

Care One Limited

Abbey Care Home

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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This comprehensive inspection took place on 25 January 2017 and was unannounced. Abbey Care Home provides accommodation and personal care and support for up to 11 older people, some who may be living with dementia. At the time of our inspection there were 11 people who lived in the service.

This inspection was to see if the provider had made the improvements required following an unannounced comprehensive inspection at this service on 13 January 2016. At the inspection in January 2016 we had found four breaches of legal requirements in relation to Regulation 12, 17, 18 and 20. We issued a warning notice for regulation 12 which was to be met by 30 May 2016. A focused inspection in June 2016 to follow up on the warning notice confirmed that it had not yet been met in full. We therefore imposed conditions on the provider's registration. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance. The overall rating from the inspection in January 2016 was Requires Improvement. One domain of 'Safe' was rated as Inadequate at that time.

At this inspection we found improvements had been made, however we found some areas which still required attention. We found a further breach in relation to regulation 12 with regard to care and treatment being provided in a safe way for service users. We also have made some recommendations in relation to staff training provision, activity provision and frequency and effective monitoring of the service.

The service had a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection we found people were supported by staff who understood how to recognise and report abuse. The risks connected with people's care and support needs had been assessed and plans introduced to manage these. The provider assessed and organised their staffing requirements based upon people's care and social needs.

Safe recruitment practices were in place which ensured that staff who provided care were suitable to work at the service.

People were supported to take their medicines safely and when they needed them. Medicines were stored safely and only staff who had received training and been assessed as competent were able to support people with their medicines.

Staff had received training to equip them with the skills and knowledge to understand and support people's individual needs, however this was not always done safely. These skills were kept up to date through regular training and staff were also supported in their roles by managers and their colleagues. The provider did not provide specific enough training in areas such as understanding dementia and a variety of training course

forums were not explored. This is an area for improvement.

People's right to make their own decisions and give their consent to their day to day care and treatment was sought and respected by staff. Staff asked people's permission before they helped them with any care or support. When people could not make their own decisions regarding their care and treatment the provider made sure decisions were made in their best interests to ensure their rights were upheld lawfully.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals and appropriate referrals had been made by the service. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals.

People were supported to have enough to eat and drink and risks associated with this were assessed and monitored by staff and other healthcare professionals. Staff followed the guidance of healthcare professionals where appropriate and helped people to access healthcare services. People's routine health needs were monitored and they had health care plans in place to make sure they received on-going healthcare support.

There was a friendly atmosphere within the service. People were treated with kindness and respect and were involved in making decisions about their day to day care and the support they needed. Staff were attentive to people's needs and knew them well. Staff supported people in a way that was caring and promoted their right to privacy and dignity. Where people were not always able to express their needs verbally we saw that staff responded to people's non-verbal requests and had a good understanding of people's individual care and support needs.

People received care and support that was tailored to their individual needs and preferences. They were supported to spend their time how they wanted to but a structured programme of activities provided or outings was not available. This is an area for improvement.

The planning and delivery of care for most people did ensure the welfare and safety of people using the service. Care plans and records reflected people's current needs including condition specific guidance in relation to conditions such as dementia and how they affected the person.

People and their relatives were given opportunities to provide feedback on the care they received including raising concerns or complaints. Systems were in place to gain the views of people, their relatives and health or social care professionals.

The service assessed and monitored the quality of service provision, however this required further time to show processes and procedures in place were sustainable and the service could maintain compliance. Risks to people were being managed but staff had not all been proactive in assessing the risk and providing care safely. Evidence we were shown did not highlight fully that systems were in place to identify, assess and manage all risks related to the service. Documentation was brief and non specific and whilst we note a number of audits were taking place we still need to be assured sufficient actions have been taken to mitigate any risks identified and ensure people's needs are met safely.

You can see what action we told the provider to take at the back of the full version of the report.

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 

The service was not consistently safe.

