The Abbeyfield Society

Hill House

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?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

The inspection took place on 28 May and 3 June 2015 and was unannounced. We last inspected this service on 20 August 2014 and identified concerns in relation to consent and to people's care and welfare. At this visit, improvements had been made to meet the relevant regulations.

The service is a residential care home that provides accommodation with personal care for a maximum of 29 older people. It has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's care needs were assessed and care records had individualised information about each person's needs. However, there were inconsistencies in quality of some care plans and in other day to day record keeping. This meant some people could be at increased risk because care records needed more up to date details and because of recording omissions.

People were treated with dignity and respect and staff were caring and compassionate towards them. People

Summary of findings

were supported to express their views and be involved in decision making about their care. They received care that was individual to their needs. Staff knew people well, about their needs and preferences and how they liked to spend their day. People were supported to remain active and independent and to pursue a variety of hobbies and interests and access the community on a regular basis.

A robust recruitment process was in place to make sure people were cared for by suitable staff. Staff were knowledgeable about people's care needs, had qualifications in care and received regular training and updating. Staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated.

People were supported to maintain their health and to access ongoing support from health care services. They received their prescribed medicines in a safe way. Health and social care professionals gave us positive feedback about the care and support provided for people. People were very complimentary about the food choices available at the home. Staff supported people with poor appetites who needed encouragement to eat and drink, including offering regular snacks and meal alternatives.

People were offered day to day choices and staff sought people's consent for care and treatment. Staff demonstrated a good understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty.

The service was well led and promoted a culture that valued each person. People, relatives and staff said the home was well run and they had confidence in the provider and the registered manager. The provider had a range of quality monitoring systems in place, these included audits of medicines and care records, monthly health and safety checks and regular meetings with people, relatives and staff.

We identified one breach of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

People received their medicines in a safe way.

People were supported by enough staff so they could receive care at a time convenient for them.

Accidents and incidents were reported and action taken to reduce risks of recurrence.

The premises and equipment were managed to help reduce risks.

Good

Is the service effective?
The service was effective.

People were supported by experienced staff who were knowledgeable about their care and treatment needs.

Staff acted in accordance with the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access healthcare services appropriately and staff followed professional advice given.

Good

Is the service caring?
The service was caring.

People were supported by staff that promoted their independence, respected their dignity and maintained their privacy.

Staff were kind and compassionate towards people and formed positive and caring relationships with them.

Good

Is the service responsive?
Some aspects of the service were not responsive.

There were inconsistencies in quality of some care plans and in day to day record keeping.

People received personalised care that was responsive to their needs.

People felt confident to raise concerns. Any concerns were listened to, investigated, and appropriately responded to.

Requires Improvement

Is the service well-led?
The service was well-led.

Good

Summary of findings

There was a registered manager in post and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management and said the home was well organised.

People and relatives' views were sought and taken into account in how the service was run.

The provider had a variety of systems in place to monitor the quality of care and took action in response to areas needing improvement.

Hill House

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.

The inspection took place on the 28 of May and 3 June 2015 and was unannounced. The inspection team included an inspector and an expert by experience.. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service; they had experience of services for older people. This enabled us to ensure we were addressing any potential areas of concern.

We reviewed all information about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We spoke with 15 people using the service, 10 relatives and looked at five peoples' care records. We spoke with 10 staff, two volunteers, attended a staff handover meeting and looked at five staff records, including recruitment, training, supervision and appraisal records. We also looked at the provider's quality monitoring systems such as audits of medicines, records, health and safety audits, and action taken in response to feedback from people, relatives and staff.

We sought feedback from health and social care professionals who regularly visited the home including GP's, community nurses, other therapists and commissioners and received a response from ten of them.

Good

Is the service safe?

Our findings

People at the home said they felt safe. One person said, "I needed to feel safe and I do feel safe here…it has been a success." Another person said, "It's very safe....I'm on the ground floor and they always make sure the windows are locked at night." A relative said, "I come in every day and I've never seen anything untoward."

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. Staff said they could report any concerns to the registered manager or senior staff and were confident they would be dealt with. The provider had safeguarding and whistleblowing policies available so staff were clear how to report concerns.

