Safequarter Ltd

Abbeygate Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on 10 and 14 March 2016 and found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always protected from risks that could have an impact on their care as these had not been identified (Regulation 12). The registered provider did not have robust quality assurance systems and audits in place to monitor and improve the quality of care and safety of the home (Regulation 17). Staff recruitment was not completed robustly (Regulation 19) and there were not always enough staff deployed to meet the needs of people (Regulation 18). Following this inspection we served requirement notices on the registered provider. They sent us an action plan which gave details on the actions they were going to take to be fully compliant with all the Regulations by 31 July 2016.

We carried out an unannounced inspection of this home on 18 and 19 July 2017. At this inspection we found that, whilst the registered provider had taken some steps to address the concerns we found in March 2016, they had failed to be compliant with all of the required Regulations as stated in their action plan.

The overall rating for this provider is 'Inadequate'. This means that it would be placed into 'Special measures' by CQC. The purpose of special measures is to:

□□Ensure that providers found to be providing inadequate care significantly improve
□□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
□□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures would be inspected again within six months. If insufficient improvements had been made such that there remained a rating of inadequate for any key question or overall, we would take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This would lead to cancelling their registration or to varying the terms of their registration within six months if they did not improve. The service would be kept under review and if needed urgent enforcement action would be considered.

However, on 17 August 2017 following our inspection, the registered provider advised CQC of their intention to close this home within two months of the notice. An application has been received to remove this location and the registered manager from our register.

At this inspection we found the registered provider had failed to be compliant with four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one Regulation of the Care Quality Commission (Registration) Regulations 2009. These have been identified at the end of this report. CQC considered the need for enforcement action to be taken against the registered provider and registered

manager to ensure compliance with these Regulations to ensure the safety and welfare of people. However, as this home is to close, and the registered location and manager are to be removed from our register, no further action will be taken.

The home provides accommodation and personal care for up to 30 older people, some of whom live with memory problems and dementia. Accommodation is arranged over two floors with stair and lift access to all areas. At the time of our inspection 20 people lived at the home.

A registered manager was in post at the home. 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.

Whilst care plans were person centred, the risks associated with people's care had not always been identified and assessments made to reduce these risks for people.

The home was not clean and well maintained. A programme of maintenance was not in place to improve and maintain the home to ensure people's safety and welfare.

There were not always sufficient staff deployed to meet people's needs and ensure their safety and welfare. Staff did not always have time to fulfil their role and were at times frustrated with the lack of clarity in their role.

The registered provider had implemented systems to monitor and review the quality and effectiveness of the service provided at the home, such as audits, however these were not effective. There was a lack of organisation in the management of the home.

Staff were assessed during recruitment as to their suitability to work with people. Staff felt the received support through training, supervisions and appraisal, however they did not feel their views were always listened to and respected.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Whilst the registered manager had reported safeguarding concerns to the local authority, improvement was required in the recording of safeguarding matters.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom. However, the Commission had not always been informed when people were deprived of their liberty, in line with the legal requirements.

People, their relatives and health and social care professionals said staff were caring and knew people well. Staff cared for people in a kind and empathetic way. However, we observed some practices which did not always show respect and dignity for people.

People were able to express their views and be actively involved in their care planning. A system was in place to allow people to express any concerns or complaints they may have. There had been no formal complaints in the service in the past year.

People received their medicines in a safe and effective manner.

People received nutritious food which was well presented and in line with their needs and preferences. Their nutritional intake was monitored and staff sought support appropriately if their weight fluctuated or there were concerns about a person's appetite.

People were supported to participate in events and activities of their choice although these were limited to the availability of staff to support them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks associated with people's care had not always been identified and addressed

There were not always sufficient staff deployed to meet people's needs and ensure their safety and welfare. Staff were assessed during recruitment as to their suitability to work with people.

Some areas of the home were not clean and were in disrepair. Maintenance schedules were not kept and there were areas of the home which required attention to ensure the safety and welfare of people.

Systems were in place to support staff in recognising signs of abuse and they knew how to report these.

People received their medicines in a safe and effective manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom. However, the Commission had not always been informed when people were deprived of their liberty; in line with the legal requirements

Staff had received training to enable them to meet the needs of people.