Risks to people's safety were not always well managed. The service was not always proactive in assessing the risk to ensure people's safety.

Staff understood their responsibilities to safeguard people from the risk of abuse.

People were safe because staff were only recruited after all essential pre-employment checks had been satisfactorily completed.

Staffing levels were flexible and organised according to people's individual needs.

People had their prescribed medicines administered safely.

Infection control practices at the service were safe.

Is the service effective?

Requires Improvement 

The service was consistently effective.

Mental capacity assessments were completed and consent was sought about the care and support people needed.

Staff training was not always specific enough to meet people's individual needs.

Systems were in place to ensure that staff received regular supervision and support.

People had enough to eat and drink to maintain good health.

People were supported to attend healthcare appointments and staff liaised with other healthcare professionals as required.

Is the service caring?

Good 

The service was caring.

Staff treated people well and were kind and considerate.

People were treated with respect and their privacy and dignity was maintained.

People were supported to maintain important relationships and relatives were consulted about their family member's care and support.

Is the service responsive?

The service was not consistently responsive.

People received person-centred care from staff who knew them well.

Activities took place but a structured programme had not been developed. Records relating to these were not all reflective of people's current activities and interests.

Feedback from people was encouraged and there was a complaints system in place.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

Quality assurance systems and audits were in place to monitor performance and to drive continuous improvement. This inspection evidenced the changes being made showed the provider was actively addressing the concerns we found at the last inspection. The rating has however stayed as 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' would require a longer term track record of consistent good practice.

The home had a registered manager in post who was a visible presence. We received positive feedback from the staff, people who lived at the home, relatives and health professionals about the leadership and overall management of the service.

The culture of the home was open and transparent and staff told us staff morale had improved.

Requires Improvement 

Abbey 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.

The inspection took place on 25th January 2017 and was unannounced. This inspection was carried out to check that improvements to meet legal requirements had been made by the provider following our comprehensive inspection on 13 January 2016.

Following the comprehensive inspection on 13 January 2016, we asked the provider to take action within a given timescale to make improvements to the physical environment of the service which posed risks to people's health and safety. We followed this up with a focused inspection completed on 27 June 2016. The actions taken were not all confirmed as completed at that time and we imposed conditions on the provider's registration.

The inspection team consisted of two inspectors 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 care service.

Before our inspection we reviewed the information we held about the service, which included the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the Local Authority and asked them about their experiences of the service provided to people. We also looked at the action plan supplied by the provider and considered information which had been shared with us by the Local Authority

We focused on speaking with people who lived at the service who were able to verbally express their views about the service. We also spoke with staff and observed how people were cared for. Some people had complex needs and were not able, or chose not to talk to us. We used the Short Observational Framework

for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed the care and support provided to people and the interactions between staff and people throughout our inspection. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care and support in the lounge, communal areas and during the lunch time meal

We spoke with four people who lived in the service, four care staff members, three relatives, one health care professional and the manager . We also spoke with members of the local authority safeguarding and quality improvement teams.

We looked at four people's care records, staffing rotas and records which related to how the service monitored staffing levels. We also looked at information which related to the management of risk within the service such as infection control records, quality monitoring audits and checks on the environment. We looked at the premises and reviewed risk assessment and management documentation.

Is the service safe?

Our findings

At our inspection in January 2016 we found the service had insufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. A subsequent focused inspection in June 2016. Identified additionally the provider had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. These were breaches of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that improvements had been made, however we noted some additional issues which required addressing.

We found staff had assessed the risks to most people's safety, and reviewed these risks to establish whether they had changed or increased. This included the risk of malnutrition, development of pressure ulcers and the risk of falls. Management plans were developed to support people to manage and minimise these risks. Where required, equipment was made available to lower the risk to people's safety, including hoists, walking frames and walking sticks. We observed staff regularly reminding people to use their frames and sticks when mobilising around the home to reduce the risk of them falling.

