

Abbey Lawns Ltd

Abbey Lawns Care Home

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place on 8 December 2016 and was unannounced.

Abbey Lawns is a privately owned care home providing both nursing and personal care for up to 61 people who have a range of care needs. The home is located in a residential area of Liverpool close to public transport routes and local amenities. During the inspection, there were 60 people living in the home.

We carried out an unannounced comprehensive inspection of this service in September 2015 and breaches of legal requirements were found and the service was rated as, "Requires improvement." After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches. We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found that some improvements had been made but breaches of regulation were still identified.

A registered manager was in post. 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.

We found that although some checks were in place, the environment was not always adequately maintained in order to ensure people's safety and wellbeing. For instance, not all windows were restricted as required and fire doors were not all maintained safely. The basement could be accessed through both an unlocked door and from the lift used by people within the home. The basement contained items that could pose a risk to vulnerable people, such as chemicals, tools, and an unlocked boiler room. We also found that the building was not always secure and members of the public could access without staff knowledge. Legislation regarding smoking was not being followed.

Medicines were not always managed safely within the home. MAR charts contained a number of recording errors, creams and thickening agents were not signed for and effective processes were not always in place for PRN medicines (as and when needed).

Staff had completed risk assessments to assess and monitor people's health and safety; however these were not always completed accurately. This meant that risk may not be identified and measures put in place to manage the risk may not be sufficient.

Safe recruitment practices were not always followed to help ensure staff were suitable to work with vulnerable people.

People we spoke with told us they felt safe living in Abbey Lawns. People told us and our observations confirmed, that there were sufficient numbers of staff on duty to meet people's needs.

The registered manager told us that two authorisations were in place to deprive people of their liberty lawfully and we found that this was reflected in people's care files. Care records showed that when able, people provided their consent in some areas of their care. We found however that consent was not always sought in line with the Mental Capacity Act 2005 (MCA).

Staff were supported in their role through induction, supervisions and an annual appraisal and staff told us they felt well supported. Regular training was provided to staff in areas the provider considered mandatory and records showed staff completed this training.

People told us they were given choice regarding meals. Specialist diets were catered for including diabetic and liquidised diets and we saw people's preferences being met. There was information held in the kitchen to inform staff of people's dietary needs. The feedback regarding meals was not always positive and the registered manager told us they had addressed this with the chef.

People living at the home told us staff were kind and caring and treated them with respect. We observed interactions between staff and people living in the home to be familiar and caring. Although we found that staff were caring towards people living in the home, the provider had not addressed risks identified during the last inspection and this does not demonstrate a caring approach.

Through discussions with staff, we found that they knew people they were caring for well, including their needs and preferences and people we spoke with agreed. However, care plans included only basic information regarding people's preferences. We found that staff worked with the aim of improving or maintaining people's independence.

People told us they were happy with the care they received, but files did not all reflect that people had been involved in the development of their care plans. We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from the point of admission.

Care plans provided basic information regarding people's care and treatment. They contained little information that was specific to the individual person and we found some care plans did not contain sufficient detail regarding people's needs. We also found that care plans were not always reflective of the care people were receiving.

There was a monthly schedule of events planned by the activity coordinator employed by the service. The latest newsletter available to people advertised upcoming events both within the home and in the local community. The recently completed quality assurance surveys we viewed showed that most people were satisfied with the activities available to them and people we spoke with agreed.

We looked at processes in place to gather feedback from people and listen to their views. Quality assurance surveys were issued to people living in the home and their relatives. The registered manager told us they had reviewed the surveys and had addressed comments individually; however these actions were not recorded. People we spoke with told us they were able to provide feedback regarding the service and one person told us about resident meetings that were held. We found however, that these meetings were not recorded.

People had access to a complaints procedure which provided relevant contact details should people wish to make a complaint.

Required improvements had not been made since the last inspection with regards to monitoring and

auditing the quality and safety of the service and processes in place were ineffective.

Policies and procedures we viewed were not current, reflective of best practice and not all provided accurate guidance to staff. We observed care files were not all stored securely within the home in order to maintain people's confidentiality.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. Staff described the registered manager as, "Supportive." Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service. Regular staff meetings were held to ensure views were gathered from staff.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding Abbey Lawns Care Home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

The environment and equipment was not adequately maintained in order to ensure people's safety and wellbeing. Legislation regarding smoking was not being followed and the building was not always secure.

Medicines were not always managed safely within the home.

Risk assessments to assess and monitor people's health and safety were not always completed accurately.