Staff knew people well and could demonstrate how to meet people's individual health and support needs.

People received nutritious food in line with their needs and preferences

Is the service caring?

Good

The service was caring.

People and their relatives said staff were caring and supportive of people's needs. Health and social care professionals said staff were caring and supportive of people.

Staff knew people and cared for them in a kind and empathetic way.

People were able to express their views and be actively involved in their care planning.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person centred. Staff at times needed further guidance about how they should support people who could become distressed or agitated.

People were supported to participate in events and activities of their choice although these were limited to the availability of staff to support them.

A system was in place to allow people to express any concerns or complaints they may have.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes in the home were not effective. Audits in place did not identify the concerns we noted at our inspection.

There was a lack of organisation in the management of the home. Staff did not feel their views were always listened to and respected.

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.

One inspector and an expert by experience completed this unannounced comprehensive inspection on 18 and 19 July 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. On 11 January 2017 the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR for this home. Following our inspection we received information from the registered provider about the closure of the home.

We spoke with eight people and one relative to gain their views of the home. Some people who lived at the home were not able to talk with us about the care they received. We observed care and support being delivered by staff and their interactions with people in communal areas of the home. We spoke with staff, including the registered manager, the deputy manager, two head of care, four members of care staff, three members of domestic or laundry staff and the cook.

We looked at the care plans and associated records for six people. We looked at medicine administration records for 12 people. We looked at a range of records relating to the management of the service including records of, accidents and incidents, quality assurance documents, two new staff recruitment files and

policies and procedures.

Following our visit we received feedback from two health and social care professionals who supported some of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

People said they felt safe in the home, although some said there were not always enough staff available to meet their needs. Health and social care professionals said the home was a safe place to live and staff knew how to meet people's needs. This was not reflected in our findings.

At our inspection in March 2016 we found people were not always protected from risks that could have an impact on their care as these had not always been identified. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. On 9 May 2016 the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by 30 May 2016. At this inspection we found the registered provider had not taken sufficient action to be fully compliant with this regulation.

Guidance and communication was unclear to ensure people were protected and risks minimised. Following a serious incident in the home on 14 June 2017, the registered manager had identified one person was at serious risk of harm and required close monitoring, every 15 minutes, to ensure their safety and welfare. There was no risk assessment in place to identify what risks of harm this person may be at or clear guidance on how this person should be monitored and what staff should do if they considered the person was at risk of harm.

Staff told us this person was being monitored hourly. Daily care records showed this person had not been observed every 15 minutes since 15 June 2017, the day after the incident. There was no information in care records to say this risk had been reduced or what actions staff had taken to ascertain this risk was no longer relevant to their care. We spoke with the registered manager about this person's care. They told us this person should still be on 15 minute checks and that this had not changed. They implemented this care immediately after we had discussed this. The risks associated with this person's care had not been fully assessed and all necessary actions implemented to ensure their safety and welfare.

Management lacked awareness of new risks to people and the action being taken to mitigate those risks. Another person who lived with a mental health condition required support to maintain their own safety and welfare. The registered manager told us this person was awaiting a move from the home to a nursing home where their needs could be more appropriately met. The local authority were supporting with this need. However, the risks associated with this person's care had not been fully assessed and all necessary actions taken to ensure their safety and welfare.

Staff told us the person remained in their room for most of the time due to the complexities of their mental health conditions. This person was unable to use a call bell to summon assistance and remained in their room on the first floor of the home throughout our inspection. Daily records showed staff saw this person every hour. When we visited this person in their room we found they were at risk of harm and were not being supported to ensure their safety and welfare. The risks associated with this person being isolated and not monitored more frequently had not been assessed.

Daily care records showed this person had fallen on 21 March 2017. The registered manager told us they were not aware this person had fallen as they had not been on duty at the time of the fall. The risks associated with this person falling or remaining in their room on the first floor of the home behind a closed door had not been assessed. Following our inspection we made a referral to the local safeguarding authority to ensure the safety and welfare of this person was reviewed.

