

Europe Care Holdings Limited

Abraham House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

We carried out an unannounced inspection at Abraham House on 31 January 2017.

We last inspected Abraham House in July 2015. At the last inspection on 21 July 2015 we found the provider was in breach of regulations relating to risk assessments, person centred care, safe care and treatment and meeting nutritional and hydration needs.

During this inspection we reviewed actions the provider told us they had taken to improve the service. We saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service. However, some further improvements were required in respect of person centred care planning and risks assessments to ensure a consistent delivery of safe care and treatment that could be evidenced in the longer term.

Abraham House is a residential care home providing personal care for a maximum of 30 older people with dementia. The accommodation is over two floors with a passenger lift to both floors. There are 26 single rooms and two double rooms. Communal areas comprise of two lounge areas, a conservatory and a dining room. There is an enclosed garden and a car park. There were 29 people living there at the time of our inspection.

We found the service continued to be in breach of one regulation under the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. The breach was in respect of Regulation 12, safe care and treatment. This included shortfalls in the review of risks after accidents and incidents and a failure to manage people's medicines effectively. You can see what action we have told the provider to take at the back of the full version of the report. We also made recommendations in relation to staff recruitment, staff training and person centred care planning.

The registered manager was present throughout the inspection. 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.

Before this inspection, we had received some concerning information in relation to poor personal care, dignity and respect, moving and handling of people and skin care management and lack of pressure care relief. We looked into these areas during the inspection.

Feedback from people and their relatives regarding the care quality was overwhelmingly positive. Views from professionals were mixed.

People who lived at Abraham House told us that they felt safe and there was sufficient staff available to help them when they needed this. Visitors and people who lived at the home spoke highly of the registered

manager and told us they were happy with the care and treatment.

Since the last inspection in July 2015, a new laundry machine and a new sluice room had been introduced into the home and this had led to an improvement in the management of the people's laundry, management of the risks of cross contamination and infection control. Staff had also received infection control training. A new contractor had been hired to carry out monthly health and safety inspections.

There were up to date policies and procedures in use by staff.

We saw copies of satisfaction surveys that had been completed by people who lived at the home. These surveys demonstrated people thought their care and the staff who supported them were excellent.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found there were policies and procedures on safeguarding people. Although some staff had not received up to date training in safeguarding adults; they showed awareness of signs of abuse and what actions to take if they witnessed someone being ill-treated.

Safeguarding incidents had been reported to the relevant safeguarding authority. Staff had documented the support people received after incidents. Staff had sought advice from other health and social care professionals where necessary. There were risk assessments which had been undertaken for various areas of people's needs. Plans to minimise or remove risks had been drawn however; these had not always been reviewed following significant incidents or accidents. Information in the risk assessment records did not always reflect the levels of risk on certain people.

The level of staffing on the day of the inspection was sufficient to ensure that the current number of people who lived at the home had their needs met in a timely manner. Systems were in place for the recruitment of staff and to make sure the relevant checks were carried out before employment. Robust risk assessments had been undertaken where staff had declared any previous or historical convictions. However, we found interview records and copies of identity documents were not in the staff files. We received signed statements from new staff after the inspection stating that they had been interviewed. We made a recommendation about ensuring that interview records and identity documents are kept to demonstrate whether staff had been recruited safely.

Staff had received regular training in safe management of medicines and regular medicine audits had been undertaken. On the day of the inspection we observed that oral medicines were administered safely and in a person centred manner. However, we found people's other medicines had not been managed safely. This was because the service had not effectively managed the needs of people who required topical creams. We found records relating to medicine administration had not been adequately completed to show whether people had received their medicines. Medicines disposal practices were not in line with the home's own policy and best practice guidance.

People were protected against the risk of fire. Building fire risk assessments were in place; however, improvements were required in respect of personal emergency evacuation plans (PEEPS). PEEPs for newly admitted people had not been kept with all other emergency evacuation documents also known as grab bag. This could cause delays to evacuate people in emergencies. This was rectified immediately.

Since the last inspection the provider had been responsive and proactive in improving the systems used in the recording of information about seeking people's consent and undertaking mental capacity assessments when the planning of their care. We found care planning was done in line with Mental Capacity Act 2005 (MCA). Staff showed awareness of the MCA and how to support people who lacked capacity to make

particular decisions. Appropriate applications for Deprivation of Liberty Safeguards had been made. We found nine out of 19 care staff had not received mental capacity training.

People who lived at the home had access to healthcare professionals as required to meet their needs.

Staff had received induction; however we found shortfalls in training required for the role. There was a policy on staff supervision and appraisals. Staff had received supervision however there were shortfalls in annual appraisals.

We found improvements in the way care plans had been written and organised. Some records were written in a person centred manner however, some further improvement were required as some files had been written in basic terms or jargon which did not reflect changes in people's needs. People who lived at the home and their relatives told us they were consulted about their care. The provider had sought people's opinions on the quality of care and treatment being provided. This was done through relatives and residents meetings and annual surveys.

