Millennium Care Homes Limited

Abbey House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13, 14 and 19 September 2016 and was unannounced.

Abbey House Nursing Home provides accommodation for up to 48 older people who require nursing, respite or end of life care. Some of the people being cared for at the home were living with dementia. The home also works with a specialist community team to provide a rehabilitation service for up to nine older people who are accommodated temporarily at the home for between two and six weeks. This is to enable the people to regain their independence following their discharge from hospital or to prevent their need for admission to hospital. At the time of our inspection, there were 42 people using the service.

Abbey House Nursing Home is an older style house set in large grounds in Hampshire. The accommodation is arranged over three floors with three lifts available for accessing these floors. The home has 34 single rooms and seven shared rooms.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

At our last inspection in September 2015, we found the provider was in breach of two regulations. The first breach was due to the fact that the provider had not done all that was reasonably practicable to mitigate certain risks to people. At this inspection, we found improvements had been made. For example, products used to thicken drinks for people who had swallowing problems were now stored securely. Slings used for hoisting were no longer shared between people reducing the risk of cross infection. We did however identify some new concerns about how this Regulation was being met, this was because the care and treatment of one person had not been provided in a safe way.

The second breach of Regulations identified at our inspection in September 2015 was because staff had not been receiving regular supervision and new staff had not completed a suitable induction programme. At this inspection, we found that whilst some improvements had been made, the provider was still in breach of this Regulation. Staff were still not consistently receiving regular supervision.

During this inspection we found two new breaches of the Regulations. People had not always received treatment appropriate to their needs. There was a failure to ensure that there were effective governance, quality assurance and auditing systems in place. Records relating to the care and treatment provided were not always fit for purpose or accurate.

Staffing levels were adequate to ensure people's needs were met safely. Appropriate recruitment checks took place before staff started working at the home.

People's medicines were managed safely. Staff had a good understanding of risks to people's health and wellbeing. Incidents and accidents were reported and investigated.

Staff understood the signs of abuse and neglect and demonstrated a commitment to ensuring people were protected from harm.

Improvements had been made to the induction programme offered to new staff and staff completed a range of training relevant to the needs of people using the service.

Where people were able to give consent to their care and support, staff acted in accordance with this and respected people's wishes. However, where there was an indication that a person might not be able to make a decision about key or significant aspects of their care, we found that staff's application of the principles of the Mental Capacity Act (MCA) 2005 was not always fully in line with the Act and its Code of Practice.

Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for.

People received a choice of meals and were supported appropriately to eat and drink.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence.

A range of activities were provided and people were given opportunities to express their views and to give feedback about the service. Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received.

People and their relatives spoke positively about the registered manager. Health care professionals had confidence in the leadership team.

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

The service was safe.

Staff levels were adequate to ensure people's needs were met safely. Appropriate recruitment checks took place before staff started working at the home.

People's medicines were managed safely.

Risks to people were assessed. Incidents and accidents were reported and investigated.

Staff understood the signs of abuse and neglect and demonstrated a commitment to ensuring people were protected from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

The care and treatment of one person had not been provided in a manner that effectively met their healthcare needs.

Staff were still not receiving ongoing supervision in their role to make sure their competence was being maintained. Improvements had been made to induction programme offered to new staff and staff completed a range of training relevant to the needs of people using the service.

Where people were able to give consent to their care and support, staff acted in accordance with this and respected people's wishes. However, where there was an indication that a person might not be able to make a decision about key or significant aspects of their care, we found that staff's application of the principles of the Mental Capacity Act (MCA) 2005 was not always fully in line with the Act and its Code of Practice.

People received a choice of meals and were supported appropriately to eat and drink.

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and caring staff and were treated with dignity and respect.

People's relatives and friends were able to visit throughout the day, and we observed them sharing in aspects of their loved ones care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's records did not always contain all of the relevant information to support the delivery of responsive and person centred care.

A range of activities were provided and people were given opportunities to express their views and to give feedback about the service. Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received

Is the service well-led?

Requires Improvement

The service was not always well led.

Records relating to the operation of the home such as supervision and training records were not up to date or fully accurate.

The systems in place to monitor the effectiveness of the service were not always being effective at driving improvements.

