had been awarded the Level 4 which included modules on coaching and supervising staff. One staff member we spoke with told us that having started work at the home with a Level 2 diploma, they were about to start working towards their Level 3 in the coming months, to increase their knowledge and skills.

Staff told us they met up with their line manager in supervisions sessions regularly which they found useful. Supervisions sessions provide staff with an opportunity to discuss their role and the care they provided. One staff member said, "I'll meet up with [Name of registered manager] every couple of months. We talk about how things are going, if I need any help, and how the residents are. It's good to take a bit of time out to talk about everything. Appraisals were held yearly, and included discussions on staff development and performance.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The manager had a good understanding of their responsibilities. She explained that everyone who was cared for within the home had capacity to make their own decisions, but was aware of the process to follow if their needs changed. She told us she had not applied for any DoLS authorisations as people were able to come and go from the home as they chose. Staff we spoke with confirmed all people who were cared for in the service were able to leave the home whenever they wished. People told us they often accompanied their relatives to the nearby town to go for a meal or to the shops.

Our observations showed, and care records confirmed, that people were asked to consent to their care. During our visit staff asked people's permission before they provided any care. For example, staff asked if people wanted to take their medication, if they needed any help to move around the home, if they wanted staff to cover their clothes with a napkin before meals, or if they wanted to take part in activities. Some people refused these requests and staff respected their decisions. Staff we spoke with told us they respected people's decisions. They told us one person did not like to go to bed and that they often slept in their chair. One staff member said, "We encourage them to go to bed, ask them why they don't want to and if there are any fears that we can relieve which will help. We do as much as we

Good

Is the service effective?

can so they are comfortable. What can you do? They know their own mind, so we have to respect that." Care records showed people had been asked to sign their care plans to show they agreed to their planned care.

People told us the food was generally very good. We saw people talked with each other over lunch, expressing their satisfaction over the meals they were eating. We heard comments such as; "How is your omelette?", "Very Good", "Good my meal is very tasty too," and "Another excellent lunch, compliments to the chef." People we spoke with told us there was always a choice available at each meal, and that staff would prepare them snacks whenever they wanted, day or night. A relative told us the home had accommodated their family member's food preferences. They said, "They go out of their way to do as much for you as they can. [My relative] wasn't well a few weeks ago. They didn't fancy eating anything. I popped down to the kitchen to see if they had anything light and sweet as we thought that might tempt them. They had a jelly ready, but I explained [My relative] wouldn't like a creamy one. The next day they had made a fruit one for them, so we could try with that. I thought that was really good. They were looking for ways to help."

People's nutritional needs were taken into consideration. We spoke with the cook who was knowledgeable about people's needs. One person required a fortified diet, and the cook told us they added cream and butter to foods such as potatoes, soups and desserts. We saw a range of fresh fruit, vegetables and meat were available. The cook told us as much food was home-made as possible, and all of the cakes, soups and pies on offer in the home were freshly made.

People could choose to spend their time in a number of communal areas, such as the lounge, conservatory or the garden. Seating areas were available outside, and raised flower beds had been used in the garden so people with mobility needs could take part in gardening activities if they chose to.

Good

Is the service caring?

Our findings

People and relatives told us staff at the home were caring, compassionate and went out of their way to make people feel as comfortable as possible. One person said, “I’m very happy here. I’m enjoying the change. I want to go home eventually. But it’s been a wonderful time here. I’ll miss some of the staff.” Another person commented, “The staff are so, so kind.” A relative told us, “All the staff are considerate. They have been trying every which way to help [My relative] with their needs. They will spend time with them, listen to them, nothing is too much trouble.”

Relatives confirmed they always felt welcome when visiting the home. One relative said, "There is a real personal feeling here. It’s like walking into a friend’s house when you come in. There are always people sitting near the entrance which is a big open place and it’s lovely to see everyone together talking or doing crafts. The staff include us in conversations about what is going on and offer us a drink. We love coming to visit.” A health professional told us, “The staff appear caring, considerate and they respect the individual’s needs. They appear to have good relationships with client’s families.”

Staff told us they enjoyed their jobs and worked within a caring team. One staff member said, “This is the home I want to come into when I’m older. You can’t say fairer than that can you. I would happily live here if I needed help.” Another staff member said, “It’s the best place I’ve ever worked, the staff team are small, we are like a little community, we all pull together for the residents.” Staff told us the cook made people a cake for their birthday and held a party for them with balloons and party games. One member of staff told us how they had gone online to source some speciality slippers for one person whose feet were too swollen to fit in their usual pair. A healthcare professional commented, “I know staff go the extra mile for people. If they haven’t got any relatives, they will buy them treats such as a box of chocolates out of their own money.” The manager told us they were in the process of arranging for a volunteer to visit the home to sit with one person who did not have any family to visit them.