People's nutritional needs were met. Risks of malnutrition and dehydration had been assessed and monitored. Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed.

People were supported with meaningful daytime activities. However, there were no meaningful activities in the morning. There was a dedicated activities co-ordinator employed and the service had used volunteers to support with some activities.

We noted that the environment within the home had been improved to make it as enabling an environment as possible for people living with dementia. The provider had sought guidance from a reputable source on adapting the home's environment to support the independence of the people who were living with dementia.

Management systems in the home required some improvements. The provider had provided staff with appropriate support, training and professional development. Outside consultants had been hired to help assess and improve the quality of the service. Visions and values of the service had been shared with staff, people and their relatives.

We saw that there were systems in place to assess the quality of the services in the home. There was a programme in use to monitor or 'audit' service provision to identify areas of weakness and address them. Staff told us there was a positive culture within the service. Staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people who lived at the home.

There was a business contingency plan to demonstrate how the provider had planned for unplanned eventualities which may have an impact on the delivery of regulated activities.

The majority of people felt they received a good service and spoke highly of their staff. They told us the staff were kind, caring and respectful.

We found the service had a policy on how people could raise complaints about care and treatment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

This service was not consistently safe.

Relatives felt their family members were safe. Feedback was overwhelmingly positive.

Risks to the health, safety and well-being of people who lived at the home were assessed and plans to minimise the risk had been put in place. However, these were not always reviewed after significant accidents or incidents.

People's medicines had not been safely managed because staff did not always sign medicines records and procedures for managing topical creams were not robust. Staff had been trained for safe administration of medicines.

Staff had been safely recruited and disciplinary measures were in place.

Is the service effective?

Requires Improvement ●

This service was not consistently effective.

The rights of people who did not have capacity to consent to their care were protected in line with the Mental Capacity Act 2005 principles.

Staff had received training. However, we found shortfalls in training required for their role.

People's health needs were met and specialist professionals were involved appropriately. People's nutritional needs had been met.

Is the service caring?

Requires Improvement ●

The service was caring.

People and their relatives spoke highly of care staff and felt they were treated in a kind and caring manner.

People's personal information was managed in a way that

protected their privacy and dignity.

Staff knew people and spoke respectfully of people they supported.

Is the service responsive?

The service was not consistently responsive.

People had plans of care which included essential details about their needs and outcomes they wanted to achieve. Care plans did not always reflect people's needs and reviews did not cover changes in people's circumstances.

The provider had gained the views of people who used the service and their representatives. Care files had not always been reviewed following significant incidents.

People had been provided with appropriate meaningful day time activities and stimulation to keep them occupied.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment. Complaints had been dealt with in line with policies and procedures.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

There were adequate governance systems within the service. Management oversight had been provided to care staff and the overall running of the service.

We found shortfalls relating to people's safety, in relation to medicines. Systems for monitoring staff training and development were not effective.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the service were implemented to improve the care and treatment people received.

Staff told us there was a good culture in the service and were kept up to date with the visions of the service. Best practice and research were used to improve the service.

Requires Improvement 

Abraham House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 31 January 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. There was also one specialist professional advisor, who had expertise in the care of older people and those living with dementia.

Before the inspection we had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Before the inspection we gained feedback from seven health and social care professionals who visited the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts, information from whistle blowers and statutory notifications sent to us by the registered provider about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us. We reviewed information from the local commissioning group and the local authority, also information that had been shared with us from other professionals and comments and feedback that we had received from staff, relatives and visitors of people who lived at Abraham House.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spent time talking with six people who lived at the home and five relatives to gather their views on their experience of the care and support provided by the service. We also spoke with 10 staff and six visiting professionals, the owner who was the nominated individual and the care consultant. We reviewed records and management systems and also undertook observations of care delivery.

Is the service safe?

Our findings

We received positive responses to questions we asked people who lived at Abraham House about their safety. People told us that they felt safe in the home and there was no bullying at the home either from the staff or from other service users. People who lived in the home we spoke with told us they were happy with the cleanliness of the home. On the day of the inspection we found the home to be clean.

We asked people and their relatives if they felt safe. Comments included: "Feel safe here, yes I do.", "They do look after me really well.", And; "I'm safe and able to say what I want, oh yes." Comments from relatives included, "Staff I had reservations about have left now (rushed residents and roughly handled them) I mentioned it to the registered manager in autumn 2016 and they've left now.", "Safe? very much so, staff are very reassuring." The registered manager confirmed that the staff members who had been reported to be rough handling people had been dismissed and no longer worked for the service.

During the inspection we observed people were comfortable around staff and seemed happy when staff approached them.

At the previous inspection of this service in July 2015 we identified a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because individual risks were not always accurate or completed in care plans and fire safety measures had not been followed robustly. After our last inspection the provider sent us a report telling us the actions they had taken to ensure risks around people's care were managed and accurately recorded.