Where people required bed rails to reduce the risk of them falling from beds, appropriate risk assessments were carried out and recorded. People's capacity to make decisions about bedrails was also recorded and where possible they were involved in decisions about bedrails. Staff made sure appropriate management plans were in place where people had bed rails to mitigate the risks associated with these. When it was not appropriate for people to have bed rails in place, we saw that people were provided with low level beds, and sensor mats in place which alerted staff if they got up at night, so staff could support them as necessary.

The numbers of falls at the service were monitored to identify any patterns. They had identified that one person had the potential to fall due to being partially sighted. Since the staff supervision of this person had increased the number of potential falls they could experience was reduced. However, we noted that whilst information in care plans was detailed and was informative for most people, there was no detailed information included in one person's night care records who was at high risk of pressure area breakdown, and how staff should support them to reduce the risk of harm. Risk of skin breakdown for this person was high as this person spent a lot of their time on the floor. Whilst we acknowledge that this was normal for this person, they were noted to have a lowered bed in a room that had a hard laminate floor. The night care plan stated they were to be checked two hourly, however staff told us and the care plan stated that this person often got out of bed and laid on the floor to sleep. Should this happen in between a two hour night check there was the potential for this person to develop a sore more easily if lying on a hard floor. This person had not yet experienced a sore, however the care plan did not detail any increased observation of this person or guidance for staff to mitigate the risk of potential harm.

Additionally on one occasion during the inspection we noted one staff member assisting the same person from the floor to a chair in an unsafe manner. Whilst the interaction was very caring, the staff member bent down and put their arms directly underneath the person's shoulders and picked them up from the floor and

transferred them into the chair. The manual handling care plan did not clearly provide guidance for this stating, 'I can transfer myself' and, 'I need one carer for some transfers. I need one staff to stand; staff can assist and support [person] from the back using their hands.' The person concerned did help with some limited weight bearing, however this manoeuvre was not done safely and would put both the person being moved and the staff member at risk of harm. When we spoke to the carer concerned and told them that it was an inappropriate move, they told us, "This is how we do it." Whilst we acknowledge that appropriate manual handling training had been completed we did not see staff implementing this safely in practice. We advised the manager of our concerns regarding this on the day of inspection and we asked that this be addressed.

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

People told us they felt safe at the service. Comments included, "I like it here, I feel safe and they look after me wonderfully well." And two relatives told us that they found that the home was very good and they felt that their relatives were in safe hands.

Staff were aware of their responsibilities to safeguard people from harm. Staff were able to describe to us signs and symptoms of possible abuse, and they were aware of the reporting procedures they were required to follow if they had any concerns. The registered manager had informed the local authority safeguarding team about any signs of possible abuse, including in relation to the development of pressure ulcers at grade three and above. The registered manager liaised with the safeguarding team and implemented advice given to further protect people from harm.

Staff were aware of their responsibility to report and document incidents that occurred at the service. These detailed what occurred and how the person was supported at the time of the incident, and action taken to prevent future incidents. We saw that incident forms were completed appropriately including in regards to episodes of behaviour that challenged staff, bruising and skin tears. We saw that where staff identified bruising on people during personal care that the required paperwork was completed and staff investigated how the bruising had occurred.

Risk assessments were also in place to identify the risk to people in the event of a fire and what support people required to respond to a fire alarm. Personal evacuation plans were in place for each person and detailed what support they required to evacuate the building in the event of a fire, including the number of staff and equipment needed.

There were sufficient staff on duty to meet people's needs, and staff confirmed there were sufficient numbers of staff to enable them to undertake their duties and spend time with people. People also felt there were sufficient staff around. One person told us, "In the morning when I wish to get up, I ring and they come pretty quickly." Another person said in regards to whether there were enough staff, "I think so, I am well looked after." We observed that staff were available and responded to people's requests promptly. We observed call bell alarms were answered promptly and on the whole people told us they received the support they required from staff.

