Safequarter Ltd

Abbeygate Residential Home

Inspection report

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Date of inspection visit:
10 March 2016
14 March 2016

Date of publication:
17 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Abbeygate Residential Home on 10 and 14 March 2016.

Abbeygate Residential Home is a care home providing accommodation and personal care for up to 30 older people. When we visited there were 25 people using the service. Most people using the service were living with dementia. The service provides single and twin room accommodation over two floors. The service is located close to the town of Winchester.

The service had a registered manager 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. The service is required by a condition of its registration to have a registered manager.

We found people had not always been protected from risks that may have an impact on them. Plans were not always in place to manage risks and keep people safe. This meant risks to people were not always anticipated, identified or managed and this could result in unsafe or inappropriate care and treatment. This included risks to people from malnutrition, skin deterioration and falls.

People did not always have their needs met in a timely manner by sufficient staff that were effectively deployed to meet their needs. We found at times this compromised people's dignity and personalised care needs. Staffing levels in the home were not based on an assessment of people's needs to evidence the staffing level was sufficient to meet those needs. People and their relatives told us there were not always sufficient staff available to meet all of the people's needs, including their social and activity needs.

The required pre-employment information relating to care workers employed at the home had not always been obtained when care workers were recruited in order to evidence safe recruitment practices had been followed. This meant there was a risk people could be supported by unsuitable staff.

Emergency plans were in place to guide staff about how to act in an emergency situation and provide them with the information they would require in those circumstances. However, people's individual support needs in the event of an emergency such as an evacuation due to a fire had not been assessed. Evacuation procedures had not been practised by staff since 2014. There was a risk people may not be safely supported during an emergency.

Deprivation of Liberty Safeguard (DoLS) applications had been made on behalf of all people living in the home. This was to ensure their rights were protected when restrictions were in place and they lacked the mental capacity to agree to these. However, applications had also been made on behalf of people who were assessed as having the capacity to make this decision without the need for a DoLS. A best interest decision

making process to determine if it was in the person's best interests to be accommodated at the home to receive care or treatment had not been followed prior to submitting applications. Improvements were needed to ensure people's rights were upheld and the correct procedures were followed prior to submitting the applications.

People who lacked mental capacity to make some decisions were supported by staff who understood how to support them in their day to day decision making. Decisions to support people with the management of their personal finances had not been documented to evidence how people or their legally appointed representatives had consented to this decision. We have made a recommendation about the application of the principles of the Mental Capacity Act 2005 and DoLS requirements.

People's care plans were person centred and described their individual needs and preferences. However because risks to people had not always been identified care plans did not contain all the necessary information to guide staff to deliver safe and appropriate care. Activities were available in the home. People and their relatives told us there was not enough stimulation for people and activities did not always meet people's individual needs. Most activities were group based and staff did not have time to spend with people on an individual basis. It was not clear how people's individual needs or participation in activities were evaluated to inform the activities on offer.

People living with dementia can benefit from participation in meaningful activity and occupation. We were concerned that the activities on offer may not be sufficient or appropriate to meet the individual needs of all the people living in the home. The environment had not been suitably adapted to support the needs of people living with dementia. For example; assisting people to orientate and find their rooms by the use of names or personalised items displayed on their bedroom door .We have made a recommendation about providing a dementia friendly service.

It was not evident that the provider's systems for the auditing of quality and safety at this service were effective. Risks to people had not always been anticipated or identified until an issue had occurred. Information gathered was not always used to identify trends or themes to help drive continuous improvement to the service people received. When issues were identified the registered manager took prompt action to make the required improvements.

Staff were adequately supported in their role through a process of regular supervision and appraisal. Staff completed an induction process and training to enable them to meet the needs of the people they supported. People were supported by trained staff.

People told us they felt safe living at Abbeygate and staff knew how to identify and act on any concerns to protect people from the risk of abuse. When safeguarding concerns were identified these were acted on to keep people safe. People's medicines were managed safely by trained staff. Arrangements were in place to ensure medicines were obtained, stored and disposed of safely.