People and their relatives spoke positively about the registered manager. Health care professionals had confidence in the leadership team.

Abbey House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over three days on 13, 14 and 19 September 2016. On the first and last days of our visit, the inspection team consisted of one inspector. On the second day the team consisted on one inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service.

During the inspection we spoke with ten people who used the service and four relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the registered manager and registered provider. We also spoke with the two visiting health care professionals, the operations manager, deputy manager, four registered nurses, five care workers, the chef, maintenance person and a member of the activities staff. We reviewed the care records of six people in detail and checked specific elements of the care records for a further three people. The medicines administration records for each person were examined. We also viewed other records relating to the management of the service such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas.

Following the inspection we sought feedback from six health and social care professionals and asked their views about the care provided at Abbey House Nursing Home.

The last inspection of this was service was in September 2015 during which we identified two breaches of the legal requirements.

Good

Is the service safe?

Our findings

At the inspection in September 2015, we found the provider was in breach of a Regulation. This was because they had not done all that was reasonably practicable to mitigate certain risks to people. Following the inspection, the provider sent us an action plan that showed what steps would be taken to meet this regulation. At this inspection, we found improvements had been made. For example, the hot water boiler mounted on the wall in the dining room was only accessible via a key fob which was locked in a key safe close by. This reduced the risk of people being scalded by boiling water. Products used to thicken drinks for people who had swallowing problems were now stored securely. Substances that would be hazardous to people were also now stored securely and the slings used for hoisting were no longer shared between people, reducing the risk of cross infection.

People told us they felt safe living at Abbey House Nursing Home. One person said, "Yes I feel very safe and secure". A relative said, "[the person] is safe, they are being thoroughly looked after".

A range of risk assessments were used within the service. People had moving and handling risk assessments; falls risk assessments and choking risk assessments. Staff ensured people had access to a call bell to summon help. Where people were at risk of falling from bed, bed rails were used and risk assessments for these had been completed. Screening for the risk of malnutrition was undertaken and a nationally recognised tool was used to assess people's risk of developing skin damage. Accident and incidents were analysed each month to identify any themes or trends in order that action might be taken to reduce the risk of further incidents.

The safety of the premises and of equipment used was monitored. Each person had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. Fire equipment tests were up to date and staff were trained in fire safety. Monthly checks were made of the hoist slings and wheelchairs to ensure these remained safe to use. Rooms were also checked on a monthly basis to ensure equipment such as the call bells, bed rails and window restrictors were in good working order. Risk assessments had been undertaken of the fire risks within the service and of the water system to ensure the effective control of legionella. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

People's medicines were stored securely within locked trolleys secured within a locked treatment room. Spare medicines were kept in cupboards or refrigerators and we did not find there was excess stock. The temperature of the fridges used for storing medicines was checked on a daily basis although the temperature of the treatment room was not checked. This is important as it provides reassurances that medicines are being stored within their recommended temperature ranges. Controlled drugs were also stored securely. We completed an audit of the controlled drugs in stock and found records were accurate. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused. We did find a number of oxygen cylinders had not been appropriately stored. We brought this to the attention of staff who told us

action would be taken straight away to address this.
Medicines were only administered by staff that had been trained and had received an assessment of their competency to do so safely. We reviewed the medicines administration records (MARs) for all 42 people. The MARs were up to date and complete and included all the relevant information to ensure the safe administration of people's medicines. This indicated people were receiving their medicines as prescribed. We observed part of a medicines round and found the nurse was knowledgeable about people's medicines and the ways in which they liked to take these. We also observed staff explaining to people what their medicines were for and asking them if they needed pain relief or other 'as required' medicines.