We observed that staff were allocated in appropriate numbers to ensure people received support when they required. One member of staff had a dual role as the cook as well as a carer. We observed that this did not impact on the care given to people and there were no prolonged periods when no staff were available in the communal lounge.

The numbers of staff on duty were based on the level of support people required and their dependency levels. Staff rotas were organised so that the appropriate numbers were on shift, and staff sickness, annual leave and training requirements were accounted for. We were told additional staff were allocated on shift to support people that required escorts to hospital appointments or where it was felt a person required one to one support to ensure their safety. Staff told us that staffing numbers were organised sufficiently to help with the morning routine and support people with their personal care.

Safe recruitment practices were in place to ensure appropriate staff were employed who had the knowledge, skills and attitude to support people. We saw that appropriate checks were undertaken to ensure staff were eligible to work in the UK, and had the appropriate knowledge and experience. Criminal records checks via the disclosure and barring service (DBS) were also undertaken to ensure staff were safe and suitable to work at the service.

People received their medicines as prescribed. One person told us in regards to their medicines, "I get all my medicines on time." Medicines were appropriately and securely stored in temperature controlled rooms or in fridges. Records about the receipt, stock balance, administration and disposal of medicines were all held accordingly. Staff had competency checks for medication administration and we saw evidence of these in staff folders. Medication administration records (MARs) kept an account of stock control. Where people did not take their medicines for various reasons, appropriate entries were used to state the reason why. We observed medicines being given and saw that these were provided in line with people's individual prescriptions. We checked how medicines were being managed and we saw that they were carefully administered with appropriate records being kept. There were arrangements for the correct disposal of medicines. Staff requested medication reviews and liaised with the person's GP if they had any concerns about people's medicines. Audits were carried out to monitor the management of medicines.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection and saw that improvements had been made. We saw the bedrooms, dining rooms, lounges, bathrooms and toilets were clean. People and relatives told us they thought the home was kept clean and there were no odours noticed. The carpets had all been cleaned since our last inspection and there were clear records kept. Procedures were in place to prevent and control the spread of infection and systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and/or gas supply. Regular checks of the fire systems and equipment had been completed.

Is the service effective?

Our findings

At our inspection in January 2016 we found the service had not taken proper steps to ensure staff were supported with training and development to ensure they were able to deliver care and treatment to people safely and to an appropriate and required standard. A subsequent focused inspection in June 2016 identified that whilst we found that some improvements had been made, the provider was still not meeting all of the requirements of the regulation relating to staff lack of knowledge in relation to specific health conditions such as dementia and care plans did not reflect this either. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. People we spoke with told us they felt the staff had the right skills and experience to meet their needs or those of their relative. Comments included, "I like the staff they treat us well." And "I believe they know what they are doing, I am looked after pretty well here."

The registered manager told us that people had a comprehensive assessment prior to moving into the service. This was to decide if the placement would be suitable and that their needs could be met by the staff.

We saw that new staff completed an induction programme on commencing work at the home. The induction programme was both e-learning and practical training, for example, fire procedures, food hygiene, safeguarding, moving and handling and health and safety. The induction also contained information to help staff understand their roles and responsibilities to ensure the safety of the staff and people who used the service. We were shown the staff training matrix which confirmed that staff had completed appropriate training and highlighted when refresher courses were required. Staff spoken with confirmed they had received training relevant to their role to help them safely care and support people who used the service effectively. Whilst we acknowledge that staff training had taken place and was up to date this had mostly been completed by the manager himself who has a training qualification. Any external training courses by other providers were sparse and infrequent and staff highlighted they would like to experience different forums of delivery, such as in a classroom setting or practical role play rather than just e learning.

We recommend that the service finds out more about different forums of training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

We saw systems were in place to ensure that staff received regular supervision and appraisals. These meetings had been documented. Supervision meetings allowed staff time to discuss their progress at work, any concerns or issues they may have and any learning and development they may wish to undertake.