During this inspection we found a considerable amount of work and monitoring had been done to meet the regulation. People had risk assessments which identified their risks in respect of malnutrition, choking, allergies; self-harming and fire safety procedures had been improved. Although some improvements had been made in respect of recording risk assessments in people's files, we found there were shortfalls in the risk management processes and reviews of risks assessments after accidents and incidents.

We looked at how people were protected against risks of not receiving care and treatment. Risk assessments had been completed which included the risks associated with malnutrition, allergies, food and fluid intake, mobility and personal care. However, whilst the care records we reviewed showed that risk assessments had been written, the information they contained did not always reflect the level of risk associated with the individuals. For example, one person had experienced two falls including one fall that resulted in a serious injury and hospital admission. We looked at the falls risk assessment which acknowledged the fall and the serious injury however the risk level had been assessed as low risk of falls.

Similarly we noted another person who had experienced frequent falls had a risk assessment which indicated they had a low risk of falls. This meant their risk assessments were inaccurate and did not reflect people's current needs.

We looked at how people were supported following significant incidents or accidents. We found accident

and incident forms had been completed following incidents and medical attention was sought in a timely manner. However, we found in three people's reviews (completed following the accidents or significant incidents) that it was not recorded how the incidents were to be prevented in the future. In addition protection plans had not been devised to inform staff how to ensure risks or re-occurrences were reduced. For example, one person suffered a serious injury following an incident in the home. On discharge from hospital a review was completed however, this did not address why this person was admitted to hospital and what measures had been put in place to protect them from similar incidents. This meant the provider had not demonstrated how they had learnt from this incident and sought ways on how to prevent it or reduce the risk in the future.

We also noted that care plan and risk assessment reviews completed needed to be improved to ensure they provided enough detail about changes in people's needs in a person centred manner. For example reviews we looked at contained a generic phrase which stated 'Continue as above, report and record any changes, concerns to the person in charge who will seek assistance from relevant professionals.' This was repeated in subsequent reviews in the care files without providing adequate detail on changes in people's care.

There was a lack of robust risk assessment and management. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at the risk assessments in place concerning fire safety and how people would be moved in the event of an emergency. We saw the service had contingency plans in place and personal emergency evacuation plans (PEEPS) should people who lived at the home ever need to be moved to a safer area in the event of an emergency. These documents gave guidance to care staff on how people needed to be supported in an emergency including the closest fire escape to their room. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. However, PEEPS were not all kept in one place which was easily accessible in the event of an emergency. This is also called a 'grab bag'. This could cause delays to evacuate people in emergencies. The registered manager acted on this immediately.

We looked at how risks around the premises were managed and found the premises had been well maintained. Building and fire risk assessments had also been undertaken. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly and any recommendations made by external fire inspectors had been acted on and completed in a timely manner. Fire evacuation drills were undertaken regularly to ensure staff and people were familiar with what to do in the event of a fire.

People who lived at the home and their relatives told us, that medicines were given correctly, on time and as prescribed by their doctors. We observed one person being given medicines. They were handed it in a medicine pot, with a drink to help them swallow the tablets. The staff member explained what the medicines were for when the person questioned why they were taking the medicines. The staff member checked that the person had swallowed the medicine before signing the administration chart.

We looked at the arrangements in place to manage people's medicines. We saw medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Controlled drugs were stored in suitable locked cupboard and access to them was restricted with appropriate checks in place.

Medicines audits (checks) were in place and we saw monthly checks carried out by the registered manager and regular audits by the local pharmacist. Actions had been taken where concerns had been identified. Staff who administered medicines had received suitable training to allow them to carry out their duties

safety.

Records of thickening powders used to thicken fluids for people with swallowing problems had been clearly recorded and the prescription information had been made available to care staff. Information was available to care workers about how to use them for individual people and records had been completed to demonstrate when they were being given. This was a noted improvement from the last inspection in July 2015.

However, we found topical medicines, such as creams were not well managed. Records showed that medicines administration records (MAR) for topical creams had not been consistently signed to demonstrate that staff had applied the creams where required and as prescribed. This meant it was not possible to determine if the prescribed creams had been applied correctly.

We noted not all staff had been observed to check if they were competent in the administration of medicines. We spoke to the registered manager and the nominated individual who informed us they were aware of the concerns in the way creams were handled. They told us they were developing and introducing new paperwork and monitoring systems to improve safety in this area. They also acknowledged that staff competence in medicines administration and management had not been fully completed and that assured us arrangements would be put into place to carry out the observations.

Medicines disposal practices were not effective and did not follow the home's medicine disposal policy and best practice. We reviewed the medicine disposal records and found the book had not been signed by the collecting pharmacist to demonstrate what medicines they had collected for safe disposal. Although records showed a medicine bin had been collected, they did not demonstrate what medicines had been collected as required by NICE guidance. The organisation's own policy stated that: 'The medicines will be taken to the originating Pharmacist along with the Medicines Disposal Book or form by a designated person. The Pharmacist will verify the returned medicines and sign the Medicines Disposal Book / Form which is then brought back to the Home and kept in the Treatment Room as before.' This policy had not been followed. We spoke to the registered manager who explained that the home had moved to a new pharmacist with different disposal procedures to what their existing policy was however the policy had not been updated to reflect their new working practice.