Care workers were currently responsible for administering prescribed topical creams, but the MAR was signed by the registered nurse after first confirming with care staff that the cream had been applied. This meant the staff member signing the MAR could not be certain that the prescribed cream had been applied correctly. The operations manager told us they planned to introduce a 'creams chart' that the care workers would complete to address this.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Care workers were able to explain how they would report any concerns to the nurse in charge or to the manager and they were confident they would take action. Information including the contact details of the local safeguarding team was available within the home. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the provider. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

Staff levels were adequate to ensure people's needs were met safely. During the early shifts (8am – 2pm) the current target staffing levels were two registered nurses and 11 care workers. After 2pm this reduced to two nurse and seven care workers. Night shifts were staffed by one registered nurse and five care workers. The service also had a registered manager and a deputy manager who was sometimes rostered to provide care but also had supernumerary office hours during which they were able to attend to their management duties such as supervising staff. We reviewed the rotas for the two weeks prior to our inspection; these showed the home was generally staffed to these target levels. The provider also employed a team of housekeeping staff, two administrators, chefs and kitchen staff and two activities co-ordinators. There are also two people responsible for the maintenance of the home. The care we saw being provided did not appear rushed and was delivered in a manner that did not compromise people's safety. Some people told us they would value the care staff being able to spend more time with them. For example, one person told us it would be nice if staff were able to "Chat with them a little longer". Overall though people remained very positive about the kind, caring and compassionate nature of the staff team. One person said, "They're so busy and cheerful….but you don't feel as if you are a nuisance".

Appropriate recruitment checks took place before staff started working at the home. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. One person said, "They seem to know what they are doing". Another said, "Oh yes I am well looked after, I can't think of anything to complain about". This person pointed at one of the registered nurses nearby, they said "They are full of knowledge". Another told us the staff were "Excellent…helpful". A visitor said, "[their relative] is always washed and dressed and looks presentable. If I was poorly I would love to come here". We observed staff providing effective care. For example, we saw staff assisting a person to move by using a hoist; staff provided the person with clear instructions and reassurances throughout the intervention. Whilst people told us the service provided effective care, some improvements were required.

The care and treatment of one person had not been provided in a manner that effectively met their healthcare needs. The person lived with diabetes and was prone to urine infections; they did not have a urine infection care plan in place. This would have enabled staff to recognise the signs and take appropriate action. Their diabetic care plan was not individualised to the person. We noted through reviewing their daily records that this person had been displaying clinical signs of a urine infection from 7 September 2016 and a urine dip test had tested positive that same day. However by 14 September 2016, the person had still not been commenced on treatment for this. Staff told us this was because they had been unable to get a suitable urine sample. The GP had visited the person on 13 September 2016, but staff had not discussed concerns about the person having a possible urine infection with the doctor. We were concerned there had been an avoidable delay in this person being supported to access appropriate treatment and support. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe care and treatment.

We did see other examples of people being supported to have access to health care services and receive appropriate ongoing healthcare support. A range of healthcare professionals including GP's, specialist community teams, dentists, physiotherapists, chiropodists and opticians had been involved in meeting people's health care needs. Each week, a GP made a routine visit to the home during which they were able to review people about whom staff had concerns or who were presenting as being unwell. One person said, "Staff offered last week to get to doctor as I was a bit poorly". A healthcare professional told us, "I am always given good information….they know what's going on…I give them parameters, they are used judicially…I don't get unnecessary calls". Records were maintained of the outcome of medical appointments and of visits from the GP or other healthcare professionals. Staff had recently been involved in a pilot being led by West Hampshire Clinical Commission Group to trial an early warning scoring tool for identifying sepsis. Sepsis is a potentially life-threatening condition triggered by an infection or injury. To help ensure staff were able to provide an effective response should a person experience a cardiac arrest, a defibrillator had recently been purchased for the service.

At the inspection in September 2015, we found the provider was in breach of a Regulation. This was because staff were not receiving regular supervision and new staff had not completed an induction programme that ensured they were suitably skilled and assessed as competent to carry out their roles. Following the inspection, the provider sent us an action plan that showed what steps would be taken to meet this

regulation. At this inspection, we found some improvements had been made but that the provider was still in breach of this Regulation as staff were still not consistently receiving regular supervision.