The registered manager told us that care and treatment provided was always agreed and discussed with the people who were able to give consent. People and relatives we spoke with confirmed that this was the case.. People told us they were able to make decisions about their daily routine, for example, times of getting up or going to bed and choices of food and clothing. Comments included, "I can make my own choices." and one staff member told us, "We do sometimes get people up and dressed if we are on nights

but only those people who want to. For example, [person] likes to go to bed at 9pm for 10 hours. They often get up for an hour in the night and then go back to bed." Whilst observing the lunchtime meal we observed one person who had difficulty making a choice regarding dessert. To alleviate this, the member of staff placed the dessert options in two different bowls and showed these to the person who was then able to make a decision.

From our observations and inspection of care records it was evident some people were not able to consent to the care and treatment provided. We were told that if an assessment showed a person did not have the capacity to make decisions then a 'best interest' meeting was arranged. A 'best interest' meeting is where other professionals and family, where appropriate decide the best course of action to take to ensure the best outcome for the person who used the service. We saw evidence of mental capacity assessments in the care records we looked at.

The Mental Capacity Act (MCA) is a person centred guide to protect the human rights of people. It provides a legal framework to empower and protect people who may lack capacity to make certain decisions for themselves. DoLS are part of the MCA. They aim to make sure that people in care homes are looked after in a way that does not restrict their freedom. The safeguards ensured that a person is only deprived of their liberty where this has been legally authorised. The registered manager and staff we spoke with demonstrated they had a good understanding of MCA and DoLS.

Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that it was. In three of the care records we looked we saw that a DoLS had been authorised through the correct procedures.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health and dietary needs were met. We saw that drinks and snacks were available throughout the day and people who used the service could help themselves to and request refreshments. Two relatives spoken with were confident that their relatives got enough food and drink.

People told us, "The food is very good here; I get a choice and have asked for a snack if I still feel hungry." Menus were planned in advance on a four week rota. People were offered a choice and the cook told us alternatives were made available if people did not like the main choices available that day. We observed the meal time experience and noted staff encouraged people to eat as much as possible and provided individual assistance and reassurance to people who needed support to eat. We saw that staff were seated at the side of the person and interacted well with the people they were supporting. The meals consisted of good portions and were well received. We saw that the dining room tables were nicely laid for each meal and the lunchtime meal dining experience was calm and relaxed. One person was observed to come down later for their meal as they preferred to eat later. The staff were aware of this and had accordingly saved this person's meal. Staff offered people choices of food and adhered to those choices throughout the meal.

Records we saw showed us that staff completed food and fluid records for those people who required

monitoring. For example one person's care plan detailed what they had eaten on a daily basis and that they required a soft mashable diet. Whilst this person was of a low weight health care professionals agreed that they would not gain weight due to their condition. Where any concerns had been identified in relation to risk of inadequate nutrition and hydration records showed action had been taken, such as a referral to the dietician or to their GP. This person had also had appropriate referrals made to the speech and language specialist (SALT) and GP.

The care records we looked at also showed that people had access to external healthcare professionals such as GPs, community and specialist nurses and opticians.

Is the service caring?

Our findings

At our inspection in June 2016 we found the service had not taken proper steps to ensure that each person was treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action to make improvements to ensuring people's privacy and dignity and this action has been completed.

At this inspection we found improvements had been made. The provider had addressed concerns previously found at the last inspection. These related to appropriate screening being in place for people at windows, and information such as bathing rotas being on display. The provider had completed these actions. The atmosphere within the service was welcoming, relaxed and calm. Staff interactions with people were kind, respectful and caring. We observed the service had a culture which focused on providing people with care which was personalised to the individual. Staff were passionate and caring. We observed lots of laughter and positive communication between people and staff. For example, we saw one member of staff caringly speak to a person who had communication difficulties and you could see their facial expression was showing happiness. People were relaxed with the staff supporting them.

