

Abbeyfield Society (The)

Abbeyfield - Richard Cusden

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 21 and 24 February 2017, the first day of the inspection was unannounced. We told the provider at the end of the first day of inspection that we would be returning for a second day.

At our previous inspection on 18 February 2016 and 22 February 2016 breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safe care and treatment, person-centred care, staffing, notifications and good governance.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found.

There was a registered manager at the service. 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.

Abbeyfield - Richard Cusden provides personal care for up to 22 older people, including those who may have dementia. It is located near Streatham and Tooting, South West London. At the time of the inspection there were 21 people using the service.

At our previous inspection we found that risks to people were not always assessed correctly, care plans were not always reflective of people's current support needs, staff training was not up to date, the provider did not always notify the CQC of notifiable incidents and systems to monitor the quality of service were not effective.

At this inspection, we found that improvements had been made.

The provider carried out risk assessments for people covering a number of areas including risk of pressure sores, risks of falls, moving and handling and infection control. We saw that these accurately reflected the risks and were reviewed every month. Although we found that staff took appropriate action when supporting people who were assessed at risk, we have made a recommendation in relation to guidelines around managing high risks for people.

Care plans covered a number of areas and were reviewed on a monthly basis by people's key workers. Where people's needs had changed, care plans and other associated documents were updated.

Improvements had been made in the provision of training to staff. Staff told us there were opportunities for training, and they felt well supported.

The provider was aware of the type of incidents that they were required to notify the Care Quality Commission (CQC) of and we received these in a timely manner.

The provider carried out a range of audits to monitor the quality of service. These included care plan audits, medicines audits, health and safety, kitchen and infection control audits. There were plans to re-introduce a programme of peer monitoring of services from other registered managers. Feedback was also sought from people and staff through surveys and meetings.

People using the service told us they felt safe living at the home. Training records showed that care workers had received safeguarding training. They were familiar with the term safeguarding and who they could report concerns too.

People said staff respected their choices and promoted their freedom. Care workers were aware of the importance of offering people a choice in how they wanted to be supported and to make decisions for themselves wherever possible. Where safeguards were needed to keep people safe and these were deemed to be a restriction on people's liberty, the correct procedures were followed.

People were supported to take their medicines. Care workers received training and were assessed in medicines management. We observed them supporting people appropriately, records were completed correctly and regular medicines audits took place.

Morale amongst the staff team had improved since the last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

We found that action had been taken to improve the safety of this service.

Risk assessments were reviewed regularly and reflected risks to individuals. However, we have made a recommendation in relation to guidelines for managing risk.

People told us they felt safe living at the service. Staff were able to identify potential signs of abuse and what steps they would take to protect people if they suspected it was occurring.

People were supported to take medicines by staff who were trained to do so. Accurate medicines administration records were kept. Regular medicines audits took place.

There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Good ●

We found that action had been taken to improve effectiveness of the service.

Staff received training and regular supervision which helped them to support people.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Decisions were made in people's best interests where they did not have the capacity to understand decisions related to their care.

The provider managed people's dietary and healthcare needs appropriately.

Is the service caring?

Good ●

The service was caring.

People told us that staff were caring and available.

Staff we spoke with understood people's needs and preferences.

People's privacy was respected.

Is the service responsive?

Good ●

We found that action had been taken to improve the responsiveness of the service.

Care plans were up to date and reviewed when people's needs changed.

Where complaints had been made action was taken to resolve them and appropriate escalation procedures followed.

Is the service well-led?

Good ●

We found that action had been taken to improve how well-led the service was.

There were a number of audits which took place to monitor the quality of service, including audits of care plans, medicines and health and safety.

The provider sought the views of people using the service and their relatives.

Morale amongst the staff team had improved since the last inspection.

Abbeyfield - Richard Cusden

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.

We undertook this comprehensive inspection on 21 and 24 February 2017. The first day of the inspection was unannounced, the provider knew we would be returning for a second day.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 18 February 2016 and 22 February 2016 had been made.

The inspection was carried out by one inspector and an Expert by Experience on the first day and one inspector on the second day. 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 we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with nine people using the service and carried out observations during an activity. We spoke with eight family members and seven staff members including the business support manager, registered manager, head of care, head of kitchen and three care workers. We looked at three care records, three staff records, training records, complaints and audits related to the management of the service.