The registered manager had recently notified us about a number of thefts of small amounts of money and valuables at the home. We followed this up with them; they confirmed the police have visited the home, but had not been able identify the culprit. They told us about the increased security arrangements in place such as encouraging people to lock away their valuables, and locking people's money in the home's safe. Also, the service have introduced billing for small expenses such as newspapers and toiletries from the home's shopping trolley to reduce the need for people to keep much cash in their room. The registered manager said, following police advice, they have recommended installation of CCTV in communal areas to the provider as a deterrent and are awaiting the provider's decision on this. These showed concerns about suspected financial abuse have been followed up and further actions taken to reduce the risk of recurrence.

Detailed risk assessments were carried out for each person and care plans were in place to reduce any risks identified. For example, the service used a falls assessment tool to identify people at increased risk of falling. Staff had detailed instructions about how to reduce those risks, such as details about footwear, any mobility equipment needed and the level of staff assistance required. One person who had a pressure mat explained this was used to alert staff to come and assist them when they woke up at night.

Three people living at the home were identified at increased risk of choking because of swallowing difficulties. At mealtimes, those three people had a designated member of staff who stayed worked in the vicinity of those people's rooms and checked them at regular intervals throughout their meal. This meant people with swallowing difficulties were supported to eat independently but had staff nearby if their experienced any difficulties.

Accidents and incidents were reported and reviewed by the manager to identify ways to reduce risks for each person as much as possible. Where people sustained any injuries, such as a bruise or cut, these were documented on a body map and staff made additional checks to monitor the person's recovery.

People were protected because recruitment practices were robust. All staff recruited at the service had a range of checks undertaken in accordance with the regulations such as interviews, confirming qualifications and training, references, identity, and checks to confirm they were suitable to work in care, known as Disclosure and Barring (DBS) checks. The service had a number of volunteers who undertook a variety of roles within the service such as visiting people, helping with the shop trolley, church services and accompanying people to appointments. Where those roles involved them having unsupervised access to people, their DBS checks were also undertaken.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. The atmosphere in the home was calm and organised; staff worked in an unhurried way and were available to support people at a time and pace convenient for them. Staff on duty were mostly long term employees who knew people well, had qualifications in care and were experienced in working in care. Most people thought the home had sufficient staff to meet their needs at a time convenient to them. Staff responded promptly to call bells, one person said, "They're busy but they never rush me", and another said, "They're busy but they come quickly if I press the bell." Staff used their time well to interact with people and ensure their needs were met.

The registered manager assessed the care needs of each person and reviewed staffing levels regularly to make sure they were appropriate for people's needs. For example, having extra staff on duty at busiest times, such as first thing in the morning and early evening. Staffing rotas showed the recommended staffing levels were maintained. Existing staff worked extra hours to cover staff sickness and leave but where needed, agency staff were also used. A couple of people commented about the use of agency staff. Whilst they understood the reasons for their use and said

Good

Is the service safe?

agency staff knew their jobs well, they preferred not to have agency staff. One person said, “They’re not familiar to us so it’s not the same.” Some staff expressed concern about whether staffing levels would be sufficient for the three additional beds recently registered. We followed this up with the registered manager who confirmed they were recruiting more staff, in preparation for having additional people.

Medicines were managed in a way that ensured people received them safely and as prescribed. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. The home used a monthly monitored dosage system. Medicine administration records were well completed and any medicines refused were documented and accounted for. Out of hours, when people were unwell and medicines such as antibiotics were prescribed, senior staff obtained these from a local on call pharmacy to ensure there were no delays in commencing treatment.

Monthly medicine audits were undertaken, with action taken to follow up any discrepancies or gaps in documentation. Medicines were securely stored in line with current regulations and guidance. For example, those which required refrigeration were stored appropriately and fridge temperatures were monitored to ensure they were kept at recommended temperatures. There were systems in place for recording all medicines received and unused stocks were returned to pharmacy for destruction. A recent audit had also been carried out by a pharmacist, their report identified some exemplary practice.

People liked the environment of the home and the surrounding gardens. The fabric and décor of the building was exceptionally good and the building was adapted to meet people’s mobility needs; it had wide corridors, a lift to the upper floor, and disabled access toilets and bathrooms. Toilet and bathrooms areas were identified clearly with signage so people could find them. Individual fire risks assessments were in place and each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire. A written contingency plan was in place in the event of a major emergency requiring evacuation of the home.

Environmental risks assessments were completed and showed measures taken to reduce risks as much as possible. Monthly health and safety audits were carried out, and actions taken to address any concerns, for example, making sure all equipment was stored away to keep corridor areas clear and by improving emergency lighting. All repairs and maintenance were prioritised and attended to. Equipment was regularly serviced as were gas and electrical appliances. Weekly fire checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. All electrical, gas and emergency lighting and fire equipment was serviced and tested regularly. Servicing contracts and evidence of recent servicing was seen for the passenger lift, lifting equipment, and the call bell system.