The provider's policy stated staff should receive four supervision sessions each year. When we reviewed the supervision records, these showed that at least 18 care workers had not received a supervision session since November 2015. None of the registered nurses had so far received supervision in 2016. Whilst staff generally felt well supported, having formal supervision is important as it helps to ensure staff feel valued and receive the guidance required to develop their skills and understand their role and responsibilities. This was echoed by one of the care workers who expressed a concern to us about the lack of supervision, they said, "I do value supervision, it's a tough job, it's nice to be told you are doing a good job, I feel a little devalued". The registered manager and provider have provided assurances that a programme of supervision has now been put in place for the coming year and systems will be in place to ensure this takes place as planned. A number of supervision took place during the inspection in relation to caring for people with urine infections and wound care. However staff were still not receiving ongoing supervision in their role to make sure their competence was being maintained. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Staffing.

Improvements had been made to the induction programme offered to new staff. New staff completed an induction during which they learnt about their role and responsibilities and undertook some essential training. They also spent time working alongside the more experienced staff and reading people's care plans which helped to ensure they were able to develop their understanding of people's needs. The induction folder for new staff was detailed and contained information about the provider's policies and the values of the organisation. A care worker told us that in their induction they had "A week of shadowing, moving and handling training, I learnt how thickened drinks look, I read the care plans, got to know about them [people]". Staff who were new to care were being supported to complete the Care Certificate. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. We did note this was not always being completed in a timely manner.

Staff had completed training in subjects such as the Mental Capacity Act 2005, safeguarding people from harm, infection control, emergency first aid, fire safety and moving and handling. The training provided was a mixture of some face-to-face training and the completion of workbooks followed by a knowledge paper which tested the staff members understanding of the training provided. The registered nurses had undertaken additional training relevant to the needs of people using the service such as the management of diabetes and the use of medical devices used for managing people's medicines during end of life care. A registered nurse was being supported to take a podiatry course. We were advised the registered nurses also all had training in catheter care and wound care although we were not able to see records which confirmed this. A care worker told us, "The training is good, but if I was not confident with anything, I would say I needed more training and I am sure this would be provided". The provider was committed to supporting registered nurses to gain their revalidation and provided opportunities for additional training. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register.

Where people were able to give consent to their care and support, staff acted in accordance with this and respected people's wishes. We observed staff asking people "Would you like me to cut up your meal for you" and "Would you like a clothes protector on". People had a 'Capacity and Choice' care plan which described how they were to be involved in decision making. For example, one person's plan said, 'I am able to consent to care, please explain all interventions to me'. However, where there was an indication that a person might not be able to make a decision about key or significant aspects of their care, we found that staff's application of the principles of the Mental Capacity Act (MCA) 2005 was variable. 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. We saw some good examples of robust mental capacity assessments supported by a best interest's consultation documented in line with the principles of the Mental Capacity Act (MCA) 2005. However, some other records showed a lack of understanding of the legal framework regarding consent. For example, in some cases consent forms were signed by relatives without there being evidence the relative had legal authority to do so. A consent form for the use of bed rails for another person had been signed by one of the registered nurses. Other people had bed rails in place, but no consent form regarding these. Some plans contained inconsistent or confusing information about people's ability to give consent to their care. For example, one person had a mental capacity assessment that said they lacked capacity to make decisions regarding their medicines. Their 'Capacity and Choices' care plan said they had 'Full capacity to make decisions'. We spoke with the deputy manager about this. They told us they would make arrangements for additional training to be provided to help ensure that the principles of the MCA 2005 were being more consistently applied.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

We looked at how the service met people's nutritional needs. Catering staff had information about people's food likes and dislikes and whether they required particular diets such as soft or pureed food. One person required a gluten free diet and arrangements had been made to ensure a range of appropriate foods was made available. The chef visited people each day to ask them which meal they would like. They told us this helped them to remain "Hands on". At lunch the chef came out to speak with one person who was not eating well. They offered the person a range of alternatives and were gently encouraging. They were also aware that another person disliked carrots and the portion size preferred by others. This helped to ensure people received food that was in keeping with their individual tastes and needs. Where people were unable to take food orally because of swallowing problems, there were suitable nursing plans in place to support this.