At our inspection in March 2016 we found people did not have individual personal evacuation plans (PEEP) in place. The purpose of these documents is to provide staff and emergency workers with the necessary information to evacuate people who cannot get themselves out of a building unaided in the event of an emergency. Whilst the registered manager had ensured these documents were in place we found these were not always up to date. For example, for one person who was no longer able to mobilise with the support of staff and required the use of a hoist to transfer. This information had not been updated on their PEEP. A PEEP was also in place which referred to another person who was no longer living at the home. We were not assured these documents were an up to date and accurate reflection of how people needed to be supported in the event of an emergency.

Care records held information on some of the risks associated with people's care such as using the garden area of the home and showering or bathing, but these were generic risk assessments and were not always specific to the person to whom they related. For three people who used bedrails the risks associated with the use of this equipment had not been assessed.

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

At our inspection in March 2016 we found there were not always enough staff deployed to meet the needs of people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. On 9 May 2016 the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by 30 May 2016. At this inspection we found there were not always sufficient staff deployed to meet the needs of people and ensure their safety and welfare.

Members of care staff told us there were not enough staff deployed to meet people's needs and carry out all the additional duties they were expected to complete including cleaning, laundry and supporting people with activities. One member of care staff told us, "In the sunshine people like to go outside but if they do one of us [member of staff] has to be out there with them because it is not safe [in the garden] and this means there are less of us to help inside." Another said, "If we were just providing care then that would be alright, but there are lots of other things we have to do too, like cleaning, laundry and activities and we can't do it all." A relative told us there were not enough staff available in mornings to support people and so staff were often rushed. They told us their relative found this distressing.

For two people who required close monitoring to ensure their safety and welfare we saw staff were not always available to monitor these people and meet their needs. Staff did not have time to sit with people and interact or provide support. One person told us, "They [staff] are so very busy. I get muddled and they just don't have time to stop with me." Another person said, "I am very lonely. They [staff] are lovely but don't really have a lot of time for me."

Following our inspection in March 2016 the registered provider told us, in their action plan, that they would introduce a staffing level dependency tool and a night staff level tool. This type of tool is used to assess the needs of people and ensure there are adequate staff deployed to meet these needs. If people's needs

change then this tool would assist in assessing whether additional staff were required to help to ensure people's needs were met. The registered provider stated they would, "Undertake an assessment of dependency levels to enable a comprehensive assessment of staffing levels which correlates to the needs of people accommodated". At this inspection we found this action had not been completed and there was no tool in place to identify the changing needs of people and the number of staff required to meet these.

Following our inspection the registered provider sent us information about a dependency tool which was available in the home at the time of our inspection. This did not accurately reflect the information we found about people's needs.

There were not sufficient staff deployed to ensure the cleanliness of the home. Staff who were employed to support cleaning duties told us there was not sufficient time for them to ensure the home was cleaned adequately. Care staff told us these duties fell to them when cleaning staff were not available and this meant they were not always available to meet people's needs. This was reflected in our findings during the inspection. For example, each afternoon there were no cleaning staff available in the home to support cleaning duties and care staff had to support these.
The registered manager told us that they were often called to support staff absences and work, "on the floor", as there were not always sufficient staff available to meet people's needs. A head of care told us they were often counted in the staffing numbers during the day. This meant management staff did not always have the time and opportunity to complete management roles in the home.

The registered manager told us that the registered provider had not allowed the employment of new staff in recent months as the number of people who lived in the home had fallen. They told us they had informed the registered provider that more staff would need to be employed in the home before they could accept any new people into the home. They had identified how many more staffing hours they felt were required to allow new admissions to the home, however they were not able to tell us how they had identified these numbers. They had not identified that there were not currently sufficient staff in the home to always meet people's needs and ensure their safety and welfare.

Following our inspection the registered provider informed the Commission of the closure of the home. They said they it had not been appropriate to employ additional care staff during a time of uncertainty in the home and that additional staff had been sourced from external agencies to support people's needs when the registered manager identified this was required. Whilst external agency staff were available to support people this did not alter our findings during this inspection.

The lack of sufficient staff deployed in the home to meet the needs of people and ensure their safety and welfare was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in March 2016 we found recruitment records for staff were not always complete as there were significant gaps in the employment records of some staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. On 9 May 2016 the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by 30 May 2016.