Safe recruitment practices were not always followed to help ensure staff were suitable to work with vulnerable people.

People we spoke with told us they felt safe living in Abbey Lawns.

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

Is the service effective?

Requires Improvement ●

The service was not always effective.

The principles of the MCA were not always followed when seeking people's consent.

DoLS applications had been made appropriately.

Staff were supported in their role through induction, supervisions, annual appraisal and regular training.

People were given choice regarding meals and preferences were met. Staff were aware of people's specialist dietary requirements. Feedback regarding meals was not always positive.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People living at the home told us staff were kind and caring and treated them with respect; however the provider had not addressed previously identified risks to people. This did not show a caring approach.

Interactions between staff and people living in the home were familiar and caring. Staff worked with the aim of improving or maintaining people's independence.

Staff knew people they were caring for well, including their needs and preferences and people we spoke with agreed.

There were no restrictions in visiting, encouraging relationships to be maintained.

Is the service responsive?

The service was not always responsive.

People we spoke with told us they were happy with the care they received, but files did not all reflect that people had been involved in the development of their care plans.

Systems were in place to gather feedback from people; however actions taken based on the feedback were not always recorded.

Care plans contained little information that was specific to the individual person; some did not contain sufficient detail regarding people's needs, or were not reflective of the care people were receiving.

Relatives we spoke with told us they were kept informed of any changes to their family member's health and wellbeing.

There were appropriate activities available to people. People had access to a complaints procedure.

Requires Improvement ●

Is the service well-led?

The service was not well led.

Systems in place to monitor the quality and safety of the service were ineffective.

Policies and procedures we viewed were not current, reflective of best practice and not all provided accurate guidance to staff.

We observed care files were not all stored securely within the home in order to maintain people's confidentiality.

Inadequate ●

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements.

Abbey Lawns Care 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 inspection took place on 8 December 2016 and was unannounced. The inspection team included two adult social care inspectors.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the deputy manager, the maintenance person, an activity coordinator, a contracted training provider, three members of the care staff, four people living in the home and three relatives.

We looked at the care files of seven people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Abbey Lawns Care Home in September 2015, we identified breaches of regulation in relation to keeping people safe. The 'safe' domain was rated as, 'Requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation regarding staff recruitment, staffing levels and safety of the premises and equipment.

At the last inspection we identified concerns regarding the safety and security of the environment. We found that not all fire safety checks were completed regularly, legislation regarding smoking was not adhered to, the building was not always well maintained and we had concerns regarding areas of land being used for public parking that were not separate from areas used by people living in the home. We found during this most recent inspection that few improvements had been made. Some carpets had been replaced and the home was clean, however we found many of the concerns identified at the last inspection had not been addressed.

During this inspection records we looked at showed that internal checks were in place in areas such as fire alarm testing, water temperatures and portable appliance checks. Contracts were in place to ensure facilities such as gas, electrics and fire safety equipment were well maintained. We viewed certificates for these checks and they were in date. A fire risk assessment was also in place and personal emergency evacuation plans had been created for people to guide staff what support people would require to evacuate the home in the event of an emergency. We found however, that the environment was not always adequately maintained in order to ensure people's safety and wellbeing.

Records showed that checks of fire doors and escape routes had not been completed since August 2016 but should have been monitored and recorded monthly. We found that a number of fire doors were wedged open around the home, including high risk areas such as the kitchen and laundry. Some doors that had automatic closures fitted were not working. We raised this with the registered manager and later observed a member of the maintenance team repairing one of the closures. The recorded checks made on automatic door closures were not dated so we were unable to establish when these were last completed. We also observed that some fire doors did not close adequately which meant people would not be protected from risks relating to fire safety.

Chemicals were not always stored securely within the home. We observed carpet cleaner and bottles of bleach left around the home which vulnerable people could access. The maintenance team had an office in the basement. We observed the door to the basement not to be locked during the inspection and staff told us it would be locked when the maintenance staff went home. Behind the door was a steep set of concrete steps leading to the basement. We looked around the basement and found chemicals, tools, an unlocked boiler room, unlocked fuse/electric room and a room used for storage of linen, table cloths, carpet rolls and pillows. This was stored up to the ceiling and posed a fire safety risk. The elevator used by people independently within the home also provided direct access to the basement area. After the inspection we contacted the fire service to advise them of our concerns.

We found that window restrictors were not in place for all windows which required them, which may pose risks to vulnerable people. The registered manager agreed to check all windows and ensure restrictors were fitted on all windows which required them.