There were failings in medicines management and administration systems at the home because the provider could not always demonstrate that medicines were being safely handled. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected from bullying, harassment, avoidable harm and abuse. We found the service had procedures in place to minimise the potential risk of abuse or unsafe care. Records seen showed some staff had received safeguarding vulnerable adults training others had not. However, the staff members we spoke with understood the types of abuse and described examples of poor care people could experience. This demonstrated they had an understanding of safeguarding vulnerable adults.

The service had whistleblowing (reporting poor practice) procedures. Staff spoken with told us they were aware of the procedure. They said they would not hesitate to use this if they had any concerns about their colleagues' care practice or conduct. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

Before the inspection we had received concerns regarding the level of care people received. We shared the concerns with other professionals at the Local Authority Safeguarding Enquiries Team. At the time of our

inspection some investigations had been undertaken and no concerns had been substantiated. After the inspection we received the outcomes of the investigations which showed that some of the concerns raised had been partially substantiated and some not substantiated. Recommendations had been made by the safeguarding professionals for the provider to consider.

We found the registered manager had followed safeguarding reporting systems as outlined in the home's policies and procedures. We noted during the inspection that contractual arrangements were in place for staff. These included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures. We noted the service had followed their procedure effectively in regards to misconduct by a staff member. The registered manager and the nominated individual told us all staff had been issued with a code of conduct and practice.

We looked at how the provider managed staffing levels and the deployment of staff. We requested a month's staffing rotas including the week of the inspection. We found the rotas indicated there were sufficient staff available for the 29 people who lived at the home. The registered manager was on duty five days a week to oversee care and senior staff on day shift across the week and at the weekend to help supervise staff. There were two staff on duty at night.

The registered manager told us that the staffing levels were kept under review and were flexible in response to the needs and requirements of the people who lived at the home. This monitoring of staffing against dependency would be essential when people's needs changed and more staff were needed to meet people's individual needs.

Several new staff had been appointed since we last visited the service. We looked at the records of seven staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home.

Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed. However; records were not present to demonstrate that interviews had taken place prior to them being offered employment and that people's identity had been verified. We discussed with the registered manager who informed us that they had seen the identity documents and copied them as well as completed interview records however they destroyed the documents soon after the recruitment process. Following the inspection we were provided with signed statements from new staff stating that they had been interviewed.

We recommend that the registered manager consider current best practice and guidance, seek advice and guidance from a reputable source in respect of safe recruitment, and take the appropriate action to update their practices accordingly.

Before the inspection we received concerns in respect of cleanliness and good hygiene. During the inspection we found the service to be clean and staff were following good levels of hygiene practices. We found a new laundry machine had been purchased to improve management of people's laundry and a new sluice room had been developed. A member of staff had been designated as an Infection Control Champion. This member of staff was responsible for sharing good practice around infection control and carried out audits. However, we found areas that could be improved and the infection control audits were not available for us to review on the day of inspection. We spoke to the registered manager and the nominated individual regarding this and they informed us the staff member in charge of this area was off duty. The infection control audits were sent to us after the inspection and demonstrated that cleaning schedules had been

undertaken in line with the home's policy.

After the inspection we were informed that a visit was arranged to audit the home by the local authority 'Infection Prevention and Control Team' in February 2017. The registered manager and the safeguarding team contacted us and informed us that this had been completed and no concerns had been found. They added that the home was commended for cleanliness of the environment.

Before the inspection the home was inspected by the Environmental Health Agency and some concerns were raised regarding the management of risks associated with Legionnaire's disease. As a result the provider was required to take actions to ensure they complied with the related regulations.

We found that the registered provider had acted promptly to address the issues raised and had carried out the actions required. The home now had a specialist consultant who audited and checked water temperatures and related areas for prevention of Legionnaires disease. We saw that cleaning regimes had been implemented and were monitored and that action had been taken to test water temperature monthly, and to upgrade sluicing facilities. This helped to maintain a clean and safe environment for people who lived at the home.

A range of certificates demonstrating that facilities and equipment within the home, such as fire safety equipment and lifting equipment, water testing were regularly checked. Current gas certificates were available to show these facilities had been checked by external contractors. We found the provider had carried out maintenance checks.

Is the service effective?

Our findings

People who lived at the home and their relatives told us they felt their needs were effectively met. Comments included; "I'm visited by my son and daughter, they are made to feel welcome." Another person told us, "I go down for breakfast, I have lunch and tea in my bedroom, the food is still hot. And; "Staff just leave me alone, I'm not rushed." Comments from relatives included, "The home environment is very important to me it is very, very tidy.", "There will be times of spills and accidents but somebody is there straight away and its sorted out." And: "The staff got her to eat a lot more than she did at home."