People told us the food was good and spoke positively about the quality and choice of food. People's individual dietary needs were met.

People were supported to meet their healthcare needs by a range of healthcare professionals. Care plans were in place to ensure up to date information was available about people's health and treatment needs to enable staff to support people with their healthcare effectively.

People were treated with kindness and compassion by caring staff. Staff knew people well and told us about

people's backgrounds and interests. People were offered choices and made decisions about their day to day care. People were able to spend time in private if they wished and to entertain visitors at all times. Staff greeted people by name and knocked on doors and waiting for permission prior to entering. People were treated respectfully.

A complaints process was in place and available to people and visitors. Complaints were acted on appropriately when they were received.

People, their relatives, staff and other professionals spoke positively about the registered manager who they found approachable and supportive. There was a positive culture in the home and the provider's values were evident in staff behaviour with people.

We found four 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 always safe.

People had not always been protected from risks that may have an impact on them. There were not always plans in place to manage risks and keep people safe.

A system was not in place to determine the appropriate staffing level to meet people's identified needs. We found at times there were not enough staff available and this compromised people's dignity and personalised care needs.

The required pre-employment information relating to staff employed at the service had not always been obtained. This meant people may not have been fully protected from the employment of unsuitable staff.

People were protected from the risk of abuse by staff who understood how to identify safeguarding concerns and any concerns were acted on.

People medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective

The principles of the Mental Capacity Act (2005) were not always followed to ensure people's rights were upheld.

People were provided with a good quality and choice of food and had access to healthcare to meet their needs when identified.

Staff were supported in their role and completed the training required to enable them to meet people's needs.

Is the service caring?

Good

The service was caring

People and their relatives told us were kind and caring. Staff knew about people's backgrounds and interests and they ways

in which they preferred to be supported.

People were supported to make daily decisions about their care. People were offered choices and asked about their views in residents meetings.

People were treated with respect and had privacy when they choose it.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were person-centred. It was not evident people always received care as described in their care plan to meet their needs.

Activities were available in the home. People and their relatives told us there was not always enough stimulation, staff availability or appropriate activities to meet people's individual needs. The specialist needs of people living with dementia were not always met in relation to the environment.

A complaints procedure was available and complaints were acted on appropriately when received.

Is the service well-led?

Requires Improvement

The service was not always well led

The provider had not implemented robust quality assurance systems to assess, monitor and improve the quality and safety of the home. When concerns were identified they were acted on.

There was a positive and open culture in the home. Staff demonstrated the provider's values in their behaviour with people.

The registered manager was available and approachable to staff, people and their relatives. They supported staff to understand and be accountable for their responsibilities in ensuring people received good quality care.

Abbeygate Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 10 and 14 March 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection we spoke with a team manager from adult services in Winchester and a specialist nurse from the local clinical commissioning group to gather their views on the service. No concerns were raised and we received some positive feedback about the service. During our inspection we spoke with a health professional from the older person's mental health team and a GP.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We requested a Provider Information Return (PIR) and this was completed by the provider before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with eight people and five people's friends or relatives. We spoke with the registered manager, the deputy manager, four care staff, one housekeeper and the chef.

We reviewed records which included five people's care plans, people's medicine administration records, four staff recruitment and supervision records and records relating to the management of the service. These included; staff training records, quality assurance records and accident and incident reports.

This service was last inspected in August 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People had not always been protected from risks that may have an impact on them. We looked at how risks to people had been identified, managed and monitored.

Where people were monitored by health care professionals their risks had been well managed and the service implemented their guidance. For example; when a person had developed a pressure ulcer advice had been sought from the community nursing team, followed by the staff and the ulcer was healing.

