Coveleaf Limited

Abbey Grove Residential Home

Inspection report

2-4 Abbey Grove
Eccles
Salford
M30 9QN
Tel: 0161 789 0425

Date of inspection visit: 26 November 2014
Date of publication: 28/01/2015

Ratings

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

Overall summary

Abbey Grove is a care home providing accommodation for 19 people. The home is a detached property, situated in a residential area of Eccles. It has small, enclosed grounds, with parking facilities and a ramped patio area. Accommodation for residents is provided on the ground and first floor. A passenger lift provides access to all floors. The home offers accommodation in 13 single bedrooms and three double rooms. There are communal spaces comprising of two lounge areas and a dining room.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the

Summary of findings

law; as does the provider. On the day of our visit, there were 15 people living at the home. They were supported by two care staff, the manager and the deputy manager. Additionally, there was a house keeper and cook.

At the last inspection carried out in November 2013, we did not identify concerns with the care provided to people who lived at the home.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the service did not have robust enough systems to prevent the potential spread of infection. On inspecting the laundry area in the basement of the building we found the washing machines and dryers were dusty. We saw a pile of dirty bed linen placed on the floor next to a washing machine. A hand washing sink was visibly unclean with dirty cloths and paper towels discarded on the sink. There was no soap or alcohol gel available or gloves or anything to dispose of paper towels and used gloves in.

In two first floor toilets we looked at, we checked the raised portable toilet seats and found that they had not been cleaned underneath. Additionally, we also found several toilet brushes were full of faecal matter and the holders were stained and dirty. In the rear hallway and lounges we noted a strong odour.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that in one instance eye drops had been given to a person, when instructions on the container clearly stated not to be given after the 20 November 2014. We noticed the medication had been given on two occasions after that date. We found medication requiring cold storage was stored in an insecure fridge used for the storage of food in the kitchen. We found medicines were therefore not stored, managed and administered safely and some people who used the service did not receive their medicines in the way they had been prescribed.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection, we saw one person who used the service was served lunch in their bedroom. Situated in the room was a commode which we found had not been emptied of faeces before the person was served their meal. When we spoke to the person about this matter, they were visibly upset that the commode had been full whilst they ate their meal.

We also spoke to two people who told us they had hearing difficulties. One person took a hearing aid out of their bag and told us staff did not know how to assist them to wear it. The other person told us they could not wear a hearing aid as no one could assist them.

These are breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In one care plan we looked at, instructions for staff indicated that the person who was permanently in bed required to be turned hourly. On examination of turning charts, the interval of turns were much longer than hourly and no record existed for the 26 November 2014. It was therefore unclear to us what turns had been made on the day of our inspection as no record had been maintained since the previous day.

In one care file we looked at, instructions clearly stated that meals and fluid were to be recorded together with weekly weights. As we were unable to locate any such records we spoke to staff who told us that the person needs had changed and they were no longer required and that the care plan had yet to be updated. This demonstrated that the care plan did not accurately reflect the current needs of the person.

In another one care file we looked, following the title page we found that subsequent pages contained the name of a different person. We could therefore not be sure who the care file related to. We were told by the manager that the subsequent name on the file was a photo coping error. We also identified poor record keeping such as failure to date and sign moving and handling assessments and resident care plan assessments had not been signed. Of the eight care files we looked at none of the care plans had been dated or signed by the person who used the service or their representative.

These are breaches of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

Improvements were required in the way registered manager effectively monitored the quality of services provided. The auditing processes undertaken were not effective as it had failed to identify the infection control concerns, medication concerns and additionally had not recognised omissions and changes required in care files.

During our inspection of the bedrooms we found call bells missing from four rooms, including one room where there was a person permanently in bed. This meant people were not able to summon support when they required it. We spoke to the manager about this concern who was unable to provide any explanation as to why they call bells were missing and why this issue had not been identified from the environmental checks including the house walk around that was undertaken.

Whilst in the kitchen we examined the contents of the First Aid kit and found that it did not contain any bandages and gauze. Additionally, the First Aid Instructions that were displayed on the wall were dated 2005 and instruction regarding burns and cardio pulmonary restitution had since changed.

This is a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

People and relatives told us that they had no concerns for their safety.

We looked at a sample of staff recruitment files and found each file contained records, which demonstrated that staff had been safely and effectively recruited.

It was not always clear from looking at care files that people had been involved in deciding what care they required and that no formal written consent had been obtain from the person who used the service or their representative.