At our previous inspection of Abraham House in July 2015, we found the service had not taken effective action to ensure people's nutritional and hydration needs were effectively met. This was because people's fluid intake was not adequately monitored to ensure they received enough to drink and nutritional care plans did not always identify the details on the prescription to ensure the correct use of thickening powders. This was a breach of Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014). After our last inspection the provider sent us a report telling us the actions they had taken to ensure people's nutritional and hydration needs were met.

During this inspection we checked to see what improvements had been made. We could see that significant and productive work had been done by the registered manager and staff to improve meal time experiences, care practices and the recording and monitoring of people's fluid intake to show they had met the breaches found at the last inspection.

All of the care plans we looked at contained information on specific dietary needs, preferences and any intolerances. People who lived at the home had an individual nutritional assessment and records were made of people's weight in order to monitor for changes or fluctuations which may require medical advice. There was also information on people's dietary needs such as diabetic diets and soft meals. We saw evidence of records completed on dietary intake charts, positional changes and weight monitoring. We could see that a nutritional assessment tool was being used and was discussed with staff during their supervision.

At our last inspection, there were concerns regarding recording and monitoring of fluids taken by people. We checked this on this inspection and found significant improvements. All drinks and totals fluids taken were recorded and if people had not received recommended amounts of drinks action was taken by the staff to ensure people had enough to drink.

We spoke to the cook on duty at the service around the needs of people who required a soft or textured diet. Nutritional support had improved however; we observed limited options were available for snacks and for mains for people requiring soft diet. We observed there were no snack provisions available to these people except for yoghurts. The cook told us how she had fortified the lunch that day with cream and butter in the mashed potato. This was to help people who had lost weight. We also saw evidence that kitchen staff had access to details of people dietary requirements. The registered manager told us they would look into alternative snacks of people who had soft textured diet and that they had employed a new cook for the

service who would be starting imminently and that the cook on duty during our visit was standing in.

The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their needs. For example, referrals had been made in a timely way to the dietician.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found a significant improvement in respect of mental capacity assessments. At our previous inspection we found DoLS applications did not tell what the application for deprivation was for. We also found mental capacity assessments were not decision specific and did not demonstrate how the assessment was completed and decision was reached.

The provider had suitable policies and procedures in place to guide staff practice and staff had been trained to improve their understanding of the principles of the MCA. During the inspection we looked at people's records and saw that the registered manager had applied to the relevant supervisory authorities for deprivation of liberty authorisations for people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible. We saw evidence showing how the registered manager was tracking the progress of the applications with the Local Authority.

During the inspection, we observed staff gained people's consent before undertaking care tasks. Staff showed a good understanding of gaining consent in practice. We saw evidence of how the service was implementing best practice. For example one person had previously had their medicines given to them covertly in a different care home; the staff had reviewed this situation and were now administering their medicines with their consent. Covert administration of medicines is where a person receives their medicines in a disguised form and without their knowledge.

The service had procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests. The records on the process showed how relatives, health professionals and senior care staff had been involved when needed to make sure decisions were only being made in that person's best interest. The registered manager showed a clear understanding of the principles of the MCA and records indicated they were applying them in practice.

Some staff had received training on the MCA however the majority were yet to be trained. However, the staff we spoke with were clear about obtaining valid consent from people or their representatives when decisions were being made in people's best interests.

We noted that the information around who held Power of Attorney for a person was being recorded so staff knew who had this in place. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs.

We found the provider had provided training to care staff in various areas of care delivery. Staff informed us they were provided with comprehensive induction training to prepare them for their role. We saw records which showed some of the staff had completed training which included safeguarding adults, MCA and DoLS, moving and handling, medicine management, fire safety and food handling. We saw evidence that further training in the Care Certificate was being provided by the local hospitals. This is a qualification for people working within the care industry. Staff we spoke to stated that they had felt this improved their skills and knowledge and they enjoyed this training. We were also informed some staff had acquired qualifications such as Qualifications and Credit Framework (QCF) level two and three and two were completing level five. This qualification had been offered to all staff who were employed by the service.

However, we found shortfalls in the training and competence checks. Not all care staff who had been employed at the service had completed training in a number of areas such as challenging behaviours, dignity and respect, falls awareness and risk assessments. Records we saw and our conversation with the nominated individual and the registered manager confirmed that a number of the training courses were due for renewal and that staff had been asked to complete these and were yet to complete them. The evidence that we received at the time of the inspection did not demonstrate that all staff who were due to undertake training had completed their training and their competence checked. We recommend that the registered manager and the nominated individual consider current best practice and guidance, seek advice and guidance from a reputable source in respect of systems for providing and monitoring staff training.

Staff told us they felt that the team at the home worked well together. One staff member told us, "We have a strong team here." Staff told us they received regular supervision from the registered manager however, the majority of staff we spoke with had not received an annual appraisal of their work performance.

We looked at the premises and people's bedrooms and found they were clean, warm, well presented and people had personalised their bedrooms with their own possessions. The provider had adapted the premises and environment to ensure it was suitable for people living with dementia.