Communal areas and people’s rooms were clean and there were no unpleasant smells. Staff followed a cleaning schedule and had the appropriate cleaning materials and equipment. Staff used personal protective equipment (PPE’s) such as gloves and aprons when providing personal care to prevent cross infection risks. A Control of Substances Hazardous to Health (COSHH) register was available to safely guide staff regarding the chemicals they were using, these were securely stored when not in use.

Good

Is the service effective?

Our findings

People felt supported by staff that were able to meet their health care needs. Most care workers had qualifications in care and had worked in the home for a number of years so were very experienced. Staff training records showed they received regular training and updating. This included training on safeguarding adults, health and safety, infection control, moving and handling. Staff said they had lots of training opportunities such as diabetes, dementia and Parkinson's disease, one staff said described opportunities as "brilliant." Staff received regular one to one supervision, and had an annual staff appraisal where they had an opportunity to discuss their practice and identify any further training and support needs.

Staff demonstrated an in-depth knowledge of people's health needs. A care professional said, "Staff are professional, they have time for the residents." People, relatives and health professionals praised the care in improving people's health and their independence. Most people in the home were mobile with the aid of standing or walking frames or sticks. Staff encouraged people to be independent and offered assistance where necessary. One person said, "They made me get walking again, which was a challenge." A relative said, "When mum came here she was unable to walk…they got her walking around the room with her frame and now she takes herself to the loo and can get to the lift to go downstairs." Another relative said, "When mum was really poorly we weren't sure what was the matter and I stayed overnight with her…they were brilliant."

Each person had an assessment of their health needs when they first came to live at the home. The service used evidence based tools to identify people at risk of developing pressure sores, malnutrition and dehydration. Most care plans provided detailed instruction to staff about how to meet people's health needs. For example, where a person was at risk of developing pressure sores, staff had detailed instructions about their skin care, pressure relieving equipment and how frequently to change their position and acted in accordance with this.

People had access to healthcare services for ongoing healthcare support. This included regular visits by local GPs, by community nurses, physiotherapists, occupational therapists and chiropodists. Where any concerns were identified, health professionals said staff contacted them appropriately and followed any advice given. The community nurses visited regularly each week to support people's health care needs, such as by treating wounds, advising on skin care and taking blood tests. Each person had a 'hospital passport' which provided hospital staff with key information about the person in the event of their needing to be admitted to hospital.

Two social care professionals commented that home couldn't cater for people whose needs became very complex, which meant people sometimes needed to move to another home. One professional said, "The manager attends and does assessments, she is clear about what home can and can't manage. They will try and keep somebody comfortable but won't take people who are too dependent." We followed this this up with the registered manager who said each person was assessed on an individual basis and, whilst Hill House wasn't a specialist home, they did they best to support people to remain at the home, wherever possible. The registered manager confirmed they made this clear to people and relatives, who knew they may need to move if their needs became too complex.

Staff had undertaken appropriate training of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and demonstrated an understanding of how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments were completed for each person, although one we looked at was out of date. The provider documentation used to assess mental capacity for day to day decisions was somewhat confusing. This resulted in staff completing it in different ways. The registered manager has since fed back to the provider who is reviewing the paperwork. When people were assessed as not having the capacity to make a decision, relatives confirmed family and people who knew the person well and were involved with relevant professionals in 'best interest' decision making. On one occasion, the registered manager was steering a tricky course between friends who wanted the best for a person and the person's own views. They demonstrated their commitment to ensuring the right decision made was for the person concerned.

People's liberty was restricted as little as possible for their safety and well-being. The registered manager told us about plans to fence off an area of the garden so more

people could access this area unsupervised without being at risk from the nearby main road. They had assessed some people who lived at the home may be at risk of being deprived of their liberty. They had submitted applications appropriately to the local authority DoLs team and was awaiting people's assessments. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. This was following a Supreme Court judgement in 2014, which clarified that, if a person lacking capacity to consent was subject to continuous or complete supervision and control and were not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

For example, one person who lived at the home sometimes exhibited behaviours that challenged the service. Staff at the home involved the person's care manager and mental health services and detailed records were kept to inform mental health practitioners involved in reviews of their care. The person had a detailed behaviour support plan, which included information for staff about triggers for aggressive behaviours. Their support plan described a stepped approach about how staff should support the person in the least restrictive way possible, in accordance with national guidance. Physical intervention was only recommended as a last resort, which some staff had been trained to undertake. The registered manager reported the person was now much more settled and staff had not needed to use any physical interventions.