On closer examination of risk assessments for nutrition and skin integrity for people who used the service, we found these had not been completed correctly and many of the scores were wrong.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). All members of staff on duty confirmed that they had no formal training in the MCA which we confirmed when we spoke to the manager who told us that training would be scheduled.

We found regular reviews had been undertaken by the manager. However, improvements were required as it was not clear to us from reviewing the care files whether people who used the service or their representatives had been consulted about changing care needs.

People told us they were happy at Abbey Grove Residential Home and that they were well cared for.

Improvements were required as we found people's privacy was not always respected in relation to their confidential information. In one bedroom we inspected, attached to the cupboard door visible to anyone entering the room were detailed personal hygiene instructions as a result of the person suffering from incontinence.

During our inspection there appeared to be minimal verbal interaction between staff and people who used the service especially if people were in the lounges. However, when interaction took place staff were polite and kind.

People's privacy was respected at all times by staff when undertaking routine tasks such as assisting people to the bathrooms.

We saw that the TV was constantly on in both lounges, but people were sat around the room and were not actively watching any programmes. Improvements were required to ensure people were regularly stimulated and though care plans detailed individual social activities it was not clear to what extent they were followed by staff.

People told us that they felt the service listened and responded to any concerns they had. We looked at eleven completed residents and relatives' satisfaction questionnaires.

Staff spoke favourably about the manager and the leadership provided.

We found there was always a handover meeting at the beginning of the shift. Staff told us the handover meeting gave them an opportunity to gain clear directions at the start of their shift and kept them informed of any changes to people's needs or wishes.

Summary of findings

Regular staff supervisions took place which we verified by looking at staff personnel files. Staff told us they believed they could contribute to the running of the service through staff meetings and interaction with the manager and provider who were very approachable.

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?

Not all aspects of the service were safe. During our inspection we checked to see how people were protected by the prevention and control of infection. We found the service did not have robust enough systems to prevent the potential spread of infections. On inspecting the laundry area in the basement of the building we found the washing machines and dryers were dusty. We saw a pile of dirty bed linen placed on the floor next to a washing machine. A hand washing sink was visibly unclean with dirty cloths and paper towels discarded on the sink.

We found medicines were not stored, managed and administered safely and some people who used the service did not receive their medicines in the way they had been prescribed.

People and relatives told us that they had no concerns for their safety.

Requires Improvement

Is the service effective?

Not all aspects of the service were effective. It was not always clear from looking at care files that people had been involved in deciding what care they required and that no formal written consent had been obtained from the person who used the service or their representative. We saw referrals had been made to other health care professionals to ensure people had their individual needs met.

On closer examination of Malnutrition Universal Screening Tools (MUST) and Waterlow assessments to determine skin integrity for people who used the service, we found these had not been completed correctly and many of the scores were wrong.

We looked at staff personnel records and found that regular supervision had been undertaken by the manager.

Requires Improvement

Is the service caring?

Not all aspect of the service were caring. During our inspection, we saw one person who used the service was served lunch in their bedroom. Situated in the room was a commode which we found had not been emptied of faeces before the person was served their meal. When we spoke to the person about this matter, they were visibly upset that the commode had been full whilst they ate their meal.

We also spoke to two people who told us they had hearing difficulties. One person took a hearing aid out of their bag and told us staff did not know how to assist them to wear it. The other person told us they could not wear a hearing aid as no one could assist them.

Requires Improvement

Summary of findings

People told us they were happy at Abbey Grove Residential Home and that they were well cared for. People told us that they liked being able to choose when to get up in the morning and that assistance would be provided by staff if required. We observed staff knocking on people's doors prior to entering bedrooms and people told us that staff respected their privacy and personal space.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. In one care plan we looked, instructions for staff indicated that the person who was permanently in bed required to be turned hourly. On examination of turning charts, the interval of turns were much longer than hourly and no record existed for the 26 November 2014.

We identified poor record keeping such as failure to date and sign moving and handling assessments and resident care plan assessments had not been signed. Of the eight care files we looked at none of the care plans had been dated or signed by the person who used the service or their representative.

People told us there was not enough to do at Abbeygrove Residential Home. Improvements were required to ensure people were regularly stimulated and though care plans detailed individual social activities it was not clear to what extent they were followed by staff.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led. The auditing process undertaken was not effective as it had failed to identify the infection control concerns, medication concerns and additionally had not recognised omissions in care files.