During our inspection people and staff spoke with each other warmly. They shared jokes and talked about the plans they had for a visit to a local museum later that day. Staff spent time with people sitting in the lounge and talking with them on a one to one basis. The home employed a hospitality assistant, whose responsibilities included setting the tables for meals and serving people’s food. This meant that care staff were able to sit at the dining room table with people and share mealtimes with them. Staff knew people very well, discussing with people their plans for the upcoming weekend and talking about their families and when they were next due to visit the home.

Care records were personal. Information had been included about people’s preferences, choices and personal histories, such as important events in their lives. This information helped staff to have an understanding of the person. Care plans had been written in a way which promoted people’s understanding. For example a care plan in place for one person who was registered blind, described to staff how they should support them with their personal care needs. This person needed two staff to support them. Their care plan stated, “Carers are to identify themselves to [Person’s name] when they approach them to explain to [Person’s name] what they want to do and why. One carer to give [Person’s name] instructions so they don’t get confused.”

People told us staff respected their right to privacy and dignity. One person said, “The staff always knock on the door. They don’t just come barging in.” When staff asked people if they needed any support, they crouched down near them, and quietly asked them if they needed any help. People’s care plans promoted their dignity. One person needed to be supported by staff to access the toilet. Their care plan said, “I am given the call bell, and staff are to wait outside my door, until I press it when then come back in so I am given time to use the toilet in private.”

Staff were proactive at organising events to encourage people’s friends, family and the local community to visit the home whilst raising money for activities and trips. The activities coordinator told us about a recent coffee morning which had been advertised in the local paper to encourage as many visitors as possible to come and have a talk, hot drink and cake with people who used the service. A large screen television in the lounge had been bought with the proceeds of these fundraising events organised by staff. One member of staff had applied for the home to be considered by a local business that sponsored community groups or charities. The home had been selected for sponsorship, and the business was providing the home with all of the materials they needed to re-decorate the

Good

Is the service caring?

communal areas of the home. When we visited testers of paint and wallpaper had been put on the walls. People were to be asked their preferences before the final decision on how the home would be decorated was made.

Care records included an end of life care plan. The manager gave us examples of the steps they had taken when supporting people at the end of their life. She told us she had liaised with the GP, district nurses and any other healthcare professionals to ensure people had access to equipment such as hospital beds or pressure mattresses they needed to remain comfortable. Where people had expressed a wish to have their religious beliefs honoured, arrangements had been made for the relevant church denomination to attend.

Compliments records included thanks from families about the support their relative had received at the end of their life. One from December 2014 stated, "There are no words that can express our gratitude for the wonderful care that you have given to [My relative] mum over the last two years. We knew from our first visit that Abbeyfield was the perfect place for her to spend her twilight years. This was particularly the case over these last difficult few weeks where, without exception all the staff have gone out of their way to make her last few weeks as comfortable as possible. The care that was given to mum and us was over and above the call of duty and greatly appreciated under the circumstances."

Requires improvement

Is the service responsive?

Our findings

We identified shortfalls in the way care and treatment was planned and delivered. Some care plans had not been written in a way that ensured people's safety and welfare. For example, where people had been assessed as requiring an electrical pressure relieving mattress, to reduce their risk of developing a pressure sore, the relevant care plan did not detail what setting the mattress should be set to. In addition, we found an electrical pressure relieving mattress was set incorrectly for one person's body weight. This meant the care provided to this person did not meet their assessed needs and placed them at risk of suffering pressure damage and discomfort. Staff we spoke with were unaware of the settings on the pressure mattress. We fed this back to the registered manager who liaised with the district nurse and changed the setting of the mattress to one which was suitable for the person's body weight.

Another person had a care plan in place which provided information for staff about how to meet their diabetes needs. Staff checked the person's blood sugar levels twice a day. Their care plan stated staff should contact the district nurse when the person's blood sugar levels were higher than nine. We saw the person's blood sugar reading had been higher than nine at each evening check for the previous two weeks. On some days the reading had been as high as 14. We asked staff if they had contacted district nurse or GP as it stated within the care plan, but they told us they had not as the person seemed well and regularly had higher readings on an evening as they enjoyed eating sweeter foods on an afternoon. Staff were not able to be specific in telling us at what point they would contact health professionals, but stated, "We'd ring if it was a lot higher than it usually was." After our inspection the manager spoke with the GP who set higher parameters for the person's blood sugars before action, such as getting in touch with the district nurse needed to be taken.

Some of the people using the service were being cared for on a respite basis, meaning they were staying at the home temporarily. We could not find evidence that care had been planned for people at the home on respite. Both of the care files we looked at for respite care had only one care plan which detailed the support people needed with medicines. Information had not been provided to staff about people's other needs, such as whether they needed staff support to move around the home, or what support they needed to manage their personal care. We spoke with staff about how they knew how they should care for people at the home on respite. They told us they discussed needs at each handover, and always asked the person receiving care how they needed support. The manager acknowledged our findings. She told us this information was often not available as people came into the home at short notice. When asked why staff had not completed a pre-admission assessment or completed any care plans when people began using the service, she acknowledged this would provide better information than relying on verbal handovers.