Prior to this inspection we had received concerns that the car park was used by the public when there was a football match on and that this would prevent access to emergency vehicles should they be required. The registered manager confirmed that the car park was rented out to the public at these times, but that only the land at the back of the home was used for this parking and the spaces at the front of the home were always available for visitors to the home and emergency services. One relative we spoke with told us they visited every day, including when football matches were on and that they never had any issue parking in the allocated spaces in the front of the home. We found that there was no separation from the land used by the public on match days, to the areas of the garden used by people living in the home. We observed people smoking in the corridor of the home, with a door propped open that led directly to the land at the back of the home used by the public. This meant that the public using the car park could have direct access into the home. The registered manager told us the designated smoking area was in the garden; however people were still smoking in the corridor which is not in line with current Smoke Free England legislation. During the inspection we saw these doors wedged open and nobody in the vicinity; this again meant that the home was not always secure.

This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. Medicines were stored in a locked clinic room and the temperature of both the room and medicine fridge was monitored daily and within safe ranges. There was a medicine policy available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We found that these drugs were stored and recorded in line with best practice.

Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed.

We looked at how medicines were managed and found that they were not always managed safely. MAR charts we viewed contained a number of recording errors. For instance, one person was prescribed a medicine twice daily but the MAR showed it had only been signed for once each day. We checked the stock and found the medicines had been administered twice each day as prescribed. Another person was prescribed a medicine to be taken once a day; however the person's MAR chart recorded it being administered twice each day. We checked the stock and found that the medicine had been administered once as prescribed and the second dose had been recorded in error. A third person was prescribed a medicine each evening; however none were signed for as administered on the MAR chart. We checked the stock and found it had been administered as prescribed.

We found that when staff applied prescribed cream for people, or provided prescribed thickening agents in people's fluids, they did not always sign to show they had been administered. The MAR charts we viewed were blank and a staff member told us care staff applied most creams but there was no system in place to

reflect this.

We found that plans were not in place for people who required PRN (as and when needed) medicine and were unable to tell staff when they needed medicines such as pain killers. One staff member told us they looked for non-verbal signs and used body language to establish when one person required pain relief; however this was not recorded within the plan of care. This meant there was a possibility people may not receive PRN medicines when they needed them.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. We found however, that not all risk assessments had been completed accurately. For instance, one person's body mass index was recoded inaccurately on their nutritional risk assessment, which meant that the level of risk identified may not be sufficient to maintain the person's safety and wellbeing. Another person's file showed that their falls risk assessment had been completed inaccurately. This meant that risk may not be identified and measures put in place to manage the risk may not be sufficient.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that safe recruitment practices were not always followed as application forms were not fully completed, identification of staff was not always available and the most relevant references were not always sought. During this most recent inspection we found that safe recruitment practices were still not always followed. We looked at four personnel files and found that application forms were not always fully completed with information regarding people's employment history and photographic identification was not held on file for two of the staff whose files we viewed. We found that although people had two references on file, they were not always from the most relevant people, such as their last employer.

Disclosure and Barring Service (DBS) checks were in place; however they were not always updated by the provider as part of the recruitment process. For example, one person's DBS check was provided from a different employer, two years prior to being recruited in Abbey Lawns Care Home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found that there was not always a risk assessment in place when staff had convictions on their DBS, to ensure it was safe for them to work with vulnerable people. We discussed this with the manager who told us they were in place for some people and would ensure a risk assessment was completed as a priority.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe living in Abbey Lawns. One person told us, "I feel safe. It's the way it's run" and another person said, "I feel safe living here, when I press the bell [staff] come."

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were able to explain how they would report any concerns appropriately both within the home and to external agencies if needed. All staff we spoke with told us they had completed safeguarding training. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the home. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made.

We looked at how the home was staffed. During the inspection there were 12 carers and two nurses on duty, as well as the registered manager, deputy manager, kitchen, domestic and administration staff, to support 60 people living in the home. Records showed that these staffing levels were regularly maintained and there were bank staff employed to help ensure there were always sufficient numbers of staff on duty to meet people's needs. Most people we spoke with told us there was enough staff and that they did not have to wait long for support. One person told us, "There's always enough staff around" and relatives we spoke with agreed. We observed people being supported in a timely way during the inspection and call bells were answered quickly.

We looked at accident and incident reporting within the home and found these were reported and recorded appropriately. An accident book was in use and care files we viewed reflected when people had been involved in any accidents, such as falls.