We saw evidence to demonstrate that the provider had taken consideration of research and current good practice in dementia care (for example, Department of Health National Dementia Strategy, Kings Fund). This highlights that attention needs to be given to establishing environments that enable people who are living with dementia to find their way around independently. We found that a set of actions had been produced from this and were being worked on. For example, there were clear signs (using pictures and words) and new flooring in the main lounge to help enable people living with dementia to move around more confidently. This demonstrated good practice.

We looked at how people were supported to maintain good health, access community health care services and receive on going health care support. There were links with the local primary health services and professionals such as district nurses, dieticians, doctors, and community mental health practitioners came into the service to offer support regularly. People we spoke with told us they were able to access health care services as required. Healthcare professionals informed us the home was proactive in referring people for specialist support in a timely manner and that advice they had given was taken on board.

Is the service caring?

Our findings

We asked people if the staff team were caring. Comments included, "Very good I like it here, they do their best." And; "I think they've been great, it's a lovely place.", "Just a home to me I'm happy enough here" and "I wouldn't swap them for anything."

Similarly relatives told us, "[Family member] wanders at night, they don't force her into bed they sit and chat with them." Another visitor told us, "They couldn't have been kinder, absolutely marvellous with her", "I think it was down to staff and their care that [family member] didn't die several months ago, they nursed her here, they're lovely and never gave up on her."

At the inspection in July 2015 we found concerns that people were not always supported to maintain their dignity. This was because staff had been observed to discuss people personal needs in communal areas. During this inspection, we spoke with people who lived at the home and their relatives and made observations of staff interactions throughout the day.

During this inspection we observed several caring and appropriate interactions between staff and people who lived at the home especially when assisting them to sit down or moving around the home. Staff treated people with dignity. We saw one staff member who was assisting someone to drink with an adapted beaker. The staff member took their time and explained the process to the person along the way. We saw that people who lived at the home responded well to staff. One person told us, "I love the girls here."

However, we observed that twelve people who lived at the home were up and dressed in the dining room when we arrived at 8 am. We saw one person asleep at the table in the dining room. We had received concerns regarding this before the inspection. People we spoke to expressed that they could get out of bed when they wanted to. During the inspection we observed people who had chosen to stay in bed until late morning. We spoke to the registered manager and the nominated individual and they assured us that people had a choice of staying in bed as long as they wanted. Following the inspection they send us information demonstrating that some people choose to get up as early as 6am and that staff support them. They also informed us that the person who we observed sleeping in the dining room had unsettled nights.

We saw evidence the registered manager had undertaken night time spot checks to monitor staff. Staff we spoke with informed us they were aware of people's choices and preferences and respected them. The registered manager advised us that they would be reviewing people's care plans and undertake further checks on staff. The information on why people had been up in the morning had not been recorded in the care files that we checked however, we have been informed that this had been recorded following the inspection.

We spoke to professionals who visited the home; views were mixed. Four professionals informed us that they felt staff were caring and witnessed warm relationships between carers and people when they visited. Two professionals however, raised concerns regarding people not receiving personal care in a timely manner and how certain staff had been witnessed speaking to people. During the inspection we did not observe any

inappropriate interactions. We looked at minutes of staff meetings and noted staff had been conversations with staff about ensuring they spoke to people with dignity and to call people by their preferred names. We saw shortfalls in training around dignity and respect. We spoke to the nominated individual and informed him of these views and they gave us assurance that this would be addressed.

People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. People told us and we saw from the records, that people were able to follow their own beliefs.

Relatives of people who lived at Abraham House told us they could visit anytime, they informed us they only avoided visiting at meal times as the home operated a 'Protected meal time policy'. The purpose of the protected meal initiative was to allow people to eat their meals without unnecessary interruption and to focus on providing assistance to those people unable to eat independently. Relatives were invited to support with meals if they wished to and felt welcomed. This meant that people were able to continue maintaining important relationships in their lives.

We saw that staff knocked on bedroom doors before entering and ensured doors were closed when people were receiving personal care. We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

We observed doll therapy being used effectively at the service. Doll therapy is a practice where adults living with dementia are provided with a doll to help ease anxiety, agitation and aggression.

We saw that using doll therapy had a calming effect on some of the people who lived at Abraham House. Staff showed compassion in how they dealt and managed these situations. We saw that one staff member had brought in additional clothing for the doll and another staff member offered appropriate reassurance. However, people's care plans had not been updated to reflect the use of doll therapy. This is important to ensure people receive consistent care and support. The registered manager and the nominated individual assured us that care plans will be developed for all people who benefitted from this therapy.

There was information available about advocacy. Advocates support people to access information and make informed choices about various areas in their lives. Relatives that we spoke with informed us that they had been more involved in the care of their family members. People's views about their care support had been sought. We saw copies of satisfaction surveys that had been completed by the people. These surveys demonstrated people thought their care and the staff who supported them were excellent.

The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people who lived at the home.

We found evidence of end of life care plans in people's records. Some staff had been provided with training on how to care for people towards the end of their life. This meant that people could be assured they would receive end of life care in line with their wishes.