During our inspection of the bedrooms we found call bells missing from four rooms, including one room where there was a person permanently in bed. This meant people were not able to summon support when they required it. We spoke to the manager about this concern who was unable to provide any explanation as to why they call bells were missing and why this issue had not been identified from the environmental checks including the house walk around that was undertaken.

We asked staff what they thought of the leadership and how the registered manager responded to concerns raised. Staff spoke favourably about the manager and the leadership provided.

Abbey Grove 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on the 26 November 2014 by an adult social care inspector, a specialist advisor and an expert by experience. The specialist advisor was a trained nurse. An expert by experience is a person who has experience of or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local vulnerable adult safeguarding team, the local NHS infection and prevention control team and NHS Salford Clinical Commissioning Group. We reviewed information sent to us by other authorities.

We reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people who lived at the home, three visiting relatives, and four members of staff. We also spoke to one health care professional who was at the home on the day of the inspection. Throughout the day we observed care and support being delivered in communal areas and also looked at the kitchen, laundry area, bathrooms and people's bedrooms.

We looked at the personal care and treatment records of eight people who used the service, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During our inspection we checked to see how people were protected by the prevention and control of infection. We found the service did not have robust enough systems to prevent the potential spread of infections. On inspecting the laundry area in the basement of the building we found the washing machines and dryers were extremely dusty. We noticed that the top of the washing machine was covered in a large build-up of soap powder. A hot water tank and boiler located in the same room were covered in a thick layer of dust. We saw a pile of dirty bed linen placed on the floor next to a washing machine. The floor was dirty and unclean and had not been swept in some time. Used plastic aprons had been left in a black plastic bag which had been left on the floor with part of its content spilling out.

In the adjoining basement hallway a hand washing sink was located. This was visibly unclean with dirty cloths and paper towels discarded on the sink. There was no soap or alcohol gel available or gloves or anything to dispose of paper towels and used gloves in. In another room, off the hallway we saw two sinks, which were also very dirty and stained. One had old and dirty cloths left in the sink area and in the other urine pans had been discarded. The light was not working in this room, which presented a hazard to people entering the room.

In two first floor toilets we looked at, we checked the raised portable toilet seats and found that they had not been cleaned underneath. Additionally, we also found several toilet brushes were full of faecal matter and the holders were stained and dirty. In the rear hallway and lounges we noted a strong odour. When we spoke to the manager about this, who told us that new carpets had recently been installed, however the strong smell of odour was still present.

These are breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked to see how the service managed medication. The service used a 'blister pack' system for the people using the service to store their medication. A blister pack is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the person's home. The pack has a peel off plastic lid and lists the contents and the time the medication should be administered. We looked at a sample of medication administration records and found that on the whole they had been completed correctly, though some records were difficult to understand. We reconciled the quantities of controlled drugs and found stocks tallied with the records.

We found that medication requiring cold storage had been stored in a fridge in the kitchen, which was full of food. When spoke to the manger about this who informed us that the fridge was specifically allocated for medication use only. This fridge could not be locked and was not alarmed and could easily be accessed by people living at the home. This meant storage arrangements for medicines requiring cold storage were not safe.

We noted that two containers containing eye drops had not been dated when they had been opened in line with good practice guidelines.

We found that in one instance where eye drops had been given to a person, we found instructions on the container clearly stated that the medication was not to be given after the 20 November 2014. We noticed the medication had been given on two occasions after that date. We found medicines were therefore not managed and administered safely and some people who used the service did not receive their medicines in the way they had been prescribed.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us they had no concerns for their safety. One person who used the service said "We are very well looked after here. I'm very happy and safe here." A visiting relative said "No concerns at all, I have never seen anything to give us any concerns, they also keep us well informed."

There were a range of risk assessments in place, which included nutrition, moving and handling, mental capacity, falls and bed rails. However, we found that risk assessments were generally incorporated with general information and as a result risks and hazards to the individual were not always clearly identified. For example, in one risk assessment we looked at, instructions were simply provided in relation to personal care, monitoring the person and ensuring his TV was at an acceptable volume so

Requires Improvement

Is the service safe?

as not to disturb others. Improvements were required to ensure risk assessments clearly identified risk and the action required to mitigate risk for the individual who used the service.