People were generally positive about the food provided. One said it was "Pretty Good" and another said, "Its very good food, good choice and it tastes nice". Hot and cold drinks were readily available throughout the day and fresh fruit was readily available in the dining room. There was always a vegetarian option each day and a pot of homemade soup available. Where people required pureed meals each element of the meal had been prepared separately so that the person could still taste the individual flavours. At lunch, meals were either served in the dining room, or on tables in the communal lounges. Some people ate their meals in their rooms. We observed the lunch time meal on the first day of our inspection. Staff provided support to eat and drink in a person centred manner. For example, we saw one care worker sit beside a person, they said, "Hello [the person] I've got your dinner". They told the person what the meal was and asked them if they were ready to eat. They chatted with the person whilst helping them with their meal, asking them if the food was nice.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said the care workers were, "Kind and considerate". Another said, "Very caring, most of them, Very patient, always cheerful". A relative told us, "The staff are very friendly". Another said, "They are very nice girls, they can make [their relative] smile…it's the little things they do". Feedback from health care professionals was also very positive, for example, one said staff all had a "Good rapport with the residents". Another said, "They [the staff] are empathic to patients, ensure families feel welcome".

Our observations indicated staff interacted and supported people in a kind and caring manner. We saw one staff member cuddle one person who was distressed. It appeared to reassure the person. We observed a registered nurse gently encouraging a person to drink some more of their fortified drink, they praised them for taking each mouthful. The atmosphere in the communal areas was good natured and sociable. A staff member told us, "There is a camaraderie between the staff and residents; we try to keep it as a family atmosphere". Staff spoke fondly about the people they supported. A staff member told us, "I love it here, being able to give something back to them [people]". Another care worker said, "I try to treat everyone as an individual". People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work.

People were supported to remain independent. For example, plate guards were offered to people to assist them with eating their meals, adapted cups were available to help people drink independently. The importance of promoting people's independence was also reflected in people's care plans with staff being prompted to ensure they encouraged people to make choices where able. A care worker said, "It's important they can do as much as they can when they are still able".

People told us they were treated with dignity and respect. One person said, "Oh yes very much so. They always draw the curtains whilst I am having my wash". We observed staff knocked on people's doors before entering and screens were used in the shared rooms to provide people with some privacy. We did note that on a number of occasions, people were hoisted in the communal areas in a manner that did not protect their dignity. This was because the intervention led to the person's clothing becoming displaced. We spoke with the deputy manager about this who took immediate action to remind staff to use modesty blankets to protect people's dignity when being hoisted.

People's relatives and friends were able to visit throughout the day, and we observed them sharing in aspects of their loved ones care. For example, one visitor came every day to help their relative eat their lunch. A relative told us, "I come every day, its helps to feel like I am still involved". People were supported to follow their religious and spiritual beliefs. The local vicar visited the service on a monthly basis to hold a service.

Requires Improvement

Is the service responsive?

Our findings

Many of the staff working at Abbey House Nursing Home had been with the service for many years and demonstrated a good understanding of people's needs. Care staff were able to tell us which people needed repositioning regularly and which people were at risk of choking. They were able to describe how they assisted people to eat including ensuring they were sat in the right position. People, their relatives and healthcare professionals consistently told us the service provided good care and that the care staff worked really hard to meet their needs. However, some improvements were required. Whilst the care and nursing staff we spoke with appeared to have a good understanding of people's needs, the care records did not always contain all of the relevant information to support the delivery of responsive care, some of which could have implications for people's care and welfare.

Records relating to the care and treatment provided were not always fit for purpose or accurate. Records relating to wound care needed to improve. Wound care plans had not been updated when the type of dressing being applied had changed. We were not always able to see what the rationale was for changing dressings. None of the body maps were dated and whilst some photographs had been taken of people's wounds, some of these were a number of months old and none included a measurement so it was not possible to clearly ascertain the size or dimension of the wound. The lack of wound measurements also makes it difficult to track how the wound is healing. This is contrary to best practice guidance. Skin integrity care plans were not always updated which meant there was a risk of care staff not having suitable guidance about how to manage the person's skin on a daily basis.