However, where people's risks had increased over a period of time, all possible measures had not been taken by the service to help reduce these risks in a timely way. For example, one person had experienced increased falls and their risk of falling was not effectively managed to protect them from the risk of injury. The person had experienced four falls which had resulted in injuries. Their last fall had resulted in a hospital admission for a cut to their head. There was a record of the incident and the registered manager had stated 'make sure they have their call bell with them at all times'. There was a known risk to this person from falls in their room described on their care plan. The person was found by staff having fallen in their bathroom one and half hours after they had last been seen by staff. However, the appropriate equipment such as a portable alarm had not been supplied to help keep the person safe so that they could call for immediate assistance if they fell or were at risk of falling. The actions identified to minimise the person's risks from falls had not been followed to reduce their risk of injury. During our inspection the registered manager arranged for people at risk of falls to have portable alarms and movement monitors to ensure the risks to them from falls were minimised.

One person had developed a pressure ulcer following a period of weight loss and poor appetite. Malnutrition can increase the risk of developing certain wounds, such as pressure ulcers. The service did not routinely use a recognised nutritional screening tool to identify, assess and manage all the risks associated with poor nutrition until instructed by the community nursing team. The risk of skin damage related to poor nutrition had therefore not been identified and arrangements had not been put in place to prevent this person's skin from breaking down prior to them developing the pressure ulcer.

One person had experienced weight loss due to dental issues. This person's care plan included a review of their changed needs and stated they required a softer food option until their dental issues were resolved. Weight records showed this person had lost three kilo grams over the past month. Nutritional screening had not been completed to identify whether this person was at risk of malnutrition and whether arrangements needed to be put in place to prevent further weight loss or protect the person's skin from breaking down. People were at risk of experiencing deterioration in their health when risks to their health were not identified, managed and monitored.

A fire safety plan was in place. However people did not have an individual personal emergency evacuation plan (PEEP) in place. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This is important for people who may not be able to reach a place of safety due to sight, hearing,

cognitive or mobility impairments. People living at Abbeygate did have needs associated with their mobility, sensory and mental capacity. A fire evacuation drill had last taken place in September 2014. The registered manager explained that during routine fire alarm tests staff were required to assemble at the fire board. There was a risk that people would not be adequately or appropriate supported in the event of a fire. This was because their individual needs had not been fully assessed and staff had not regularly practised evacuation procedures to ensure people's safety.

The failure to ensure the risks to the health, safety welfare of service users had been assessed and acted on to mitigate risks was a breach of Regulation 12 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information was available to staff to guide them of the actions to take in an emergency such as a utilities failure. An emergency plan detailed the procedures staff should follow. This included emergency telephone contacts, procedures for missing persons, the emergency location of utility supplies and an alternative location if people were required to evacuate the building. Regular safety checks were carried out on equipment and facilities such as hoists, the lift, baths, beds and water coolers.

People did not always have their needs met in a timely manner to ensure their dignity would be upheld. At times during our inspection we noted there were no staff available in the larger lounge where most people were sitting. We were approached by three people who required support when there were no staff available in and around this area. One person had requested assistance to use the toilet; this person was crying and told us they were 'scared' they would fall. Another person had soiled themselves and requested urgent assistance with personal care. The third person had requested adjustments to their cushions and with making themselves comfortable. A call bell was available in the lounge but this was not easily accessible and people had to ask others to call the staff on their behalf. Staff attended to people once they were made aware. At times we observed this compromised people's dignity because they had to ask others for help and call out if they needed the toilet because staff were not on hand to assist them discreetly. At other times for example during lunch we observed there were sufficient staff to meet people's needs.

Staff found it hard to personalise some people's care because of the staffing numbers and how staff were deployed. Whilst people and their relatives said people were cared for safely some people and their relatives were concerned staff did not have enough time to interact with people or to spend quality time with them. Staff told us they did not always have sufficient time to interact with people as they only had the time to complete the required tasks. Two people told us they had to wait in the mornings for staff to assist them, one person said "I was waiting for ages this morning for them to get around to me. They could do things better in the morning they are thinly spread". People's relative's comments included "Staff do their best, but there is just not enough staff to meet every resident's needs". Another relative said "staff are fantastic; they just do not have time to spend with each of the residents". We observed some staff that were patient and responsive to people's needs, but did not appear to have time to sit and chat with people to provide the social connections and reassurance people valued. For example one person said "staff haven't got the time when I get weepy".