Two members of staff we spoke to were able to confidently explain safeguarding vulnerable adults and whistleblowing procedures and what action they would take if they had any concerns. The remaining member of staff who had been in post for three months was unclear what action they would take in the event of concerns. Training records we looked at verified that all staff had received training. There was a safeguarding adult's policy and procedure in place, which described the procedure staff could follow if they suspected abuse had taken place. The policy also provided an overview of the different types of abuse that could occur such as physical, financial or sexual.

We looked at a sample of staff recruitment files and found each file contained records, which demonstrated that staff had been safely and effectively recruited with appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks undertaken and suitable references obtained.

On the day of our visit, there were 15 people living at the home. They were supported by two care staff, the manager and the deputy manager. Additionally, there was a house keeper and cook. People who used the service, relatives and staff told us they had no concerns about staffing levels. We also looked at staff rotas and found there were sufficient numbers of trained staff on duty to provide appropriate levels of care and support for the current numbers of people staying at the home.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were able to confirm that they had provided consent for the care and support they received from the service, who acted in accordance with their wishes at all times. Throughout the inspection we witnessed staff seeking consent before undertaking any routine task with people. However, it was not always clear from looking at care files that people had been involved in deciding what care they required. We found that no formal written consent had been obtained from the person who used the service or their representative.

We saw referrals had been made to other health care professionals to ensure people had their individual needs met. These included the GP, dieticians and Speech and Language Therapists (SALTs).

We spoke to a health care professional who was visiting the home on the day of our inspection. They told us that they believed the service was very caring, though it was a difficult environment due to the age of the building. Staff interacted effectively with people who used the service and could be relied upon to follow any instructions left in support of peoples care.

We found regular reviews had been undertaken by the manager. However, improvements were required as it was not clear to us from reviewing the care files whether people who used the service or their representatives had been consulted about their changing care needs. One relative did tell us that they had a meeting with the manager to discuss the changing needs of their loved one who was due to be moved to a nursing home.

On closer examination of Malnutrition Universal Screening Tools (MUST) and Waterlow assessments to determine skin integrity for people who used the service, we found these had not always been completed correctly and many of the scores were wrong. In one care plan we examined we found that the MUST score had been calculated as four. The care plan also stated that if the score was higher than two then a referral to a GP or dietician was required. We found this had not been done. We spoke to the manager about these concerns who told us that she had been made aware of these errors following a review by the local authority and that she was currently liaising with the district nurse to address these errors. We were able to confirm that the local authority had been working closely with the service to address the use of these screening tools.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Care home providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. We found the service had made applications in connection with DoLS for people who used the service which were detailed in individual care files.

We saw there were procedures in place to guide staff on when a DoLS application should be made. We spoke with staff to ascertain their understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Two members of staff we spoke to had a working knowledge of the MCA whilst the third member of staff indicated he had no knowledge at all. All three members of staff confirmed that they had no formal training in the MCA, which we confirmed when we spoke to the manager who told us that training would be scheduled.

We looked at staff personnel records and found that regular supervision had been undertaken by the manager, but we found no evidence of annual appraisals in the last twelve months. Supervisions and appraisals enabled managers to assess the development needs of their support staff and to address training and personal needs in a timely manner.

We were informed that there were currently sixteen members staff employed by the service, seven of whom were recruited in last six months. We looked at training records and found that all staff had received training in medication administration, safeguarding and manual handling, however other training had been inconsistent. For example, only four members of staff were currently trained in First Aid and seven members of staff required formal training in infection prevention and control, an area where we had identified concerns. We spoke to the manager about these issues who said that training concerns would be addressed as a priority.

Requires Improvement

Is the service effective?

During our inspection we used the Short Observational Framework for Inspection (SOFI) during lunch. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw that people were asked where they wanted to sit and assisted with seating their adjustments. We found the atmosphere to be both calm and relaxed. We saw people were encouraged to be independent when eating their meals, though support was given where needed with eating and drinking.

A choice of meals and drinks were offered to people and they were often asked whether they were ok or needed anything. People were also provided with further servings. Not all tables were provided with napkins. We watched meals being taken on trays through the dining room to other rooms where people chose to eat; some trays were covered but most were not. One person who used the service told us; “The food is nice.” Another person said “Sometimes the food is not so good,” where as another person said “The food is excellent, plenty of choice.” A visiting relatives told us; “No concerns about food, within reason they cater for the individual.”

Requires Improvement

Is the service caring?

Our findings

During our inspection, we saw one person who used the service was served lunch in their bedroom. Situated in the room was a commode which we found had not been emptied of faeces before the person was served their meal. When we spoke to the person about this matter, they were visibly upset that the commode had been full whilst they ate their meal.