One person, who had used the service on a respite basis for over a month, had initially come to the home after experiencing multiple falls. Records showed they had a number of falls whilst being cared for in the home, but no falls risk assessment had been carried out, nor was there any information provided for staff about how to reduce the likelihood of this person falling again. Their daily records showed staff had arranged for a visit from a GP, taken a urine sample and put in place a sensor mat which alerted staff if people got out of bed at night, so they could check on the person to see if they needed any support. However, the lack of a care plan which described how this person's needs were going to be met meant they could be at risk of receiving inconsistent or unsafe care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to the care people received were not always accurate. Where people were being closely monitored regarding their food and drink intake, and their positional changes to reduce the likelihood of them developing pressure damage, these records were poorly completed. Records had gaps which did not evidence that care had been delivered as planned. We saw repositioning charts without entries for over 12 hours, when the person's care plan stated they should be repositioned every two hours. Food charts sometimes had no entries after breakfast, so they didn't evidence what people had been offered or had actually eaten. Fluid balance charts had not been totalled up at the end of the day, and on occasion recorded that people had taken only 250ml of fluids over the course of the day.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Staff we spoke with assured us people had been more frequently turned and offered and accepted more food and fluids than the records suggested. One staff member said, “We definitely turn [Person’s name] more regularly than that. We’ve been praised by the district nurse about how well we are caring for them, they haven’t had any pressure sores even though they have been in bed for such a long time. We’re in their room all the time. Perhaps we just aren’t great at remembering to write it down.” We spoke with a healthcare professional involved in the care of some of the people whose records showed gaps. They said, “I have absolutely no concerns about the care at Abbeyfield. I know they provide excellent care. We’ve never had any issues with pressure damage. They bend over backwards to go the extra mile and do as much as they can for people to make them comfortable.” They continued. “The standard of care is very good. They might not understand the importance of documenting the care the way NHS services do. But I’m sure that they will have been delivering it as they should.”

People we spoke with told us their needs were met. One person said, “The care is very good. It’s been excellent.” A relative said, “We are very, very happy. [My relative] gets a good standard of care.” A healthcare professional told us, “When I’m requested to visit it is appropriate and when I visit I am always confident that the carers have a good knowledge of their client’s needs.”

Where people had been admitted to the home on a permanent basis, pre-admission assessment tools had been used to determine their needs. The support they required from staff was detailed in their care plans. People’s assessments and plans of care had been reassessed regularly and updated where their needs had changed.

Staff spoke knowledgably about the people they cared for. They described their needs and the individual way they provided care. One staff member said, “We do read care plans, but we make sure we get to know everyone and will speak to them while we are giving any care so that we know we are doing it the way they want us to.”

A full time activities coordinator was employed to arrange events, visits and social stimulation within and outside of the home. During the two days we visited groups of people took part in a domino tournament, decorated Halloween pumpkins and went on a trip to a local museum to look at a visiting exhibition of poppies to commemorate the people who served in the first world war. People told us they enjoyed the activities within the home and that there ‘was lots’ to get involved in. One person said, “I’m not normally one for organised games. But actually [Name of activities coordinator] makes it great fun, and we have a bit of a competition going between ourselves. There were regular events such as a ‘knit and natter’ group which was organised weekly and relatives were welcome to attend and have a chat whilst taking part in arts and crafts. The home had access to a mini bus once a week to go on outings further afield, and people and staff described the places they had recently visited, such as the Northumberland coast and local market towns. The activities coordinator also told us they ensured people who were cared for in bed were given social interaction by spending time talking or reading with them.

People and their relatives were invited to attend ‘residents meetings’ to discuss their views on how the home was run and any future plans. Representatives from the provider’s organisation visited the home twice a year to talk with people individually about their experiences of the home. Reports which detailed the findings of these interviews with people showed people were very positive about the home.

Complaints records were well maintained. There had been one complaint within the previous 12 months. Records had been kept detailing the nature of the complaint, the investigation which had been undertaken and correspondence with the person who had made the complaint. In addition to formal complaints, minor issues had been detailed within the complaints records to ensure these were responded to and addressed.

The home’s compliments book contained entries from relatives and health professionals. One health professional had commented, “Very pleased with what the home are doing. The staff should be praised for all the progress and effort with [Name of person].”