Is the service responsive?

Our findings

We asked people who lived at the home if they felt their needs and wishes were responded to timely and appropriately. Comments included, "I'm not going to start complaining because there is nothing to complain about." Another person told us, "I go up and down in the lift every day, no problems; I can do what I want, when I want."

One relative told us, "The odd time staff have to call a Doctor or need a blood test, they're on the phone to inform me.", "Every three months or so I sit down with the Registered Manager and go through care plan." Another relative said, "I trust them to gauge how he is, there is good communication and I feel I can come and talk to them anytime."

At our previous inspection in July 2015 we found the service had not taken effective action to ensure people's care was person centred. This was because people's records had not been written in a way that provided adequate detail to enable staff to care for people in accordance with their individual needs and preferences and people had been observed to have their needs unmet for long periods of time. This was a breach of Regulation 9 of the Health and Social Care Act, 2008 (Regulated activities 2014)

During this inspection we checked to see what improvements had been made We found that significant work had been done by the registered manager and staff to improve the care records, to include people's preferences, likes and dislikes. Records demonstrated people and their relatives had been involved in the review of their care. However, we found some improvements were still required to the care records in respect of person centred care planning and accuracy of the records.

We looked at how the service provided person centred care. We found assessments had been undertaken before people were admitted to the home to ensure the service was the right place for them. A care plan had then been developed outlining how these needs were to be met. During the last inspection in July 2015, we found improvements were required around person centred care planning.

We looked at six people's care plans. We noted the care plans were held on a secure computer system and staff told us they had full access to this information. We found the care plans were organised and clearly written. They also included people's personal preferences, life histories, and aspirations. However three of the care plans we reviewed were not very person centred. For example we saw one plan that recorded '[name removed] requires mobility aids' and went on to record the action as 'ensure aids are accessible and working.' This information did not contain sufficient detail to provide care to this person and was not person centred.

We saw another person's plan around social support that recorded 'promote therapeutic activity.' We saw one plan that recorded 'X pads are worn as allocated' and another that recorded an outcome as 'became more concordant.'" We asked a staff member what this meant and they did not know.

People's care records were reviewed for effectiveness, however; this was not consistent throughout the files we looked at. We found in the files that we looked at care records had been reviewed monthly however, in four of the files significant incidents or accidents had occurred but had not been included in the reviews to demonstrate the change in people's needs or level of risk. This meant that care plans did not always reflect accurate information on people's risk.

We spoke to the registered manager who told us that they wrote most of the care documentation but acknowledged this was hard and new senior staff would start to take on more of this role moving forward. We recommend that the registered manager consider current best practice and guidance, on completing care plans and reviews and take the appropriate action to update their practices accordingly.

We reviewed how the service responded to complaints. We looked at the policies and procedures along with information provided to people and their relatives. People had been fully informed on how to make any complaints and were given detailed information on how or who to contact. The procedure was on display in the hallway and in the passenger lift. People we spoke with confirmed they knew how to make a complaint. We saw a significant number of compliments which were displayed in the entrance hall. We saw people had made positive and complimentary comments about the service. We also found the service had received one formal complaint which had been dealt with in a timely manner and in line with the organisation's policies. Appropriate steps had been taken to investigate the complaint.

People were provided with suitable activities to occupy their time in a meaningful way. There was a National Association for Providers of Activities for Older People (NAPA) accredited activity co-ordinator employed by the provider to facilitate appropriate activities in line with their preferences. We observed her working with people in a person centred manner and putting significant effort to ensure each individual took part in the activities. We heard her saying to one person; "Do you want to do some singing with me?" She was holding both of the person's hands and looking into their eyes to ensure a good level of communication. She went around all residents in the room politely trying to get them to engage. People were later seen to be dancing to music with the coordinator.

There was a choice of activities to suit different people. We saw activity plans which included, crafts, signing and board games and performers. People had suggested their own activities and these were considered. We found the service had encouraged relatives to join in with activities within the home. This had helped improve participation in arranged activities and people did not always have to wait for the activity coordinator. However, adequate stimulation was required in the morning as we found there were limited meaningful activities. We spoke to the registered manager and they assured us that they would review their staff deployment. We were assured that this would resolve the lack of stimulation in the mornings.

Two visitors told us that there was often music and singing arranged in the home and that outside musical entertainers visited on a regular basis. We observed people dancing whilst music was being played and they appeared to enjoy the activity, joined in the song with enthusiasm.

We looked at how people were supported to maintain local connections and take part in social activities. We found people were encouraged to maintain local community links. People and their relatives told us they were fully supported with this involvement. People were supported to maintain contact with their families.

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). We received overwhelmingly positive feedback from people and their relatives regarding management and the provider.

We also received mixed feedback about management from staff. Comments included: "The manager is firm but fair", "The manager is supportive" and "I don't like the way the manager speaks to staff or to residents.", "Oh yes, quite easy to talk to", And: "Anything I want just knock on door (of Registered Manager) and get listened to."