We discussed staffing numbers and roles with the registered manager. They told us that staffing levels had remained the same over the years and "never changes". They thought there were sufficient staff to meet people's needs and were confident staff would say if there were not enough. They told us staff worked as a team to meet people's needs. The service did not have a systematic approach such as a staffing level dependency tool in place to determine the number of staff and range of skills required in order to meet the needs of people Keeping people safe at the current staffing level was not determined by people's individual support needs or risks, or the skills and knowledge of staff. If people's needs changed or a number of staff

that did not know people well worked the same shift, staffing levels and skills deployed may not be sufficient. In the absence of a systematic approach to determine the number of staff and range of skills required, from what we observed and what people told us sufficient staff numbers were not always deployed to meet people's needs and ensure their dignity. This was a breach of regulation 18 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from unsuitable staff. Some recruitment checks, such as proof of applicants' identity, investigation of any criminal record, and employment and character references, had been satisfactorily investigated and documented. However, the provider's application process did not ensure that a full employment history was given by applicants or that gaps in employment history were accounted for. Unexplained employment history gaps could identify that further information may be available which might make applicants unsuitable to work with people who use care and support services. We discussed this with the registered manager who agreed the provider's application form in use did not ensure applicants provided a full employment history and a written explanation for gaps.

We found that the provider had not fully protected people by ensuring that the information required in relation to each person employed was available. This is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Abbeygate. Staff had completed training in safeguarding people from abuse and the staff we spoke with understood the indicators of abuse and the process to report any concerns. Staff were aware of the whistle blowing procedure if they were not satisfied that issues were dealt with appropriately in the home. A safeguarding policy and procedures, including the local authority multi-agency safeguarding procedures, were accessible to staff for guidance.

Through our discussions with the registered manager it was evident that when people were vulnerable to abuse, action was taken to protect people from harm. For example; the registered manager had contacted social services to discuss concerns about a person and put plans in place to monitor their safety and wellbeing. Records showed concerns were being monitored as agreed. Staff were confident that the registered manager would act on any concerns. People were supported by staff that understood the indicators of abuse and acted on concerns.

People's medicines were stored, administered and disposed of safely. Medicine containers were dated when they were opened, and stock checks ensured that medicine records accurately reflected the medicines stored. A community pharmacist had conducted a medicines audit in November 2015. All recommendations from this had been implemented at the time of our inspection. People's medicine administration records (MARs) demonstrated that people received their prescribed medicines at the times required. Senior staff who administered people's medicines were aware of the medicines that people received to manage known health issues. People's allergies were clearly recorded, to ensure people were protected from possible harm. Some people's health needs meant they required regular blood tests to inform the dosage of their medication. These were carried out by the district nurses. Records described what doses to administer and senior staff followed these to ensure people were administered their required medicines safely. People's medicines were managed safely.

Requires Improvement

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be made in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had completed training in the MCA (2005) and were able to demonstrate they understood the key principles which they applied in their day to day work with people. For example; we observed that staff asked people if they wanted to take a medicine, what they wanted to eat and where they wanted to go. People were supported by staff who obtained people's consent about their day to day care and treatment needs.

The registered manager had written confirmation of people's legally appointed representatives. This ensured they knew who they were legally obliged to consult in the event the person lacked the mental capacity to make specific decisions. Such as those concerning finance and property or health and welfare.

Not all decisions had been made by following the principles of the Mental Capacity Act (2005). Records showed that a mental capacity assessment had been carried out prior to some decisions being made about people's care and treatment. However, applications for DoLS had been made on behalf of all of the people living in the home whether they lacked the mental capacity to agree to their care and treatment or not. Applications made on behalf of people did not include information about the restrictions in the home which amounted to a deprivation of their liberty. Restrictions included; coded keypads on the front door and an internal door to the kitchen and offices and locked doors to the garden areas. A best interest decision making process was not followed to determine whether it was in the person's best interests to be accommodated at the home to receive care or treatment, even though they will be deprived of liberty prior to submitting the applications. We discussed this with the registered manager who told us they had understood applications were required for all people living in the home irrespective of their ability to voluntary agree to any restrictions.