The provider had been considering a merger with another care company. During the consultation period, many people, relatives, and health professionals had written to the home to express their satisfaction with the current provider and the care provision of the home. Comments from these letters included; "Nothing was too much trouble for them and they were always ready to listen, help, advise and provide the appropriate care needed." The piece of mind I had knowing that [My relative] was being well cared for with all his needs being met and more I'm sure. I could visit whenever I liked (no set visiting hours is amazing). I

Requires improvement

Is the service responsive?

cannot recall many of the activities available to [My relative] if he wished. If he chose not to do them it was no problem and it would not be long before he was brought a cup of tea in his room."

Requires improvement

Is the service well-led?

Our findings

A schedule of audits and checks were detailed within the provider's quality assurance manual to monitor, assess and improve the quality of the service delivered. These included audits of infection control procedures, administration tasks, and a monthly inspection of the standard and cleanliness of the accommodation. However, none of these checks had been completed since June 2015. The registered manager told us this coincided with the decision that the provider would not merge with another organisation, and since that period of time they had been focussed on other areas of the business. They told us as the home was small, and because they were there every day they monitored the quality of the service on a daily basis.

People's care records contained evidence that their care plans and documentation had been reviewed, but none of the audits had been completed since June 2015. The care plan audits did not highlight the shortfalls in care planning, delivering and recording which we identified as part of this inspection.

The accident book used to record accidents and incidents was designed to be used to record employee accidents. It did not include prompts related to care delivery, such as if accidents had been observed, if people had been in communal areas or in their bedrooms, or to record the action taken to monitor people after accidents or to reduce the likelihood of them reoccurring. We saw information recorded by staff was inconsistent and did not always include full information about how the accident occurred or actions taken in response. We saw some examples where this information had been included in people's individual care records. But this meant it was difficult for the manager to assess correct action had been taken as it was not recorded consistently in the same place. The manager told us they checked every accident and incident form, but most forms did not have any evidence recorded on them to show that they had been reviewed. Accidents and incidents had historically been analysed for trends. However, we saw this analysis had last been completed in April 2015.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in post. She was present on the second day of our inspection and assisted us with our enquiries. People, their relatives and staff spoke highly of the manager. They told us she was knowledgeable, and encouraged them to share their thoughts on the service. One person said, "[Name of manager] is very nice. She'll always say hello, and check I'm happy." A relative said, "I've known this home for 30 years now, and [Name of Manager] has been here forever. She tells you what's what and she is straight forward. There is no sense that she's evading any issues. We have had no complaints but when [My relative] was first admitted we were all finding our feet. [Name of manager] was very happy to listen to any of our suggestions, and straight away acted on them. She's positive, anything we ask she'll say yes and then she'll work out how she can do it."

Staff told us the management in the home was supportive. One staff member described how there was a 'no blame culture' where staff felt happy to speak up if they were not sure about something or if they had suggestions for improvements. They said, "I made a mistake when I first started working here. It wasn't a huge deal, but I didn't follow the procedure as I hadn't known about it. Straight away the seniors put me right, but it was done in a really nice way. They explained what I should have done and made sure I understood why." Staff told us they attended regular staff meetings where they were encouraged to share their feedback and suggestions for how to improve the home.

Staff were relieved that the future of the home had been decided, and that the planned merger had not gone through. They said there had been some unrest during the time of uncertainty, but that the atmosphere and morale within the staff team was very positive now that the provider was no longer planning to merge with another organisation.

The manager told us the aim of the service was to offer "a home from home experience with a warm and welcoming ethos." Throughout our conversations with people, relatives and staff we were repeatedly told Abbeyfield House – Alnwick was very 'homely', with people describing it as a 'home from home' and one member of staff commenting, "There are no hard and fast rules here. Everything is about what the residents want. It's so friendly and relaxed, but still mindful that we provide the right standard of care."

The manager told us she was well supported by the provider, a not for profit organisation run by a committee.

Requires improvement

Is the service well-led?

The committee met each month to review information about the care provision and management information relating to the home. The chairman was involved in meeting regularly with the registered manager to discuss any staffing issues, discuss large purchases and the general management of the home. The chairman also carried out an annual appraisal with the registered manager.

The home had strong links with the local community. It was supported by 'The Friends of Abbeyfield' a group of local people who raise funds for the benefit of the people using the service. The 'Friends of Abbeyfield' consisted of relatives, staff, and local residents of the area, and funds raised were spent on activities, outings, and each person using the service received a card and flowers on their birthday. The manager told us she worked to build relationships with other care providers and local organisations. She said that people who lived in sheltered accommodation within Alnwick were invited to all of the events held in the home. The committee were in the process of discussing opportunities for local high schools and branches of the scouts to develop and practice their community involvement in a supervised environment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risks related to people's care and treatment had not been appropriately assessed and mitigated against. Regulation 12 (1), (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Records kept in relation to people's care and treatment were not always accurate. Systems in place to assess and monitor the quality of the service were not robust. Regulation 17 (1), (2)(a)(b)(c)**