Is the service safe?

Our findings

At our previous inspection which took place on 18 February 2016 and 22 February 2016, we found that risk assessments were not always completed correctly or updated in a timely manner which meant they did not always reflect people's support needs.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

The risk assessments we saw, for example those for pressure sores, moving and handling, infection control and falls prevention were assessed every month and scored correctly in the examples we saw. We saw instances where people's needs had changed and risk assessments were updated to reflect these changes. The moving and handling risk assessment was updated for one person when their medicines had changed.

We found that staff had documented what actions they would take to reduce the risk and completed daily records documenting what steps they had taken.

The tissue viability and pressure sore care plans contained details of steps that care workers were taking to manage risks to people in this regard such as purchasing pressure mattresses and cushions. This care plan included skin assessment body maps where care workers made notes of any changes to people's skin condition.

Each risk assessment was given a score which was given a risk rating. For example, the Waterlow scores, which were used to give an estimated risk for the development of a pressure sores, were scored as either 10+ at risk, 15+ high risk or 20+ very high risk. The guidance stated 'for scores of 10 or more state actions to reduce the risk.' Similarly, the risk assessment for infection control stated that scores between 1 and 7 were low risk, 8-14 a moderate risk and 15-18 a high risk. Where people were identified at moderate or high risk the risk management plan was to 'introduce risk management strategies.'

The risk management guidance did not always give staff enough guidance about how to manage the risks to those people who were deemed to be 'at risk', 'high risk, or 'very high risk' for the pressure sores and those of 'low', 'moderate', or 'high risk' for infection control.

We recommend that the provider seeks guidance about utilising effective risk management guidelines to further support people deemed to be at risk to ensure that people are effectively protected from avoidable harm.

We asked people if they felt safe in the presence of staff. They told us, "Yes, everything is OK", "If they were to act badly several people would take them on", "Yes, I get on well with them and they are doing a good job", "Yeah, they look after us", "I think so, never had any issues", "Yes, I do feel safe" and "Yes, I am really happy with them."

Training records showed that care workers had received safeguarding training. They were familiar with the term safeguarding and who they could report concerns too. One care worker said, "If I witnessed poor practice, I would take it up with them or speak with one of the managers." Where concerns had been found, the provider took appropriate action to try and ensure a similar situation did not occur.

We found there were enough staff to support people and there were robust recruitment checks in place. People told us, "There is always someone around here when you need them", "Yes lots of staff always around."

Staff files contained evidence of new starter forms, Disclosure and Barring Service (DBS) checks and references. We also saw application forms and a record of answers to interview questions. The DBS check assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people and includes criminal record checks.

The registered manager was supported in her role by a head of care, an administrator and four senior care workers. There was one activities co-ordinator employed for 15 hours per week, which were usually split over three days including weekends.

In the morning, there was one senior care worker and three care workers between 07:00 and 21:00; they were split over two shifts 7:00 and 14:30 and 14:30 to 21:00. There were three waking care workers on duty at night, between 20:45 and 07:15.

We saw the rotas from 19/12/2016 until 26/02/2017. Staffing levels were consistent throughout this period. The provider used bank staff to cover for absence through leave or sickness, no agency staff were used.

People were supported to take their medicines by staff who were trained and competent to do so.

After completing medicines training, care workers completed a competency assessment. We saw completed training certificates and assessments in the files that we saw. Staff had signed to indicate they had read the safe management of medicines policy.

We asked people if staff supported them with medicines and if they were happy with the support received. They said, "Yes, they do. They will inform me if anything has been changed and what is going on", "Yes, I always get them on time. I would forget to take them otherwise. Very happy", "Yes, four or five times a day and an injection by the nurse every month. Yes, I am very happy", "Yes, they do. I am happy with it" and "I don't take a lot of medication. But they do help me take some in the mornings."

We observed a medicines round, the care worker asked people's consent before giving them their medicines. Where people did not take their medicines, the care worker respected their decisions and went back at a later time that was more convenient for them. The medicines trolley was secured in between the times that medicines were being administered and MAR charts were completed after they had witnessed people taking their medicines.