A GP visiting the service commented on how well three people with swallowing difficulties were doing. Each person had been seen by a speech and language therapist (SALT). They had detailed care plans in place in accordance with their advice which identified how staff could reduce their swallowing/choking risks as much as possible. This included positioning each person upright for meals, about preparing food to a pureed consistency to make it easier to swallow. One person with a swallowing difficulty said sometimes their lunch included pureed peas and sweetcorn, which they did not eat. This practice was not in accordance with SALT recommendations about pureed food. We followed up with the registered manager and asked about whether staff had received any specific training from SALT about managing people with choking risks. They said staff were trained to undertake first aid to manage any coughing/ choking emergencies, however, they were not aware of speech and language therapy training available for staff in Devon. In response, they contacted their local therapist to arrange this training.

People were supported to maintain a balanced diet. The cook came around each day to ask about menu choices. One person said, "The food is good and nothing is skimped." Another said, "The cook comes to see us every day and all you have to do is say the gravy's too thick and it'll be put right the next day." Catering staff had detailed information about people's dietary needs and preferences. One person said, "I'm diabetic and also I can't have onions and I don't like spicy food so she makes me individual cottage pies and offers me fish instead." One relative said "When mum was poorly she was having trouble ……so they listened to me and they got her creamed vegetables and meat."

Lunch was a sociable occasion with people at small tables and meals served restaurant style. Most people had chosen salmon, which looked appetising, and were offered additional vegetables and sauces on salvers. The dessert trolley had a range of desserts available and a note on each table reminded people they can ask for ice cream.

Where people were identified at risk of malnutrition or dehydration, care plans showed staff needed to monitor their food and drink intake as well as their weight. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. For example, going to the supermarket to buy their favourite brand of yogurt, offering an ice cream or milkshake drink if they didn't eat their meal. People were offered drinks regularly and some people had access to cold drinks and snacks in a fridge in their room. One person was on a very limited diet when they first came to live at the home. They were now trying a wider variety of foods and were pleased about this.

Good

Is the service caring?

Our findings

Staff had positive and caring relationships with people that used the service. People and relatives were full of praise for the care they receive from staff and many had chosen Hill House, on the basis of its local reputation. One person said, “My friends found it for me and I liked it straight away. It’s very pleasant and very good.” Another said, “I’ve nothing but praise for it here”. One relative said, “This home was highly recommended to us and it’s brilliant...the carers are lovely with such a positive and caring attitude.” A third person said, “It has exceeded our expectations.. we’ve never noticed any incivility, the staff are all very friendly, cheerful and natural.” One staff member, when asked about what the best thing about the home responded, “We care, we really do care.”

Some people already had friends who lived at the home before they came to live there and others had made new friendships. One person said, “I like it here as my friends are near and can visit more often, and I go out into town on the bus and meet them for coffee.” Another said, “I am really happy, we look after each other.” Visitors were made welcome at any time and were coming and going all day long.

Staff knew the people they were caring for well, their needs, preferences and personal histories. A staff member was chatting with one person about a recent family wedding and another greeted a person with a hug. A staff member noticed that another person was having a bad day and put an arm around them to comfort them. One person who was feeling uncomfortable said how a member of staff suggested putting a pillow alongside them, and they said “Straight away I felt more comfortable”.

People looked well cared for and several people enjoyed a visit to the hairdresser whilst we were there. Staff knocked on people’s doors before entering and closed the door for privacy when delivering personal care. One person said, “Staff respect the fact that this is our home.” One relative speaking about their mother said, “Staff are caring, treat her with dignity and respect, they seem very caring towards mum.” Staff said people were asked about their preferences for male or female care staff and that some preferred female staff only and others didn’t mind. Most people agreed with this, however, one person said, “I was surprised the other day when a gentleman came in to wash me… they didn’t ask me, but I’ve got used to the gentleman now.”

People’s records included information about each person’s communication support needs. For example, whether they needed glasses or wore a hearing aid. Staff were skilled in interacting, speaking appropriately with people, and there was a calm and peaceful atmosphere in the home throughout our time there.