We also spoke to two people who told us they had hearing difficulties. One person took a hearing aid out of their bag and told us staff did not know how to assist them to wear it. The other person told us they could not wear a hearing aid as no one could assist them.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were happy at Abbey Grove Residential Home and that they were well cared for. One person told us "I like it here." Another person said "I am very well looked after." Other comments from people who used the service included; "The staff are great." "Staff are very nice." "Staff are excellent, they are very good. I don't have any problems here."

We saw that people were well groomed and well presented. We observed peoples' nails were trimmed and clean. Bedrooms were personalised with people's belongings. Double rooms were fitted with blinds to maintain individual dignity and privacy. People told us that they liked being able to choose when to get up in the morning and that assistance would be provided by staff if required. People's care plans contained instructions on personal hygiene and individual requirements for bathing and showering and the level of support required.

Improvements were required as we found people's privacy was not always respected in relation to their confidential information. In one bedroom we inspected, attached to the cupboard door visible to anyone entering the room were detailed personal hygiene instructions as a result of the individual suffering from incontinence.

During our inspection there appeared to be minimal verbal interaction between staff and people who used the service especially if people were in the lounges. However, when interaction took place staff were polite and kind.

People's privacy was respected at all times by staff when undertaking routine tasks such as assisting people to the bathrooms. We saw people were able to spend private time in their bedrooms if they wished. Family members told us there were no restrictions on when they could visit the home and were always made to feel welcome. Staff told us that the service catered for people's spiritual and religious needs and that a priest and lay preacher occasionally attended the home.

We observed staff knocking on people's doors prior to entering bedrooms and people told us that staff respected their privacy and personal space.

We had a mixed response from families as to whether they were involved in making decisions about the care their relatives received. One relative explained how they had raised concerns about the changing needs of their loved one which resulted in a meeting with the manager. This in turn led to a decision being made to move the person to another home as a result of developing nursing care needs. Another relative told us they never had any input in their relatives care or received much feedback. The relative provided an example of when their loved one was moved to a different room and they had never been consulted or even told why the move had been made.

Requires Improvement

Is the service responsive?

Our findings

In one care plan we looked at, instructions for staff clearly indicated that the person who was permanently in bed required to be turned hourly. On examination of turning charts, the interval of turns were much longer than hourly and no record existed for the 26 November 2014. The last recorded turn was at 4pm on 25 November 2014 the previous day and the turn prior to that had been at 1pm which was a gap of three hours. It was therefore unclear to us what turns had been made on the day of our inspection as no record had been maintained since the previous day.

In another care plan we looked at instructions clearly stated that meals and fluid were to be recorded together with weekly weights. As we were unable to locate any such records we spoke to staff who told us that the person needs had changed and they were no longer required and that the care plan had yet to be updated. This demonstrated that the care plan did not accurately reflect the current needs of the person.

All care plans that we looked at reflected the wishes and choices of people who used the service. However, in one care file we looked at relating to a person who used the service, following the title page we found that subsequent pages contained the name of a different person. We could therefore not be sure who the care file related to. We were told by the manager that the subsequent name on the file was a photo coping error.

We identified poor record keeping such as failure to date and sign moving and handling assessments and resident care plan assessments had not been signed. Of the eight care files we looked at none of the care plans had been dated or signed by the person who used the service or their representative.

This is a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us there was not enough to do at Abbeygrove Residential Home. One person who used the service said "No activities that I'm aware off. I would play cards and dominoes if available. I like art and would draw if I could." A visiting relative said "There is not enough happening to stimulate people physically and mentally." We asked staff what they did to stimulate people. Two members of staff told us that they engaged in one to one activities such as playing dominoes or reading, while the third member of said that they only engaged in group activities. One member of staff said "They do activities like games and children visit from local schools. You could probably do with more, you need it to be more organised."

Throughout our visit we did not see any set activity programme or any member of staff engaging in any individual activities with people though we saw individual interaction between staff and people who used the service. We saw that the TV was constantly on in both lounges, but people were sat around the room and were not actively watching any programmes. Chairs in the main lounge were set around the walls which was not conducive to people interacting with each other. Improvements were required to ensure people were regularly stimulated and though care plans detailed individual social activities it was not clear to what extent they were followed by staff.