We spoke to health care professionals about their views on the service and management. Majority of the views were positive however, we received some feedback from professionals expressing that at times they did not feel listened to or supported by the service. We shared the feedback with the nominated individual who assured us they will resolve this by having a discussion with their staff and the professionals who visited the service.

Staff told us there was a positive culture within the service and everyone got along well. They informed us they felt supported to do their job and were equipped with skills and knowledge as required.

The registered manager told us in their provider information return (PIR) 'We have achieved the Investors in People (IPP) Gold standard. Gold is only awarded to the highest performing organisations that can prove outstanding leadership.', 'The official IPP report stated that; "Abraham House is an impressive Home which: (a) has a clear understanding of what it wants to achieve, how this will be achieved and the values that underpin its objectives, which are understood, shared and supported by the people who work there.' IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management.

At the last comprehensive inspection in July 2015, we identified the service was not meeting regulations in relation to person centred care, meeting nutritional and hydration needs and maintaining people's safety. At this inspection, we identified that the registered manager and the provider had put a significant effort to make improvements to address the shortfalls. Although there were areas which continued to require further improvements, we found that there were clear values and visions on where the service was going and significant efforts had been made to follow best practice and research.

We saw evidence to demonstrate that the management and leadership at the home were willing to learn and develop the service based on best practice. For example we noted the registered manager had written on their PIR 'We consult with subject matter experts and we subscribe to a range of network/initiatives that provides us with regular updates on best practice. For example Social Care Institute of Excellence (SCIE), National Institute of Clinical Excellence (NICE), Skills for Care, Lancashire County Council, Lancashire Care Association (LCA) CQC, Registered Nursing Home Association (RNHA), National Association for Providers of Activities for Older People (NAPA), Croners, Kings Fund, Alzheimer's Society, Stirling University Dementia

Services Design Centre, and Bournemouth University Dementia Institute.' We saw evidence to demonstrate how some of this knowledge had been used to improve the service for example the Kings Fund Audit which was used to improve the environment. This meant Abraham House had maintained links with external organisations.

During this inspection we identified a breach of regulations relating to medicine management and risk management. We also made recommendations in respect of person centred care planning, staff recruitment, training and appraisals. This demonstrated that the arrangements for assessing quality and safety required further improvements to ensure they were effective and robust in identifying concerns.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication was described by staff as being "excellent", with regular staff meetings, handover every day, a communication book and notice board. We looked at the minutes of a recent staff meeting. Topics discussed included reminders for staff to follow, moving and handling procedures and ensuring wheelchairs were in good working order and clean.

There were a significant number of quality assurance systems and tools for auditing the service. Following our last inspection in July 2015, the provider had introduced a consultant to audit health and safety aspects in the home, a legionnaire's inspector and a care consultant to audit the quality of the care people received and governance systems in the service. We saw that the home's external consultant made regular visits to the home to check the monitoring and audits within the home. This included, checking recruitment, that staff training was up to date, looking at any complaints and checking what activities had been made available to people. They spoke with people living there and staff and checked their supervisions and monitored the internal audits. Records were kept of the visits and the action plan and timescales for action for any outstanding issues. The person responsible to take any action to improve was stated and a timescale was placed on the completion of follow up actions.

We found audits had been undertaken for various aspects of care delivery including care plans, premises, care quality audits and medicines. Infection control audits were not available for us to review.

A wide range of policies and procedures were in place at the service, which provided staff with clear information about current legislation and good practice guidelines. These had been reviewed regularly to make sure they were updated to reflect any necessary changes. A new set of policies had been written in line with current practice and were due to be introduced. People were actively encouraged to be involved in the running of the home. We saw meetings were held and minutes of recent meetings showed a range of issues had been discussed.

There was a Residents Committee which comprised of people who lived at the home, their relatives and volunteers who visited regularly and facilitated with activities as well as listening to people. A resident's committee newsletter was produced to keep people informed of any developments and upcoming events. This was complimented by a resident's newsletter which had been designed to ensure it was suited for people living with dementia. Staff meetings were used as opportunities to plan ahead.

We found the provider had systems in place to enable them to learn from significant incidents such as accidents, or safeguarding concerns however this was not robust and needed to be improved. Local safeguarding board protocols for reporting incidents had been followed. However these had not been fully implemented as we found reviews did not always address causes of incidents and protection plans were not always drawn following incidents.

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities. Incidents and accidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. Maintenance checks were being done regularly by staff and records kept. We discussed the need to ensure documents were kept in an organised and secure manner and in a way that they are accessible to staff who deliver care.

The service had a business contingency plan to show how they would deal with unplanned events that affect the delivery of regulated services.

We spoke with the nominated individual and the registered manager during the inspection. Both were responsive to any issues raised and proposed courses of action to make necessary improvements. We discussed in detail with the registered manager and the nominated individual the level of improvements made in the home and the challenge for the service to continue to improve and move forward.

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
Diagnostic and screening procedures	The provider did not have adequate medicine management and administration systems in place at the service and systems for assessing and managing risks were not robust.