At this inspection we found the registered manager had recruited only two new members of staff since our last inspection. Both recruitment records included proof of identity, an application form and a Disclosure and Barring Service (DBS) check. These checks help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. For one

person gaps in their employment history had been identified although no clear record of the reason for these had been made. The registered manager told us they had discussed these gaps with the member of staff although there was no record of these discussions. For this person, whilst two references had been requested prior to them commencing work at the home, a reference had not been provided from their most recent employer. We spoke with the registered manager about the processes they followed when recruiting staff and the need to ensure adequate records were maintained of these. They provided further information to us following our inspection to show they had taken action to address this.

Cleanliness in the home was poor. Whilst the kitchen was a clean and well maintained area, most other areas of the home required extensive cleaning. There were persistent strong odours around the home as carpets, flooring and other upholstery in some bedrooms and communal areas were unclean. Equipment used to ensure the safety and welfare of people such as hoists, toilet frames, pressure relieving cushions and walking frames were unclean and required deep cleaning or to be discarded. Table mats placed on tables at mealtimes were damaged and could not be maintained hygienically. The home was dusty and in need of extensive cleaning to ensure all living areas, including bedrooms, were clean.

We spoke with the registered manager about the cleanliness of the home. They told us they were "Ashamed at the state of the home," as they understood the need for the home to be clean to reduce the risk of infection to people. Cleaning staff told us did not have sufficient time or resource to ensure the cleanliness of the home as they were only able to complete, "Basic cleaning duties," during their shifts. Cleaning staff worked every day between 08:00hrs and 13:30hrs with a member of laundry staff available between 12:00hrs and 16:00hrs on weekdays. They recognised some areas of the home needed refurbishment and deep cleaning but they did not have the time to do this. A relative told us the home needed a 'deep clean' as persistent odours in the home had been noted by them and other visitors. There were no cleaning schedules completed to identify the duties required of cleaning staff and to monitor the cleanliness of the home.

Some areas of the home were in disrepair and required attention to ensure the safety and welfare of people. The garden area and entrance to the home were overgrown and uneven with slip and trip hazards evident. The back garden had a patio area to provide people with an area to relax outside. A member of staff told us, "It's not safe for people to go out there alone without us [staff] because of the steep banks." The steep sloped banks in the garden were not secured or clearly marked to alert people to these.

Areas inside the home were in need of decorating and refurbishment. Some carpets and floor areas were cause for concern as they were trip hazards and some window restrictors, in place to reduce the risk of accidents, were broken. Areas which would be accessed in the event of an emergency evacuation of the home, such as stair cases, were used as storage areas and patches of flooring in these areas were trip hazards.

A member of staff was employed to complete any maintenance duties in the home. Electrical, gas and water checks were completed routinely in the home to ensure this equipment was safe to use. However we found systems in place to identify maintenance issues in the home were not used consistently or effectively. The registered manager told us they were restricted in the actions they could take to improve the environment of the home by the funding available to them from the registered provider. We told them of the areas of concern we had found and they told us, "I know there is a lot to do."

On 17 August 2017, the registered provider informed the Commission that they had previously recognised the significant alterations required to the building of the home in order to make it fit for requirements and fit for the future and had been working to review these requirements. The registered provider informed the Commission the home was to close and people who lived and worked at the home had been informed of

this action. The registered provider and registered manager had been unable to share this information at the time of our inspection for legal reasons. However, this did not alter our findings on the day of our inspection when we reviewed the safety and welfare of people who lived at the home.

There was a lack of effective systems in place to ensure the home was clean and well maintained. Areas of the home required attention to meet people's needs and ensure their safety and welfare. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the safeguarding of people and had an understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. They were aware of how to report this both in the service and externally to the local authority and CQC and they felt confident the registered manager would deal with their concerns promptly.

The registered manager told us how they had liaised with the local authority safeguarding team about one person and described how they were working with them to ensure their safety and welfare. However, records for this safeguarding matter were not always clearly documented to show the actions the registered manager had taken to support this person's needs.

People received their medicines in a safe and effective way. They were administered by staff who had been suitably trained and had a good understanding of the policies and procedures around the safe administration of medicines. Medicines were stored and administered safely. A system of audit was in place to monitor the administration, storage and disposal of medicines. There were no gaps on medicines administration records (MAR) which meant people received their medicines when they were required. For medicines which were prescribed as required (PRN) a protocol was in place to support staff in the safe administration of these medicines.