There were no concerns raised regarding the cleanliness of the home. One person told us, "I think it's homely, but a bit run-down" and another person said, "[Relative's] room is always clean." We observed a number of domestic staff on duty during the inspection. There were gloves and aprons available to staff to access at various points around the home and we observed staff wearing these appropriately in line with infection control guidance.

Is the service effective?

Our findings

When we carried out a comprehensive inspection of Abbey Lawns Care Home in September 2015, we identified breaches of regulation in relation to the effective domain and this domain was rated as, 'Requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation regarding staff support systems and seeking people's consent to care and treatment.

At the last inspection we found that consent was not always sought and recorded in line with the principles of the Mental Capacity Act 2005 (MCA) and during this inspection we found that although some improvements had been made, consent was not always sought in line with legislation.

During this inspection we looked to see if the service was working within the legal framework of the 2005 MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that two DoLS applications had been made and were authorised and staff we spoke with were aware of this. We looked at the care records for one of these people and found that the DoLS authorisation was clearly recorded within them.

One care file we showed that the planned care had been discussed with the person but they did not want to sign. We found however, that consent was not always sought in line with the MCA. For example, one care file contained consent forms signed by the person's relative, but there was no evidence that the person lacked capacity and was unable to provide consent themselves. Care records showed that when able, some people provided consent in areas such as photography and the use of bed rails, however not all files reflected that consent to care was sought.

Staff we spoke with told us they always asked for people's consent such before providing personal care. We observed however, that staff did not always seek consent before entering people's rooms.

When people were unable to provide consent, mental capacity assessments were completed, however there was no evidence that best interest decisions were made and that relevant people were consulted regarding these decisions. This meant that the principles of the MCA were not always followed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that staff had not all completed training considered mandatory and not all

staff had received regular supervisions. During this inspection we found that improvements had been made in these areas. We looked at how staff were inducted into their job role. All staff had completed a care awareness course which included the principles of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers work towards and have their practice assessed and signed off by a senior member of staff. Staff we spoke with told us their induction was sufficient and that they shadowed more experienced staff when they first commenced in post. Personnel files contained completed induction booklets.

We looked at ongoing staff training and support. Staff we spoke with told us and records we viewed showed that staff received regular supervisions and an annual appraisal. Staff told us that they felt well supported in their role. Staff told us they had completed training in areas such as moving and handling, medicines management, mental capacity and DoLS and infection control and training records reflected this. A staff member told us they were confident they could request additional training should they require it and that it would be provided.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, community matron, dietician and optician. People told us the doctor was called if they were unwell and relatives we spoke with agreed.

We observed the lunch time meal in one of the dining rooms and saw that tables were laid with table cloths, cutlery, crockery and condiments. People told us they were asked each day what meal they wanted for lunch and that alternatives were always available. We could see that people's preferences were catered for, as for instance, some meals had gravy whilst others did not. We heard one person requesting a meal for their tea that was not one of the choices being offered that day and observed that they received this meal at tea time. Hot drinks were served with meals and we found that there was a relaxed atmosphere in the dining room and people were not rushed.

Specialist diets were catered for including diabetic and liquidised diets. We saw however, that all ingredients of the meal were liquidised together and so it did not look appealing and not all meals were very hot. There was information held in the kitchen to inform all staff of people's dietary needs, including drinks that needed to be thickened. We saw staff supporting people with their nutritional intake when necessary and this was done in a discreet way.

When asked about the food people's comments included, "The food's alright" and "The food is okay." A relative we spoke with told us, "Personally I wouldn't say the food is the best. If [residents] ask for something different they get it. If [relative] fancied an egg or some fish, they'd do it." Quality assurance surveys also reflected that a number of people were dissatisfied with some of the meals provided to them. We discussed this with the registered manager who told us they had spoken with the chef regarding feedback received.

Is the service caring?

Our findings

When we carried out a comprehensive inspection of Abbey Lawns Care Home in September 2015, the caring domain was rated as, 'Good.'

During this inspection people living at the home told us staff were kind and caring and treated them with respect. Staff were described as, "Good" and "Friendly and approachable." One person told us, "Staff are nice people; they are like my family." Relatives we spoke with agreed and their comments included, "Nothing is too much trouble for them", "Staff are fantastic" and "I am made up with the care [relative] gets."

Although we found that staff were caring towards people living in the home, the provider had not addressed risks identified during the last inspection and this does not demonstrate a caring approach.