Improvements were needed to ensure applications to deprive a person of their liberty were made appropriately in line with the MCA principles, prior to submitting the application for authorisation by the local authority, to ensure people's rights were upheld.

Most people were supported to manage their personal money by the registered manager and deputy manager. People's money was kept in the office and records were completed and checked by these two

people to account for people's spending. However, the decision to support people to manage their money had not been recorded to evidence people's consent to this arrangement or the consent of those with the legal authority such as Power of Attorney for financial affairs in this decision making. This could mean people or their representatives were not appropriately involved in decisions about the management of their finances. There was a lack of written evidence to document the assessment and how the decision had been reached. It is good practice to document such decisions to ensure there is written evidence to demonstrate legal requirements have been met.

We recommend the provider reviews the Mental Capacity Act Code of Practice 2005 in relation to good practice for the recording of mental capacity assessments, best interest decisions and DoLS applications for people.

An induction programme was in place for new staff. Induction included working alongside experienced staff to learn about people's needs. Staff completed training in areas identified as mandatory by the provider. This included; health and safety, safeguarding, infection control, food hygiene, dementia, the Mental Capacity Act (2005), deprivation of liberty safeguards and equality, diversity and inclusion. Records showed and staff we spoke with confirmed they completed and refreshed their required training or this was planned. The provider had not yet implemented the care certificate. The care certificate sets out the learning outcomes, competences and standards of care that care workers are nationally expected to achieve and adhere to in their daily working life. This meant people could not be assured all staff had achieved these standards. The registered manager told us they were in the process of introducing the care certificate.

Staff told us they were supported appropriately in their role; felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Staff also told us that they received an annual appraisal. Records confirmed staff received supervision and appraisal as they described. Most staff in post had completed a qualification in health and social care. People were supported by staff that completed training to meet their needs and were supported in their role.

People spoke positively about the choice and quality of food provided. Comments included "The chef will make whatever food I ask" and "The food is delicious". People were offered hot drinks during regular tea rounds. Cold drinks were available to people at other times, such as water and squash. One resident commented they would like afternoon tea with cake more regularly and more cups of tea than currently provided. This person's care plan reflected their 'love' of cake. We spoke to the registered manager about this who said they would address this. We observed that people were asked for their preferences for example one person when asked for their breakfast choice said "porridge and marmite sandwiches" and this was provided.

The chef was informed by staff of people's specific dietary needs before their arrival at the home. People's dietary and fluid intake was recorded daily so that staff could monitor that people were eating and drinking well. A person's relative told us how their relative's dietary needs had been catered for and how this had helped to reduce their symptoms from a health condition. The registered manager told us that when people had lost weight they were weighed weekly and the GP was consulted about the use of dietary supplements and vitamins and a higher calorie diet was provided. We checked people's weight records and saw that most people were maintaining a stable weight.

We observed lunch time and breakfast in the home. Staff were attentive and helpful, for example; people were asked if they required any help or to have their food cut up. When a person asked for more food this was given. People were offered drinks throughout their meal and no one was rushed.

People's care records included a care plan from their GP which provided details of their current health and treatment needs. People's nominated GP's and district nurses visited the service routinely and as required to provide treatment. We spoke with one GP who said "It's lovely, patients generally settle well and staff have a good understanding. People's health concerns are well managed they (staff) are very good at looking after people who become unwell and those who are dying when we put in the healthcare". Records demonstrated people had seen relevant health care professionals such as opticians, the older people's mental health team, chiropodists, dentists and hearing aid checks and specialist consultants when required. People were supported to maintain good health.

Good

Is the service caring?

Our findings

People told us staff were caring and they felt safe with staff. We observed some positive interactions between people and staff. For example; when a person became anxious at lunch time we observed a staff member go to that person and hold their hand and reassure them. We observed the registered manager talking to people and checking how they were throughout our inspection and people greeted her warmly. A visiting mental health professional told us "The registered manager treats everyone as an individual and equal; if we have someone and they go to Abbeygate then I am delighted".