Requires Improvement

Is the service effective?

Our findings

People who were able to express their wishes felt they were involved in their care and were offered choices and support to maintain their independence. Health and social care professionals felt staff requested their support appropriately and followed guidance provided for them to ensure the safety and welfare of people.

At our inspection in March 2016 we made a recommendation that the registered provider review the recording of mental capacity assessments, best interests decision making processes and Deprivation of Liberty Safeguard applications. We saw improvements had been made in the recording of these processes.

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 in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA.

Where people had the mental capacity to consent to their treatment, staff sought their consent before care or treatment was offered and encouraged people to remain independent. Where people did not have capacity or had fluctuating capacity to consent to their treatment, there was information held in care records about how people could be supported to make decisions for themselves and who should be involved in any best interests decision making for the person. There was information for staff as to whether a person had selected a legal representative such as a Lasting Power of Attorney to make decisions on their behalf.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For nine people who lived at the home an application had been approved by the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. The deputy manager had systems in place to monitor and review these safeguards. Staff had a good understanding of these safeguards in place and information in care records showed the reason for the safeguard being in place. Further work was required to ensure the information relating to any safeguard in place was fully incorporated into care plans. We spoke with a head of care who told us this would be addressed.

We found the home was meeting all the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, the registered provider had failed to advise the Commission of any Deprivation of Liberty Safeguards which were in place at the home. This is required by law and is therefore a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Records showed health and social care professionals including GP's, social workers, specialist nurses and community psychiatric nurses visited the home to provide advice and support as this was required for

people. Health and social care professionals said staff were always available to support them on their visits and they knew people well and were able to articulate their concerns.

Whilst verbal communications with professionals was good, these conversations were not well documented. Care records did not always clearly identify the concerns staff were expressing to professionals. For example, they did not clearly document when staff were concerned they could not meet the needs of a person and how this had been escalated. This meant, whilst actions may have been taken to ensure the safety and welfare of people this was not evident as it was not always clearly documented in people's care records.

A program of supervision sessions, induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. Staff felt supported through these sessions to help them to provide safe and effective care for people.

The registered manager monitored all staff training through the use of a training matrix. This showed staff had access to and completed a wide range of training which included: moving and handling, fire training, safeguarding, mental capacity and deprivation of liberty. All staff had received an induction to the home. Staff told us they were encouraged to develop their skills through the use of external qualifications such as National Vocational Qualifications (NVQ) and the Care Certificate if they had not completed this. This certificate is an identified set of standards that care staff adheres to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. NVQ are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

People told us the food provided at the home was very good and they enjoyed a variety of foods in line with their preferences. One person said, "The food is nice." Another told us they enjoyed the food they were given and, "It always looks nice on my plate." We saw people had a choice of nutritious meals at each meal time and were supported and encouraged to enjoy a sociable experience at mealtimes. Care records reflected people's preferences, likes and dislikes as well as any special dietary requirements they may have. The cook was aware of these. An assessment of people's nutritional status was reviewed each month or more frequently if this was required. People's weight was monitored and if there were any concerns with this or with a person's appetite staff sought guidance and support from the GP.

Good

Is the service caring?

Our findings

People and their relatives said staff were caring and had a good understanding of their needs. One person told us, "The staff are very kind. I feel listened to and if I need anything the staff are there to help, they are very good to me and I am pleased to be here." Another said, "I like it here because they care for me and my friend and the staff are really good to us." People were mostly valued and respected as individuals and appeared to be happy and contented in the home. Health and social care professionals said staff were caring and kind.

Staff knew people well and used good communication skills as they addressed people by their preferred name and took time to recognise how people were feeling when they spoke with them. For example, one person did not want to join in an activity which was taking place in a communal lounge. Staff spoke with them kindly and recognised the person wanted to sit quietly and read their paper. They supported the person to move to another lounge area and returned to check they were settled after a short while. Another person was calling out from their room and a member of staff went to them and spoke calmly, quietly and slowly, reassuring them they were there to help and encouraging them to express themselves.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. People's rooms were personalised with their own furniture and belongings if they chose and name plates on each bedroom door were personalised to reflect people's life, likes and preferences. Doors remained closed to people's rooms at all times unless people requested they were open. Staff knocked and waited for a response before entering people's rooms. A telephone was available for people to use in a quiet corridor in the home and staff explained how they supported people to have privacy when they spoke with family and friends on the phone.