Staff were respectful towards people and asked for their agreement before providing care. People and relatives were involved in making decisions about their care and treatment. People signed their care and treatment records to confirm they agreed with them. Staff involved people in discussions and decision making with health professionals and where they lacked capacity, they consulted relatives about what the person wishes might be.

The service had good links with the local church. On one of the days we visited, there was a communion service which a number of people attended. There was also a short Sunday service at the home, and a longer service once a month. Handbell ringers also visited regularly and people were able to sing along with them.

Requires Improvement

Is the service responsive?

Our findings

There were inconsistencies in the record keeping at the home. Some care records we looked at were very detailed about people's specific needs and gave detailed instructions for staff about the care needed whilst others were less so. Some people's food and fluid intake records varied from day to day, with gaps in some records we looked at. For example, one person with a swallowing difficulty had a poor appetite. Their care plan lacked detail about what to do when the person did not eat their meal and there were gaps in their records of daily food and fluids. This meant it was not clear whether this was a recording omission or whether they had not eaten or drunk much on those days. However, staff demonstrated a good knowledge of the person's eating and drinking, and they had regular drinks and snacks whilst we were there. Similarly, although records of medicines administered were well documented, records of prescribed creams applied were not. These gaps in record keeping increased risks for people.

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

We discussed two care records in particular with the registered manager which did not include enough detailed information, and these had been updated when we returned on the second day of our visit. The registered manager told us about imminent plans to transfer all care records into an electronic format. This meant all care plans would be reviewed and updated as part of that process. They also planned to introduce a more accessible system for staff to record the application of prescribed creams, so staff would be prompted to complete them.

Care records had detailed information about each person, their family and their life before they came to live at the home. This included each person's interests and hobbies. For example, how one person liked the daily paper, and another liked needlework and they had their cross stitch framed on display on their bedroom wall. Other records included details about people's favourite music or TV programmes. People had spacious rooms, many with views over fields and a well-stocked garden that several people enjoyed walking around. Each person's room was individual to them with things that were meaningful for them. For example, photographs, furniture and pictures from their family home.

People's care records showed what aspects of day to day decisions each person could make for themselves and what aspects they needed support with. People were offered day to day choices, for example, about whether to remain in their rooms or to join others in the communal areas. During the morning, only a couple of people were in the lounge, most people came downstairs for lunch. One person said, "I prefer to be in my room but that's my choice" and another said, "I read in my room and watch TV...my interests are not necessarily the same as others so I don't often join in."

People received care that was personalised and responded to their needs. The home used a call bell system whereby each person had a call bell pendant around their neck, so they could summon staff help wherever they were in the home, which several people said they found reassuring. One person said "I only have to press the bell and they're there…they're all helpful, never cross and they all help me." Another said, "I find they like to know how I like things…I've never once been made to feel uncomfortable" and " Staff know how I like my routine." A care professional said, "The best thing about the home is the personalised care from staff who build strong relationships with people."

Each person had an allocated key worker who consulted and involved them in regular reviews of their care and treatment. For example, one persons' review recorded the person felt their memory was not as good as it used to be and they struggled with mobility some days and walked with a frame.

The service employed an activities co-ordinator five afternoons per week and a display board showed the activities and entertainments available each week. This included trips out, a weekly shopping trolley, musical entertainment and the co-ordinator told us about their reminiscence sessions that people enjoyed. People really enjoyed flower arranging when we visited and staff showed us the planted raised bed people had done in the garden. Other popular activities included making decoupage cards, and planting hanging baskets.

One person said, " She (the activity co-ordinator) is tireless in keeping people occupied." Another said, "I don't know what we do but we have a good time." Each person had a record of what activities they had enjoyed and any hobbies they enjoyed. One person said, "I go down in my wheelchair if there's e.g. a quiz.....and I watch Millionaire every night to keep my brain going." Another person said, "We had the

Requires Improvement

Is the service responsive?

quiz ball yesterday....she throws the ball and we get a question....I enjoy that." Other people told us they went with staff to do their shopping and enjoyed going out for walks.

The co-ordinator's responsibilities included visiting people who preferred to stay in their rooms to have a chat or undertake an activity with them. Some people also had regular visits from volunteers if they didn't have relatives or friends to visit them. This made a positive contribution to their lives, avoided isolation and helped people to be able to go out and keep active.