Medicines administration recording (MAR) charts included a patient information chart with a list of medicines, what the tablet looked like, the dosage and the administration times. These were clearly laid out and easy to understand. MAR charts were completed correctly, with no gaps and PRN or "as needed" medicines were recorded on MAR charts to ensure that these were administered and monitored safely.

The head of care completed monthly monitoring of medicines, looking at MAR charts to check that these

had been signed correctly, expiry dates on medicines and that the correct codes on the MAR had been used.

A pharmacist audit was completed on 22/01/2016 and 22/11/2016, this looked at the method of obtaining repeat prescriptions, receipt of medicines, storage, administration, recording, disposal, medicines reviews, information and training, medicines policies and Standard Operating Procedures.

Is the service effective?

Our findings

At our previous inspection which took place on 18 February 2016 and 22 February 2016, we found staff training was not being renewed within the provider's required timescales. We also found that none of the staff had received training in MCA and DoLS or managing behaviour that challenged.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

We reviewed the staff training log and saw evidence that MCA and DoLS training had been delivered to 18 out of 26 eligible staff. Dates had been scheduled for the remaining staff to complete this. The registered manager told us that challenging behaviour training was being reviewed by the provider however it was currently covered under the dementia training which had been delivered to all staff on 31/01/2017. The Behaviour and Communication Support Services (BACS) at the local authority also came in and delivered training on how to manage behaviour that challenged for specific people using the service that had been referred to them. We spoke with a member of the BACS team during the inspection who confirmed they had done this with the staff at the service.

Staff had received relevant training in other areas including medicines, nutrition and wellbeing, moving and handling, health and safety, emergency first aid, infection control, equality and diversity, safeguarding, care planning and dignity and respect.

There was a two week timescale to complete the induction workbook and five days shadowing for new starters. New starters were allocated a senior care worker and a peer care worker to work alongside them. The induction included an overview of the provider's history, vision and values and the organisational structure. New starters completed the Care Certificate as part of their initial training with the provider. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. There are 15 different standards that are covered as part of the Care Certificate, these include duty of care, equality and diversity, working in a person centred way, communication, privacy and dignity, fluids and nutrition, awareness of mental health, dementia and learning disabilities, safeguarding, basic life support, health and safety and infection control.

The registered manager told us that all the four senior care workers and the head of care would be completing the Care Certificate training to deliver it to new starters in future. We saw a completed example of a Care Certificate record for a care worker who had started in May 2016 and completed their certificate by September 2016.

Training was tracked and reviewed monthly by the administrator which helped to ensure that training was booked for those whose training was expiring.

We reviewed three staff files which contained records of staff supervision and appraisals. Care workers were

given the opportunity to discuss aspects of practice and career development during their supervisions. Their appraisals were used to discuss their role, set their training and development plan and any objectives for the coming year. A care worker told us, "Supervision is good, have it every quarter with [the registered manager]", another said "We did not get an opportunity as seniors to do the care plans, we are learning more now."

Human Resources (HR) surgeries had been held in January 2017, where a HR officer visited the service and was available to speak to staff in relation to any HR related queries.

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

We asked people and their relatives if staff respected their choices and allowed them freedom. They said, "If she doesn't want it she won't have it. The office staff are brilliant notify me if anything happens. I can take her out whenever I want. She can smoke outside", "Yes, I can do whatever I like", "I can do anything I like. I don't feel restricted in anyway", "They let us pick what we want to do on a daily basis", "Yes, she is always given a choice about what she wants to eat or when she goes out" and "You can go out and no one stops you. They will even get you a cab. You can go wherever you want. I don't want to just sit around."

Care workers were aware of the importance of offering people a choice in how they wanted to be supported and to make decisions for themselves wherever possible. They said, "Some have dementia, but they still make choices, we encourage that." They were also familiar with the MCA and how they would support people who lacked the capacity to make certain decisions, "If people cannot make choices, we involve their family or other people like the doctor" and "We involve the BACS team sometimes."

Where people were assessed to have the capacity, they had signed their agreement to their care plan. Where people lacked capacity these had been completed by their key workers 'in their best interests.' Care workers gave examples of best interests meetings they had been part of when coming to decisions related to people's care.

Where people were subject to a DoLS authorisation, their documentation was in place in their care records.