Staff had a good understanding of how to ensure most people's dignity was maintained. For example, when people had finished their meal in the main dining area, staff supported them to ensure they were able to freshen their face and hands and ensure their clothing was clean.

People and their relatives were involved in providing information to inform their care plans. Care records showed staff interacted with people to understand their needs, views, preferences and dislikes. Relatives were involved in the planning of care for their loved ones.

Residents meetings were held every three months. Minutes from these meetings showed people were asked their views of the home and made suggestions for improvements such as new activities or ideas for meals.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were encouraged to express their views and be involved in making decisions about their care. Health and social care professionals said staff knew people well and understood their needs.

People needs had been assessed prior to their admission to the home and these assessments were used to inform care plans. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for on admission to the home. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them and they identified who needed to be involved in their lives and in helping them to make decisions.

Some care plans lacked guidance so staff could support people and respond to their needs. For example, one person presented with behaviours which staff told us, and we saw, appeared to be distressing for the person and other people including staff and their visitors. Care plans in place identified that the person may display these behaviours. There was no guidance available for staff on how they should support this person with these behaviours or how they should be recorded to monitor for any patterns or further triggers. The registered manager and staff told us that they were aware they were unable to meet this person's needs and were working with professionals to support this person until their needs could be more appropriately met in another care setting.

Care plans were mostly person centred. They gave clear information on how people liked to be supported, what they were able to do themselves and when staff should offer or provide support. For example, for one person their 'Preferred daily routine' document gave staff guidance on when they liked to get up, retire to bed and how they always wanted staff to offer to support them to visit the toilet before a meal time. Another person required staff to be positive when they were distressed. Their care plans held clear information on how they liked to be supported, the way in which they communicated their concerns and how staff should ensure they were able to meet their needs.

Monthly care plan reviews were completed with people to review the care they had received. These records included information about any incidents which had occurred in the month, any changes in care needs and any discussions about their care which staff had with the person. Further action was taken to address any changes required. For example, one person's care plan had been updated to reflect their mobility had deteriorated and staff were aware of this need.

At our inspection in March 2016 we made a recommendation about the activities available for people, in particular those which were suitable for people who lived with dementia. We saw activities in the home had improved although these were dependent on the availability of staff to support them. There was a program of activities in the home. People told us they enjoyed participating in quizzes, bingo and musical activities although these were not always regularly held. One person said, "We get some activities once a week, some

every four weeks. I go to the garden every day except when it is raining." People had access to daily newspapers and magazines. During our inspection a musician visited the home and people told us how much they had enjoyed this. There was no activity coordinator in the home and the registered manager planned all visiting entertainers whilst care staff supported all other social interactions when they were available. People were able to attend religious services in line with their preferences and a Catholic and Church of England clergy regularly visited the home to carry out services. A list of activities people attended was held with their care records. This showed most people participated in an activity during the day, including receiving visitors, although these records were not always well maintained.

The complaints policy was displayed in the entrance to the home. People and their relatives were aware of the policy and felt confident any concerns they raised would be addressed promptly by the registered manager other staff. The registered manager told us there had been no complaints made in the service since our last inspection.

Inadequate

Is the service well-led?

Our findings

People and their relatives said they felt able to talk to staff and the registered manager if they had any concerns and that these would be dealt with promptly. Staff felt supported by the registered manager in the day to day running of the home although they did not always feel their views were listened to.

At our inspection in March 2016 we found the registered provider did not have a robust quality assurance system in place to assess, monitor and improve the quality of care provided in the home and the safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. On 9 May 2016 the registered provider sent us an action plan detailing the actions they were going to take to ensure they were complaint with this regulation by 31 July 2016. At this inspection we found whilst systems were in place to monitor and review the quality and effectiveness of the service provided at the home, these had not been used effectively and had not identified the concerns we raised at our inspection.

A programme of 25 separate audits had been introduced in the home by the registered provider. The audits had to be completed by the registered manager, the deputy manager or a head of care. These included audits of accidents and incidents, health and safety, infection control practices and management and administration practices. The registered manager was also required to send a monthly 'Manager's report' to the registered provider to update them on matters such as the number of people in the home, staffing issues, environment of the home and management issues.