People's relatives told us staff were caring, one relative said "Staff have a positive, friendly and welcoming attitude, they all know people's names my relative is well cared for here. One relative told us about their mother who had died at the home and said "They were excellent really great; I don't think she would have got any better care". People were supported by caring and compassionate staff.

We found that staff knew people well including their personal histories. For example; a staff member told us about a person's previous job and how activities related to this helped to calm them when they became unsettled. A person's relative told us how staff involved a person in practical tasks such as laying the table as they had always enjoyed being busy

We observed people making decisions about their care. This included decisions about their personal care, their activities and their food choices. People's preferences for their daily routines were detailed in their care plans and staff told us how they used this information to ensure people's preferences were met. For example; who preferred a later breakfast and people who preferred to be in a quieter lounge or smaller group. One person was wearing an identity badge and staff told us this was their decision as they worried about becoming lost and this helped to reassure them.

Residents meetings were held every three months. Records showed that people were asked their views on the food available and the entertainment provided. People had made suggestions for events such as a cheese and wine party and a coffee morning which were then provided. People were also consulted on the attitude and approach of staff including temporary staff and whether they were treated with kindness, dignity and respect. Records showed that people had responded positively to these enquiries. People were supported to express their views about their care.

People were able to spend time in their room if they chose to. People received their visitors with in their room or in a communal area as they chose. The home had three lounges, one of which was seldom used during the day. This enabled people to spend time alone if they preferred not to go to their room. People's visitors told us they were welcomed into the home throughout the day and evening. One person confirmed their relatives and friends could visit "Anytime they want".
Staff greeted people by name and were observed to knock on people's doors prior to entering people's rooms.

Requires Improvement

Is the service responsive?

Our findings

People's care plans included a pre-admission assessment of their needs. This was used to develop the person's care plan. People's care plans were person centred and described their individual needs and preferences. This included a 'preferred daily routine' document that described how people preferred to receive their care. For example; a person's plan stated their breakfast choice, the number of staff they required to support them, the things they could do in their personal care routine and the drink they preferred with their medicines. Staff were aware of people's preferences and the information they gave us corresponded with people's care plans.

Although people's care plans reflected how they would like to receive their care and support this was not always delivered, for example; one person's plan stated they struggled to remove their undergarment and required help with this. This person told us they had gone to bed on several occasions with their undergarment on because they had not received this assistance. Daily notes confirmed the person had 'assisted themselves to bed'. When we informed a senior care staff member about this they told us they would ensure this support was provided. A person's care plan described their love of a particular activity and how they should always be encouraged to participate in this. Although the activity was provided during our inspection the person was not made aware it was available. It was not evident people always received the support as described in their care plan.

People's care and support plans were summarised in a 'support plan at a glance' document. This gave brief information about people's important information and was readily accessible to staff and were necessary agency staff or other professionals. Information included the things staff must know to keep the person safe and their critical care needs; such as medical conditions, mobility support and allergies. A monthly care plan review documented changes as well as summarising how people's needs had been met during the month. We saw evidence that where people were able, they had contributed to the review of their care and confirmed this had been discussed with them. However, because risks had not always been identified and assessed people did not always receive the care they required to maintain their safety and welfare, for example; in relation to their falls management.

Staff recorded the care people received in people's daily records. People's changed needs were reported at handovers between staff. We observed a staff handover where people's needs were discussed and reported on including; accidents, health issues and people's general wellbeing.

A weekly programme of activities was delivered in the home. This included monthly musical entertainment, a weekly art and crafts session, a monthly quiz, Bingo and games sessions. An activity was scheduled each morning and afternoon. Most of the activities available were group based. Staff told us they were unable to spend time with people on an individual basis to meet their social or activity needs as they had to prioritise care tasks. One staff member commented "If we had more staff then we could spend more time with the residents".

Some people and relatives told us staffing levels were not sufficient to provide the level of social stimulation

people needed and valued. Some relatives told us they did not always feel enough activities were available or suitable for everyone, and two relatives told us there was not enough 'stimulation' for people. A person said "No we don't have many activities" and a relative said "She needs stimulating and things to do. There is a lot of sitting in the lounge at weekends which drag as there is not enough to do". We saw for example on a Sunday a bible reading was at 10am and a film was shown in the afternoon.