Each care file we looked at covered all aspects of personal care which included mobility, nutrition, personal hygiene and continence. This enabled staff to understand what people's care needs were and how they could best meet their requirements. However, improvements were required were concerns with challenging behaviour were identified as we found no specific care plans to address those needs.

Other documentation stored within care files included daily notes, personal evacuation plans in the event of an emergency and the involvement from any external medical and health care professionals.

We looked at how the home dealt with formal complaints. We looked the complaints policy and procedure and looked at how the home recorded and dealt with such concerns. Complaints were dealt with in a timely manner. People and relatives confirmed that if they had any concerns they wouldn't hesitate to approach the manager of provider who regularly visited the home.

People told us that they felt the service listened and responded to any concerns they had. We looked at eleven completed residents and relatives' satisfaction questionnaire. Comments were very favourable about the quality of the service provided. Comments included; "Present staff are very caring and helpful to residents. A good team." "The care offered is outstanding." "Very pleased with the care and attention given by staff." "You can't improve on excellence."

Requires Improvement

Is the service responsive?

We looked at notes relating to a residents' meeting that had taken place in April 2014. One person stated they would like more choice of meals, which was actioned by the cook speaking to the person about their preferred choices.

Requires Improvement

Is the service well-led?

Our findings

The manager undertook a number of audits to ensure the service was meeting the required standards. The audits covered a number of areas. We looked at an audit monitoring tool used by the service, which indicated care plans and medication were checked on a weekly basis. Environmental checks including a house walk around was also undertaken. However, the auditing process undertaken was not effective as the manager had failed to identify the infection control concerns, medication concerns and additionally had not recognised omissions in care files.

During our inspection of the bedrooms we found call bells missing from four rooms, including one room where there was a person permanently in bed. This meant people were not able to summon support when they required it. We spoke to the manager about this concern who was unable to provide any explanation as to why they call bells were missing and why this issue had not been identified from the environmental checks including the house walk around that was undertaken. We were told that immediate steps would be taken to address the matter.

Whilst in the kitchen we examined the contents of the First Aid kit and found that it did not contain any bandages and gauze. Additionally, the First Aid Instructions that were displayed on the wall were dated 2005 and instruction regarding burns and cardio pulmonary restitution had since changed. We spoke to the manager about these issues who was not aware that there were no bandages which further questioned the effectiveness of auditing processes used by the service. We were told that immediate steps would be taken to replenish the contents of the First Aid kit.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our visit the registered manager was very visible on the floor supporting people who used the service and staff. The registered manager had worked at Abbey Grove Residential Home for a number of years

We asked staff what they thought of the leadership and how the registered manager responded to concerns raised.

Staff spoke favourably about the manager and the leadership provided, comments included; “It’s good. They have helped me when I first came into this type of work.” Another member of staff said “The manager is really good. They listen and take action. Things get done.”

We found there was always a handover meeting at the beginning of the shift. Staff told us the handover meeting gave them an opportunity to gain clear directions at the start of their shift and kept them informed of any changes to people’s needs or wishes. One member of staff told us; “The manager is always present at handovers where we discuss concerns. We always know what is going on.”

The service had systems in place that encouraged feedback from people and relatives, which included questionnaires that were circulated and resident meetings. The manager also told us they dealt directly with any informal feedback received. We looked at one feedback form dated March 2014, where a visiting health care professional commented “Lovely atmosphere, manager one of the best. Well run by all.”

Staff told us they believed they could contribute to the running of the service through staff meetings and interaction with the manager and provider, who were very approachable. We looked at minutes from a staff meeting conducted in June 2014 where issues such as the laundry and night time breaks were discussed.

We spoke to staff about whether they understood their roles and responsibilities and whether they received the support they required to provide a good standard of care to people. Staff confirmed that they felt supported by management and were clear about their roles and responsibility. One member of staff told us; “My aim is to make their day as good as possible.” Another member of staff said “To look after residents and make sure they are clean and have everything they want.”

The manager told us they were always available either to attend or give guidance to staff during the evening and night time in the event of any emergencies. Staff confirmed to us that the manager was always at the end of the phone to give advice.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used services and others were not protected against the risks associated with appropriate standards of cleanliness and hygiene.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected against the risks associated with the safe storage, management and administration of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Suitable arrangements were not in place to ensure the dignity and privacy of people who use services was maintained and that care provided was able to meet the needs of people with any disability.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Failure to maintain accurate records.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regularly assess and monitor quality of services provided through effective auditing systems.**