We observed people's dignity and privacy being respected by staff during the inspection, such as referring to people by their preferred name and providing personal care in private. We heard people use their call bells and they were answered quickly. This meant that people did not have to wait long if they needed support. People were given plenty of time to eat their meals during lunch; they were not rushed in any way. We observed interactions between staff and people living in the home to be familiar and caring. One relative told us, "Staff treat [relative] with respect."

Through discussions with staff, we found that they knew people they were caring for well, including their needs and preferences and people we spoke with agreed. Care plans included only basic information regarding people's preferences, such as when people prefer to go to bed or get up in the morning. Staff told us people had a choice regarding the gender of carer that supported them with their personal care, however this was not reflected in people's care plans that we viewed. People we spoke with told us they did not have any preference regarding this. During the inspection, we observed people's preferences being met with regards to meals.

We found that staff worked with the aim of improving or maintaining people's independence. People we spoke with told us staff encouraged them and allowed them to make decisions regarding their care and to assist themselves as much as possible. One person we spoke with held the staff in high regard and explained how they had supported them to become more mobile since they moved into the home. We found however, that this culture of promoting independence was not reflected within people's care plans.

The registered manager told us there was nobody currently living in the home that had any specific religious needs but that they would always respect and meet people's religious or cultural needs. People we spoke with told us they felt their religious needs were met; one person told us they attended a local church regularly. The newsletter reflected that the home had links with local churches as activities were planned which involved these churches.

We observed relatives visiting throughout the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us their

visitors were made welcome and relatives we spoke with agreed they could visit at any time.

If people had no family or friends to represent them, the registered manager told us they would liaise with the local authority and ensure that advocacy support was arranged for people. The registered manager told us there was nobody living in the home that currently required this support as each person had friends or family to represent them if they were unable to do so themselves.

Is the service responsive?

Our findings

When we carried out a comprehensive inspection of Abbey Lawns Care Home in September 2015, we identified breaches of regulation in relation to the responsive domain and this domain was rated as, 'Requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation regarding complaints and we found improvements had been made, however other concerns were identified.

At the last inspection we found that there was no effective system in place to manage complaints regarding the service. During this inspection we found that people had access to a complaints procedure which provided relevant contact details should people wish to make a complaint. The complaints process was reflected within the service user guide which people were provided a copy of when they moved into the home. The registered manager told us they had not received any formal complaints and so had no log in place but that they would implement one when required in order to monitor any complaints and their outcome. People we spoke with told us they would feel comfortable raising any concerns they had.

Care files we viewed had been reviewed regularly. One file we viewed reflected that staff had spoken with the person about their care and another file contained an annual care plan review signed by a relative. We found however that not all care files reflected that people had been involved in the reviews of their care.

We looked at how people were involved with the development of their care plans. People we spoke with told us they were happy with the care they received, but files did not reflect that people had been involved in their creation. One care plan we viewed included document called 'My life before you knew me.' This provided information about the person, their family and previous jobs. It also included a section to reflect who the person wanted in their care, however this was blank. None of the other care files viewed contained this document.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from the point of admission. We observed care plans in areas such as personal care, eating and drinking, elimination, mobilising, breathing and maintaining comfort and safety.

Care plans provided basic information regarding people's care and treatment. They contained little information that was specific to the individual person and we found some care plans did not contain sufficient detail regarding people's needs. For example, one person's file contained a maintaining safety care plan that stated 'Complete full nursing care plan to meet all needs' and 'Complete full risk assessment.' It did not provide information on how staff could support the person to maintain their safety. Another person's file did not provide clear information as to their cognitive ability. Their care plans reflected that staff spoke with them regarding their care, but had gained consent from a relative and the person's medical history suggested they may have some cognitive impairment. There was no care plan in this person's file, or in any other we viewed, regarding cognition, even when people had a diagnosis of dementia.

We also found that care plans were not always reflective of the care people were receiving. For instance, one person's file recorded that they needed support to reposition every two hours using a slide sheet. There were no records to show this support was provided and when we discussed this with the deputy manager, they told us this was not needed as the person could move independently. The person's file also stated their pain should be assessed using the Abbey pain scale but this was not used. This meant that care plans did not provide staff with accurate information regarding people's needs.

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

Relatives we spoke with told us they were kept informed of any changes to their family member's health and wellbeing. One relative told us, "They tell me what's going on; if [relative] is upset or anything." Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files. Handovers were in both verbal and written form. The written handovers recorded any significant information regarding each person that day, such as changes to people's health or updates on medical issues. A diary was also in use for night staff to record and specific information regarding care provided to people overnight. Staff we spoke with told us that communication in the home was good.