People's care plans included information about their occupation and entertainment needs. However, it was not clear that people's needs were met in this respect. For example; we looked at a person's care plan which stated they had always been busy and they liked to have things to do. This person told us there was not enough to do and they would like more activities. A record was kept in people's care plans of the activities they had participated in and we saw this person had attended 11 activities in the past eight weeks. Other care plans we reviewed showed a similar level of engagement in activities. Another person's plan stated they were 'unsure' of their activity and entertainment needs. One person told us about an activity that was important to them but this was not in their plan. It was not clear how the monitoring information about people's participation in activities and their individual needs was actively being used to gauge people's response to activities or evaluate people's activity needs.

We saw some people were engaged in activities during our inspection. This included; musical entertainment and an arts and crafts session. We also observed that some people were sitting in the lounge for long periods without any stimulation or activity. We noted two people who were living with dementia were often seeking contact or reassurance from staff that were not always available to spend time with them. Many of the people living at Abbeygate were living with dementia and the home was advertised as offering specialised care for people living with dementia. People living with dementia can benefit from participation in meaningful activity and occupation. We were concerned that the activities on offer may not be sufficient or appropriate to meet the individual needs of all the people living in the home.

We noted that some people were wandering around the home and asking for directions to their rooms. It was not evident that the environment had been adapted to meet the specialist needs of people living with dementia. For example; people's bedroom doors were not personalised to make them more recognisable, with their name or personal items they recognised. Some of the corridor walls were bare and did not include stimuli such as pictures or objects to help people orientate themselves.

We recommend that the provider reviews the activities provided and the environment, based on current best practice, in relation to the specialist needs of people living with dementia.

Catholic and Church of England clergy regularly visited the home to carry out services. In addition the registered manager showed us an example of how they met other individual needs relating to spiritual support. People's care plans' included information about their past and how this affected the way they were today. For example; a person with a background in the military, noted how they liked to look smart at all times. We observed the person was clean and smartly dressed during our inspection.

The complaints process was available in the hall for people to refer to. There was one complaint received since the last inspection. This had been investigated appropriately. The complaints policy detailed who to contact to raise a complaint. This included the registered manager and the provider. Contact details were also given for the Care Quality Commission and the Local Government Ombudsman should the complainant remain unsatisfied with the provider's response. A relative told us "I know who to speak to if I had a concern, I find them very approachable.

Requires Improvement

Is the service well-led?

Our findings

The governance system in place to monitor the quality of the service and identify the risks to the health and safety of people was not always effective. Although there was evidence that the registered manager took prompt action to address shortfalls when identified they had not identified all of the concerns we found. For example; risks to people had not always been identified and managed until instructed by a healthcare professional or until the risk had already impacted on people's health and welfare, such as the risk of skin deterioration associated with malnutrition. Although people's care plans were reviewed monthly, when safety needs and risks were identified the manager had not identified the shortfalls in relation to people's risk management and care planning that we found.

Systems did not effectively support the registered manager to monitor that a good quality service was being provided in accordance with national guidance. For example; guidance in relation to; managing the risks to people from malnutrition, guidance related to the specialist care needs of people living with dementia and the implementation of the MCA (2005) code of practice regarding decision making and applications for DoLS. The manager had not identified that people were not always receiving care in accordance with current best practice to ensure people received safe and appropriate care.

Systems were not in place to support the manager to learn from safety incidents and evaluate staff's management of these incidents. Whilst individual incidents were reviewed the audit system in place to monitor and audit peoples' falls had not been used since June 2015. A lack of effective auditing of falls, to include identifying patterns and trends for example, the timings, reasons or outcomes of the falls, could put people at risk as all possible measures might not have been had been taken to prevent reoccurring accidents.