For the month of June 2017 we saw none of the concerns we had identified during our inspection with the cleanliness and maintenance issues in the home had been highlighted in the 'Manager's report'. The infection control audit completed for June 2017 identified none of the concerns we found with unclean equipment and upholstery. There was no evidence to show what the registered provider did with these reports to help improve the quality of the service provided at the home.

The provider had not prioritised the maintenance of the home. We asked for the last maintenance audit. We were given an audit dated July 2016 which identified some minor general maintenance observations such as missing curtain hooks, stains on ceilings and areas in need of repair. This stated, "Curtains and carpets renewed when needed." We saw this had not happened. The concerns we had identified with the cleanliness and maintenance of the home had not been identified through further audit.

The system in place to monitor and review incidents and accidents in the home was not effective. For example, for one person whose care records identified they had fallen in their room on 21 March 2017, there was no record of this fall in the accident records and the registered manager was not aware this fall had happened. Whilst an accident book was maintained to record slips, trips, falls and other accidents, there was no review of the accidents to look for trends and patterns in these. There was no log of any incidents which had happened in the home. A serious incident which occurred in the home had not been clearly logged. Whilst the registered manager told us they had sought advice and support from health and social care professionals following this incident the records associated with this were not clear. They lacked order

and did not show how the incident had been investigated and that all appropriate actions had been taken to ensure the safety and welfare of the person. We were not assured all incidents and accidents which occurred in the home were recorded and reviewed effectively to ensure the safety and welfare of people.

Whilst care plans were reviewed with people monthly, these had not been audited. The audit plan for the home identified 10 per cent of care plans should be audited each month. We saw this had not happened. The registered provider had failed to identify the lack of robust risk assessment records in care plans.

There was a lack of consistent and effective audits in the home to monitor and ensure the safety and welfare of people. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and staff had been asked for their views of the service in questionnaires circulated in June 2016. The registered manager was able to provide copies of all the feedback they had received. This information had been collated but only some actions identified from the feedback. For example, of seven questionnaires completed three stated relatives did not feel staff had sufficient time providing care for their relative. One stated, "I wish there were more staff." There was no information to show any actions which had been taken in view of these comments, or any feedback provided to people and their relatives. Feedback from this survey had been discussed with people at a meeting in May 2017.

A staff survey completed in June 2016 had been responded to by three members of staff. All responses identified a clear need to improve team working in the home. One said, "I think Abbeygate needs improving on team work. There is no 'I' in team." This feedback had been discussed at a team meeting in July 2016 to try to improve the team working at the home. However, during our inspection three members of staff told us there was a lack of 'team spirit' in the home particularly between care staff and domestic staff.

Four members of staff told us there was nowhere for them to have a break away from work whilst on duty as the registered provider did not provide a staff room. We saw staff had raised this issue with the registered manager at a previous team meeting and no action had been taken. Five members of staff told us they had been advised by the registered provider and registered manager that the home environment would be improved but that this had not happened. They told us they were disappointed that no action had been taken to improve the home for people who lived there. Staff did not always feel their views had been listened to and addressed.

Whilst staff understood and supported a clear ethos of person centred care in the home, there was a lack of organisation with the management of the home. Staff roles were not clearly defined and time protected for them to fulfil the role they were employed to complete. The registered manager was supported to manage the home by a deputy manager and two head of care. However, these staff were often called on to support other roles in the home, such as providing care for people, which meant they were not always able to fulfil their roles effectively. The registered manager told us they recognised that some of their duties such as monitoring audits and record keeping were not as good as they could be as, "There is just so much to do." Senior carers and care staff told us they were required to fulfil care roles as well as domestic duties and support activities. They told us it was often difficult to prioritise what role they should be fulfilling and this could be frustrating.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to inform the CQC of notifications of Deprivation of Liberty Safeguards in place in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure the risks associated with the health, safety and welfare of people had been assessed and mitigating actions taken to reduce these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure effective systems were in place to ensure the home was clean and well maintained to ensure the safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure consistent and effective audits in the home were completed to monitor and ensure the safety and welfare of people.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had failed to ensure there were sufficient staff available to meet the needs of and ensure the safety and welfare of people.