We looked at the records of two people who had a urine infection. They did not have a short term care plans. Short term care plans describe the additional care people require to address a specific or acute health care need such as a urine or chest infection. Some of the tools being used to monitor and review risks to people's health and wellbeing were not being effectively or consistently used. Some people were living with conditions or needs that would normally mean their fluid intake should be monitored. This was not always happening. Food charts were being used to monitor some people's dietary intake, but these were not always being fully completed which limited their effectiveness as a monitoring tool. Repositioning charts contained gaps. Staff told us this would be due to the person declining the care, but there was no record of this. One person was being provided with thickened fluids following their discharge from hospital, but there was no evidence of an assessment from a speech and language therapist and the person did not have a dysphagia care plan. Dysphagia is the medical term for swallowing difficulties. Care plans did not contain adequate guidance for staff on how they might respond to behaviour which might challenge others. Behaviour monitoring charts were not being used to help identify triggers to the behaviours and inform care planning. Staff were not using pain assessments. We did not see any evidence that people were in pain, but we were concerned the lack of pain assessment might mean staff had no objective way of identifying when people's needs in relation to pain had changed or worsened for example.

Records relating to the care and treatment provided were not always fit for purpose or accurate. This is a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Good Governance.

Handover meetings were conducted every day during which staff shared information about any new concerns about a person's health. These were now led by the nursing staff which care staff told us made them more effective. Many people living at Abbey House Nursing Home were able to understand and make decisions about how their care and support was provided and we saw they were encouraged to do this on a daily basis. However it was not clear that people or their families, where appropriate, were involved in the monthly reviews and evaluations of their care plans. This was an issue that we identified in our last inspection report. We were not able to see that any improvements had been made with regards to this.

Daily records were completed but these were quite task orientated and did not focus on the person's experience of their care. Some care plans contained information about people's likes and dislikes, their preferred daily routines and about their lives before coming to live at the home, but this was not in place for each person. This information is important as it helps staff to engage with the person in a meaningful way, particularly those people that might be living with dementia. The operations manager told us they had already identified the quality of care plans was an area which needed to improve and they described the measures they were putting in place to provide additional training and support to the service on developing more robust and person centred care plans.

A range of activities were provided. The service employed two staff, who worked for 40 hours between them to lead the activities provision within the service. They provided a range of both group and one to one activities for people living at the home. A schedule of activities was advertised and included singers, a visit from a therapy cat, hand pampering and 'Music for Health'. People were also involved in a gardening club and taking part in events to fund raise for a new summer house. Most of the activities took part in the sun lounge, although there was another smaller lounge upstairs which was suitable for smaller group activities and also used as the hair salon. There was a computer available in this lounge that people could use to make video calls to their relatives who might live some distance away. Summer and Christmas fayres were held and a harvest celebration was being planned. Children from a local school visited to take part in carol singing. People had 'social activity plans' which gave some information about the activities they liked to be involved in. For example, one person liked gardening and listening to the birds. Records were kept of the activities each person took part in and these showed people cared for in their rooms also received some opportunities for one to one interaction with staff. One to one care had also been provided to take people to visit relatives in hospital or for personal shopping trips. Overall people were positive about the activities provided. One person said, "There are so many people here and things going on…I don't find it boring".

People were given opportunities to express their views and to give feedback about the service. Prior to our last inspection an annual survey had been undertaken with people and their relatives, the results had been shared with them and where areas for improvement had been identified, the leadership team had taken action to address many of these. A new survey was currently underway. Meetings with people and their relatives twice a year and were used as an opportunity to update people about staffing matters, improvements to the environment and activities. At the last meeting in March 2016, a number of relatives had made positive comments about the home such as, 'The staff are always very happy and smiling and its lovely to see' and 'You all do such a fantastic job and work so hard'. Another meeting was planned for October 2016.

Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received. People told us they were confident they could raise concerns or complaints and these would be dealt with. One person said when asked who they would talk to if they worried about something said, "It depends on what it was, a general worry then the senior nurses…..or the very senior lady, she comes most days to say hello". Records showed complaints or comments were used as opportunities for learning or improvement and where necessary remedial actions were put in place to prevent similar incidents from

occurring again. The service user guide provided a clear, user friendly description of what people could expect from the service and included a charter of rights and information about the complaints procedure. It also included a helpful leaflet about how people could protect themselves from abuse.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives felt the home was well managed and well run. Overall staff were also positive about the leadership team. A staff member told us, "The manager is very supportive". Another said, "They are a strong leader, very good at knowing what's going on, they quickly read a situation…they know something about each of the residents". A third said, "I do feel I could go and talk with her". A health care professional told us they felt there was a "Good leadership team", whilst another told us the registered manager and senior staff were "Incredibly knowledgeable" about the people using the service. They told us, "I trust them". Most staff told us the service was a good place to work and they enjoyed their job. One staff member said, "I love it here". Another said, "I love my job, it's so rewarding, it's fantastic". A registered nurse told us they really enjoyed the variety of the work including the care and support of those people using the rehabilitation beds.