Not all people and their relatives were given the opportunity to give their views about the service as the registered manager told us satisfaction questionnaires were given out on an ad hoc basis. This system meant there could be a risk the views and experiences of some people or their representatives were not taken into account to drive improvements to the service. Information from quality satisfaction questionnaires was not collated to enable the registered manager and provider to identify any trends or themes in the feedback received. The registered manager had responded to individual issues raised, for example; records showed a person's relative had said they had not been told about a person's medicine and this was addressed. The service's feedback system was not sufficiently robust to identify the concerns relating to staffing levels and activities we were told about so that action could be taken to address these concerns before they quality of care became compromised.

The provider had not implemented robust quality assurance systems to assess, monitor and improve the quality and safety of the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where audits had identified shortfalls the registered manager had taken prompt action to make the identified improvements. This included an environmental audit by the provider in August 2015. The

registered manager had ensured the actions identified were completed including; painting, flooring and some renovations. The registered manager had also made improvements to the management of medicines following a pharmacy audit in 2015. These included; staff training completed, people's allergy status updated and staff had signed the medication policy as read. The provider had employed a consultant to review care planning arrangements in the home in July 2015. Improvements identified by the consultant had been acted on including; detailed medication care plans had been introduced and care plans had been reviewed and improved to reflect people's preferences and personalised needs.

People, their relatives, visiting professionals and staff spoke positively about the registered manager. For example; a person's relative said "The registered manager is very good, I couldn't wish for anything better they are very approachable it's really good here they couldn't get better care then here". Staff praised the registered manager who they described as "approachable" and said they were encouraged to raise any issues or concerns. One member of staff told us "We're like a family, we all pull together." Another staff member said, "I'm happy here. The place is well-run, the manager's approachable and everyone knows what they are doing."

The registered manager's office was in an area that included the kitchen and laundry and this was locked by a coded keypad and as such not accessible to people without assistance. However, we noted the registered manager was frequently out and about in the home. We observed the registered manager interacting with people in a caring and friendly manner. They assisted people were required and responded promptly to people's needs and requests.

The atmosphere in the home was positive. Staff communicated with each other and with people in an open and friendly manner, greeting people by name and exchanging pleasantries. A staff member said "It's a very open culture the manager says 'come whenever you need to, my door is always open for staff and residents'. The provider's values were described in their 'philosophy of care' included in their statement of purpose which was available to people and visitors in the entrance to the home. Values included; people's rights to choice, independence, civil rights and privacy. The registered manager told us they monitored staff behaviours to ensure they were aligned with these values. Records showed staff had discussed values in team meetings such as respecting people's privacy. We observed staff offering people choices and respecting people's privacy.

Regular team meetings were held and records showed meetings included information about policies and procedures to update staff on their responsibilities. A staff handbook was given to all staff and this included the expectations of staff behaviour within the service in relation to; gifts, dress, use of mobiles, equal opportunities, and whistle blowing. Records showed staff were supported to understand their responsibilities and held accountable when improvements were required. For example; where staff were required to make an improvement in their practice this was raised at supervision and monitored for progress.

The registered manager followed the requirements of their registration to notify CQC of specific incidents relating to the service. A notification is information about important events which providers are required to notify us by law. This enables us to monitor services and act on information of concern. We found relevant notifications such as safeguarding incidents and serious injury had been sent to us appropriately. The notifications showed the registered manager had taken appropriate action to notify the relevant agencies to keep people safe. A healthcare professional said "the home manager contacts me if she is concerned about anything or wants advice. She informs me of any hospital admissions, falls or those who are ill/end of life. If there are any safeguarding alerts, (the manager) investigates thoroughly and works willingly with us to put things right".

People's and staff records were stored securely, protecting their confidential information from unauthorised persons, whilst remaining accessible to authorised staff. Processes were in place to protect staff and people's confidential information.

The service had links with local community organisations such as churches, schools and the library. These organisations visited the home to provide entertainment and services for people.

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 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 People had not always been protected from risks that could have an impact on them because risks were not always identified, assessed and mitigated. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home Regulation 17 (1) (2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated with unsuitable care staff. The information specified in Schedule 3 was not available, notably a full employment history. Regulation 19 (3) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent, skilled and experienced persons were not deployed to meet people's needs as required.

Regulation 18 (1).