People felt confident in raising any issues of concern with the registered manager or senior staff who were easily accessible each day in the home. One person said, "If I had a problem I'd speak to the manager who is a very, very nice lady, most approachable…I'd also talk to my family and my sister would speak to the manager too." They confirmed any concerns were investigated and responded to quickly. People gave us examples of issues they had raised which they said were addressed immediately. For example, one person raised that their curtains were frayed and they were replaced straight away.

People and relatives had regular meetings during which they were invited to raise any concerns and make suggestions. For example, one person raised that the minibus trip to Honiton once a week was very popular and couldn't always take all the people who wanted to go. In response, the minibus trips were increased to twice a week, which everyone was happy with. Staff meeting minutes showed issues raised by people were discussed with staff so that lessons could be learned from people's experiences and improvements made.

The provider had a formal complaints policy which was available in the home. It included details about how people could raise concerns outside of the home, if they remained dissatisfied with how the home had responded to their concerns. A complaint log was kept, which showed any concerns raised and detailed actions taken in response. Since we last visited one formal complaint had been raised, which was appropriately investigated and responded to.

Is the service well-led?

Our findings

People, relatives, professionals and staff were very positive about the leadership at the home. They said the home was well organised and managed. One person said, "The registered manager is very thoughtful." Another said, "The whole system seems to reflect on the manager…the standard is very high…they have done a good job of choosing staff…some of them are quite young but they're good."

The manager operated an "open door" policy and her office was just inside the front door of the home. People, relatives and staff confirmed they were available and responded to issues raised with them.

The registered manager was very experienced and had worked at the home for a number of years. They had a detailed knowledge of individuals and their needs and had developed strong relationships with local health and social care professionals. They were well supported by an area manager who visited the home regularly. The registered manager sent monthly reports such as about accidents/incidents, staffing levels so these could be monitored. However, following a reorganisation within Abbeyfield, the provider quality monitoring visits were somewhat lapsed and these arrangements were currently being reviewed. In the meantime, the registered managers of the two local Devon homes had visited one another's service to undertake quality monitoring visits, which is good practice.

There was a range of quality monitoring systems in place. There were documented systems for cleaning and checking of equipment such as hoists, hoist slings and wheelchairs. Also, audits of medicines management, record keeping and infection control. Where we identified concerns about the consistency of record keeping, these had already been highlighted and discussed at a staff meeting and actions were underway to make the required improvements. This showed the quality monitoring systems in place were effective. The manager had a recognised health and safety qualification and did a monthly health and safety audit and acted on any areas identified. For example, the need to have a safer outside space.

Staff worked well as a team, most had worked at the home for a long time and there was a very low turnover of staff. Staff had delegated roles and responsibilities, for example, one had a lead for medicines management, and others had responsibilities for monitoring and auditing care records. The registered manager was up to date with recent regulatory changes. They notified the Care Quality Commission about important events they were required to tell us about.

The service had regular residents/relatives meetings where they were consulted about decision making in relation to the home. For example, the February 2015 minutes showed there was a discussion about the increase in beds planned and the impact on existing service. This included looking at staffing levels. One person asked about locking their room door, and was assured they were entitled to lock their own door whenever they wanted to. Another person asked about the addition of an induction hearing loop, the registered manager said the previous one didn't work well but agreed to make further enquiries. Other discussions included inviting suggestions for menus, asking people whether they needed any repairs in their room and consulting about a change in suppertime to a later time, which people were happy with.

Similarly, the service had regular staff meetings and staff were consulted and involved in decision making about the home. February and April 2015 staff minutes showed a variety of issues had been discussed, including staff uniforms, timekeeping, and a change to the staff appraisal process. Also, about the theft of recent monies at the home, and the need to increase security by introducing additional security checks of the house. The minutes showed the registered manager reminded staff about respect and being polite to people at all times. Record keeping was discussed, staff were reminded of the importance of record keeping and examples of records not being completed properly were discussed. Other issues discussed included the need to tidy equipment away, keeping emergency exists clear and the recent regulatory changes.

Accident/Incident reports and complaints received were monitored to identify any trends and identify people at increased risk and showed that actions were taken to reduce risks. Where concerns were identified about staff performance, these were managed appropriately in accordance with the provider's policies and procedures. Individual staff supervision was used to re-enforce the values and behaviours expected of staff. It was also used to discuss people's feedback and any lessons learned from accidents/incidents or other concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services were not protected against the risks associated with inaccurate records. This was because there were inconsistencies in quality of some care plans and in other day to day record keeping. This is a breach of Regulation 17 (2) (c).