We asked people what they thought of the food, if they received it on time and whether they got a choice. Comments included, "Food is enough and if you want more the cook will give you more. If you are allergic to something they will sort it out. They make me some Jamaican food it is very good", "Very good. They tell us what is on the menu", "I like the food always something different every day", "Not bad, lots of choice in what we get", "Very nice." A relative told us, "I think she enjoys the meals, she is always talking about it."

There were four kitchen staff employed, two working on weekdays and two on weekends. We spoke with the head of kitchen, who told us that breakfast was usually served from 08:00, lunch around 12:00 and supper around 17:00.

The head of kitchen told us, "I make the menu according to what they like." They were aware of who required a soft diet and anyone on a specialist diet or those that required nutrition support. A list of people

and their dietary needs was also on display as a reminder.

Food was labelled with the date it had been opened to ensure staff knew whether or not it was safe to use or should be thrown away. The kitchen was well stocked with a plentiful supply of snacks and biscuits, the head of kitchen told us, "This is their home, whatever they want they can have it."

Crisps and snacks were served to people during the day. We sampled the lunch which was appetising and we observed a caring attitude from staff during lunch, covering people's food when they went to the bathroom, asking them what they would like to eat and encouraging them to eat and drink.

People were referred to healthcare professionals in relation to their health needs.

Hospital passports were in place for people using the service, the registered manager told us that these were due to be replaced by a 'red bag' system that was utilised in a local authority. This was a system whereby if someone needed to be admitted to hospital, all of their relevant documents would be transferred to hospital with them in a red bag. This was due to be implemented from May 2017.

We saw examples where people had been referred to a dietitian due to concerns about their weight, care workers also completed a record of food and drink consumption that was reviewed by health care professionals. Evidence was seen of input from community services such as podiatry, Speech and Language Therapists (SLT), a Community Psychiatric Nurse (CPN) and the BACS team.

Is the service caring?

Our findings

People and their relatives told us staff were aware of the importance of respecting privacy and dignity, "I don't think it is a problem", "Yeah, they respect her dignity. If she has a little accident they do their best to help her", "If they are helping me get changed they will shut the door. It's just little things like that", "Very good. They talk to you in a dignified way and they respect anything you want", "I have a feeling they are respected", "I think they try their best. Small things like the way they talk to you and respect what you want to do."

They also told us that there was always someone available to speak with if needed, "Always someone around", "There is always someone around when I am here", "Staff is always here. That is perfect as well. The head lady looks after me as well", "I don't need a lot of help but there is always someone around if I did" and "Yes there is, but you also get a lot of time on your own. It is good."

Some care workers acted as key workers for people using the service. Care workers were familiar with people's preferences, such as the activities they liked. They knew what things made people happy or sad, we checked this against people's care records. A care worker told us, "We ask residents what they can do for themselves, we don't take away their independence."

We saw some positive examples of a caring attitude by care workers during our observations of a medicines round and a morning activity. In the activity, people were taking part in different tasks. The activities coordinator spoke to people on a first name basis and was encouraging everyone to take part. People were offered drinks and a choice was given of several different biscuits.

There was a relaxed atmosphere at the service and care workers were seen going around speaking with people and actively engaging with them throughout the inspection.

Family members were able to come and visit their relatives and spend time with them.

Is the service responsive?

Our findings

At our previous inspection which took place on 18 February 2016 and 22 February 2016, we found people were at risk of not having their needs met as care plan documentation was not always fully completed or up to date.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

People's care records were kept up to date to ensure that the information about how to meet their needs was current and accurate.

We asked people if they had been involved in planning their own care and whether their care plans were regularly reviewed. Comments included, "I am. They will always ask me what I like and don't like and if anything needs to be done differently" and "Yes, they did and my daughter was here too."

Each person had 10 care plans covering a range of needs including social contact/activities, health and psychical wellbeing, psychological and mental health, personal care, tissue viability and prevention of pressure sores, mobility and fitness and falls prevention, toilet needs and promoting continence, nutritional health, sleeping and night care and personal safety and risk.

Each care plan list people's needs and wishes and details of the steps that staff needed to take to support people to meet these. These were evaluated monthly by key workers to ensure they remained accurate and up to date.

Personal profiles were completed for people using the service where available, giving details of their family background, relationships, interests/hobbies and important milestones.