People told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges, whether to join in activities or spend time in their rooms. When people chose to spend time in their room, call bells were available so they could call staff for support when required.

We looked at the social aspects of the home. There was a monthly schedule of events planned by the activity coordinator employed by the service. The latest newsletter available to people advertised upcoming events both within the home and in the local community. These included bingo, jigsaws, Christmas movies, Christmas parties, indoor bowls, word searches and events at local churches. We were also told about trips out, such as a recent trip to Southport and to the Botanic Gardens. The recently completed quality assurance surveys we viewed showed that most people were satisfied with the activities available to them and people we spoke with agreed.

We looked at processes in place to gather feedback from people and listen to their views. Quality assurance surveys were issued to people living in the home and their relatives. We viewed surveys that had been completed in September 2016 which showed some people were not satisfied with the meals available and some surveys also included comments regarding the décor of the home and the upkeep of the gardens. The registered manager told us they had reviewed the surveys and had addressed comments individually, such as speaking with the chef regarding meals, however these actions were not recorded and it was not evidenced that the feedback from the surveys had been analysed and actioned to help improve the service.

People we spoke with told us they were able to provide feedback regarding the service. One person told us, "We have resident's meetings. I get a chance to have my say." We found however that these meetings were not recorded and the registered manager told us they did not take place regularly as not many people attended. The registered manager told us they had an open door policy and that this was why people did not feel the need to attend regular meetings.

Is the service well-led?

Our findings

When we carried out a comprehensive inspection of Abbey Lawns Care Home in September 2015, we identified breaches of regulation in relation to the well-led domain and this domain was rated as, 'Requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation in relation to monitoring the quality and safety of the service.

At the last inspection we found that audits were in place in areas such as medicines management and care planning, however no other checks of the service were evident. During the inspection we found that no improvements had been made. The registered manager told us that the provider visited the home each week, however there were no records of these visits and we were told that they did not undertake any checks regarding the quality or safety of the service during these visits. The registered manager told us they contacted the provider each week to provide an update regarding areas such as occupancy, any incidents and any hospital admissions.

At the last inspection it was identified that the registered manager only completed audits regarding medicines and care planning and we found at this inspection that this had not improved. The audits completed in relation to medicines and care planning did not identify all of the issues we highlighted during the inspection. There were no other audits completed, such as checks on staff recruitment, health and safety, the environment, infection control or accident analysis. This meant that a number of the issues we raised with the registered manager had not been previously identified by them or the provider. This meant that systems in place to monitor the quality and safety of the service were not effective.

Following the last inspection, the provider told us what they would do to make improvements within the service to ensure it provided safe and high quality care and to meet regulations. We found during this inspection however, that not all of these improvements had been made. For instance, there were still concerns regarding staff recruitment, governance of the service, adherence to the principles of the MCA, as well as the safety of the building and premises.

Policies and procedures we viewed were not current and not all provided accurate guidance to staff. For instance the recruitment policy did not reflect all of the necessary safe recruitment practices and another policy referred a regulatory body no longer in existence. A medicine policy stated that a medicine fridge should be kept under 25 degrees Celsius, when the recommended range is between 2 and 8 degrees Celsius. This meant that the policies and procedures of the service were not accurate and did not reflect current legislation or best practice guidance.

We observed care files were not all stored securely within the home in order to maintain people's confidentiality. We found archived care planning information was stored in old pharmacy boxes around the home in rooms that were not locked. This meant that people had access to confidential information regarding people living in the home that did not need it. The registered manager told us they had limited space for storage within the home, but that they would ensure people's records were stored securely.

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

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. Staff described the registered manager as, "Supportive." Staff we spoke with told us they, "Enjoy the work" and "Everybody works well as a team in order to give the best possible care to people." Another staff member told us, "Families, service users and staff all get along well together." People living in the home told us they were happy with how the home was run. One person told us, "I wouldn't change a thing."

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

Regular staff meetings were held to ensure views were gathered from staff. Records we viewed showed that staff meetings took place every few months and covered areas such as staff rotas, safeguarding, sickness policy and safe recruitment processes.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding Abbey Lawns Care Home.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	consent was not always sought in line with the principles of the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not always managed safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	safe recruitment practices were not always followed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The premises and equipment were not always safely maintained.

The enforcement action we took:

Issue a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	systems in place to monitor the quality and safety of the service were not effective. Care plans did not all provide detailed, accurate information regarding people's current care needs.

The enforcement action we took:

Issue a warning notice.