The registered manager had been at the service for some time and knew the service, the staff team and visiting professionals well. They were well respected by the multi-disciplinary team. The registered manager was supported by the provider's operations manager who visited the service at least monthly to meet with the registered manager and to carry out checks. The provider also visited the service on at least a weekly basis and appeared to have a good understanding of the service. However, some areas of how the service was run needed to improve.

Records relating to the operation of the home such as supervision and training records were not up to date or fully accurate. We were concerned this meant the registered manager could not be assured staff were competent and had all of the training relevant to their role and this was up to date. Some of the provider's policies and procedures needed to be updated or did not reflect current practice within the service. For example, the training policy said that there would be a documented training plan for each job position. This was not in place.

Whilst there were systems in place to monitor the effectiveness of the service, some of these were not always being effective at driving improvements. The registered manager undertook 6 monthly audits of the effectiveness of infection control within the service and an action plan had been produced as a result of these. However four of the actions resulting from the August 2016 audit had also been actions from the March 2016 audit. The concerns we noted in relation to wound care and other aspects of people's records had not been identified by the care plan audits. Medicines audits were undertaken and medicines errors investigated. However, we noted that a contributing factor to a recent medicines error was the staff member administering the medicine had to 'keep answering the phone' whilst doing the medicines round. We had identified during our inspection that this continued to be a challenge for staff. For example, despite the nurse wearing a 'do not disturb' tabard, within a ten minute period they were interrupted three times by other staff asking them questions. Interruptions are a known risk factor for errors occurring during medicines administration. There was no regular cleaning and testing programme in place for equipment used to manage incidents of choking and checks were not in place to ensure the first aid kits remained well stocked.

Staff meetings took place periodically, but these were not well attended by staff. For example, only five of

the 43 care staff attended the last care workers meeting in June 2016. A general staff meeting was held in March 2016 with only 14 staff attended. The service employs approximately 75 staff. Staff meetings are important tools for sharing developments with staff and for discussing how the delivery of care can be enhanced, poor attendance could possibly result in staff not receiving information and support needed to carry out their jobs well. The registered manager and operations manager agreed to look at ways of rescheduling meetings at different times to try and increase attendance.

The action plan submitted following our last inspection had not been fully completed. Staff were still not receiving regular supervision. The action plan stated all staff would be trained in health and safety, but records showed only 18 of the 75 staff had undertaken this training. The action plan stated three monthly training audits would be undertaken. These were not in place.

There was a failure to ensure there were effective governance, quality assurance and auditing systems in place. This is a breach of Regulation 17(1) (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Good Governance.

We spoke with the registered manager about the concerns noted above. They explained that some of the slow progress with the planned improvements was due to the staffing issues. Following our last inspection a new deputy had been appointed but had left in March 2016 and so progress with improvements to the supervision programme and with improving care plans had been delayed. A second new deputy had now been appointed and had been in post two weeks but had already undertaken some essential supervision with staff and made some improvements to some of the records such as those used for recording wound care and for monitoring food and fluids. The registered manager was confident that despite the areas requiring improvement, people experienced good care and were satisfied with the support they received. This was confirmed by the feedback we received from people, their relatives and from the healthcare professionals that worked closely with the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment of one person had not been provided in a manner that effectively met their healthcare needs. This placed them at risk of harm. Regulation 12 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to the care and treatment provided were not always fit for purpose or accurate. Regulation 17(2) (c). There was a failure to ensure there were effective governance, quality assurance and auditing systems in place. This is a breach of Regulation 17(1) (2) (a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were still not receiving on-going supervision in their role to make sure their competence was being maintained. Regulation 18 (2) (a) Staffing