There were a range of activities that took place within the home, put together by the activities co-ordinator. These were run jointly by the activities co-ordinator and the care workers. The business support manager highlighted that the provider ran a programme called 'Golden moments' where each quarter they focussed on different themes and built activities around them. These themes included companionship at Christmas, animals, the great outdoors and pie week. In our observations, people enjoyed the activities and were encouraged to take part in them.

We asked people who they would speak with if they had concerns and did they think they would be listened to. They said, "I would speak to the manager. I think so", "Initially I would go the manager or the deputy. I think they would", "The policeman or the head lady. She does listen to me. She is alright and does everything she can for me", "The manageress. Yes, she would", "The carers or someone in the office. Yes, I think so", "I am going to talk to [the manager]", "The main manager, she is really good and will help you with anything."

The complaints procedure and forms were available at reception along with feedback forms so that people using the service and their relatives could share their views and raise any concerns.

A complaints log was maintained by the provider. We reviewed the complaints that had been received since the last inspection. There had been four recorded complaints, some as ongoing complaints regarding the same situation. The provider responded to complainants when complaints had been received and followed their escalation procedures when complaints were not dealt with according to the satisfaction of people using the service.

Is the service well-led?

Our findings

At our previous inspection which took place on 18 February 2016 and 22 February 2016, we found the provider had failed to send in statutory notifications to the Care Quality Commission (CQC) as required. We also found there was a lack of effective audits to measure the quality of service provided.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

A log of CQC notifications regarding significant incidents or events was kept by the provider. This included a summary and details of the progress in relation to any investigation. We reviewed a list of notifications that had been submitted since the last inspection and it was clear that the provider was aware and knew under what circumstances to submit a notification to CQC, whether it was a death of a person using the service, a serious injury or a safeguarding concern.

Checks were completed by senior care workers, the head of care, the registered manager and the business support manager to monitor the quality of service.

These included a health and safety checklist which looked at the environment, infection control, and waste management. An infection control audit was carried out annually, a kitchen audit every quarter, medicines audits were done monthly and more thorough ones annually. Care plan audits were completed looking at whether essential information had been recorded and all the care plans had been updated. Random, unannounced spot checks were carried out and had taken place in September 2016, October 2016 and February 2017. Some of these were also carried out at night.

A business support manager had started in January 2017, their remit was to support the service and the registered manager. One of the audits they had developed was a quality monitoring audit which was due to launch in March 2017. This was based around peer reviews, a system of registered managers visiting services other than their own. We saw an example of these audits which were based around the five key questions of CQC's inspection model.

People using the service told us they felt it was a good service. We also asked them what the service did well. Comments included, "Yes, it is a very good service. The food I really enjoy it", "Yes, I think it is, can't say about everyone else. I really like the staff and the fact it is safe in here", "I really enjoy living here. I would rather be at home but as that is not an option, this a good second best", "Yes, I really do. Everything is really good" and "I would recommend this home to my friends."

People's views were sought by the provider. In September 2016 quality assurance questionnaires for people were completed. Those with no capacity were supported to complete these by family members. People were asked for their views on how they were treated, quality and choice of food, decoration and maintenance, safety and security, their social life, quality of life and services received. Eight responses were received. There was evidence the provider acted on the feedback received, a meeting had been held to

discuss the feedback so that improvements could be made.

An employee satisfaction survey was also completed, nine responses were received with the feedback being positive. Care workers themselves felt that staff morale was better than it had been previously when we last inspected, telling us "100% better than before", "[The registered manger] is hands on", "[The registered manger] encourages us to take on more responsibility", "[The registered manger] is down to earth", "I'm very happy", "[The registered manger] encourages you to progress", "Everything is running smoothly, it's much better than before."

A residents' meeting and a separate residents' and relatives' meeting had been held in January 2017. Monthly staff meetings were held for both day and night staff. A separate senior staff meeting was held and also one for the catering team. We saw that actions identified at these meetings were followed up. Staff had requested a separate staff room to take breaks in, telling us "We would like a staff room, sometimes there is no place to take a break" and the registered manager told us they were aware of this and this was being looked at.

We reviewed the business model for 2016/2017 which included a SWOT analysis. A SWOT analysis is a study undertaken by organisations to identify its internal strengths and weaknesses, as well as its external opportunities and threats.