All of the people we spoke with including relatives were complimentary about the staff and the manner in which people were cared for. Comments included staff were, "Very good and very helpful." And, "The staff here appear to be genuinely caring." And, "The care I receive is first class really." People went on to say they could more or less, manage on their own, but needed help to put cream and stockings on as they are mostly independent. They had been very worried when they first moved in, as they didn't know quite what to expect. They told us, "Well you hear such awful things, but I soon settled in and am really happy here now." "The staff are very nice, so kind and very caring." One member of staff brought in their phone which had an app on it to store music and they would play people's requests for them.

Staff were able to describe people's needs and preferences in a clear, concise and compassionate way. We saw that staff treated people with dignity, spoke to them respectfully and promoted their independence. Everyone looked relaxed and comfortable with the care provided and the support they received from staff. Staff interacted with people positively at each opportunity. For example, we saw staff greeting each person as they entered communal areas. We saw this when one person who had spent most of the morning in their room was visibly pleased to be greeted by the staff member as they entered the dining area. This person did not socialise a lot and then proceeded to actively engage in conversation with the member of staff. Staff addressed people by their preferred names, and chatted with them about everyday things and significant people in their lives. Staff were able to demonstrate they knew about what was important to the person.

We observed during our inspection that positive caring relationships had developed between people who used the service and staff. Staff told us how they respected people's wishes in how they spent their day and the individually assessed activities they liked to be involved in. People were supported to maintain relationships with others.

One relative told us that they considered their family member was happy living at the service and with the relationships they had with staff. They told us that even though their family member had limited verbal communication their body language would indicate if they were not happy and this was not the case.

People were encouraged and supported to make choices, express their views and be involved in their own care as much as they were able to. Staff involved people in conversations and also supported the inspector to communicate with people at the home. We saw that staff knew the people they supported very well and were able to anticipate their needs. All staff spoke about people with warmth, respect and were able to describe their preferences, their interests and their care and welfare needs.

Relatives told us they were kept up to date and felt involved in what happened in their family member's life. They felt staff listened to and respected their opinions and views. Relatives told us they were always welcomed at the home by staff. They felt comfortable when they visited and told us they always found a positive and welcoming atmosphere at the service. One relative told us that every time they visited the home they could see that people were relaxed around staff.

We saw staff respected people's privacy and own space. One person told us that staff gave them privacy in their room if they wanted to be left alone. For example, one staff member told us, "We know people here really well, like we know [person] has different sounds for different things, so when you invade their personal space they will shout at you and you just have to move away. If I help them to the toilet and I have understood correctly, they let me know by stroking my face. That's their way of saying, yes you got it right [staff member]."

One relative told us they liked the approach that staff used with their family member and that staff were always respectful towards them. People were encouraged to be as independent as they could be. Staff told us that most people who lived at the home were dependent on staff for most of their care needs. However, they made sure that people still had control over their lives by ensuring they were supported to make and communicate their choices.

There were systems in place to request support from advocates for people who did not have families. Advocates are people who are independent of the service and who support people to have a voice and to make and communicate their wishes.

Is the service responsive?

Our findings

At our inspection in January 2016 we found the service had not taken proper steps to ensure that they maintained an accurate record in respect of each service user. A subsequent focused inspection in June 2016 identified that whilst we found that some improvements had been made, the provider was still not meeting all of the requirements of this regulation. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. The plans of care for each person had been all been fully reviewed since the last inspection. All the care plans reviewed included a full assessment of people's individual needs to determine whether or not they could provide them with the support they required. Most of the care plans were comprehensive and provided staff with the guidance they needed in how to support people with their identified needs such as personal care, receiving their medicines, communication and with their night time routine. However we found an example whereby a person's care plan did not full address a person's pressure area care needs and manual handling appropriately. This was fed back to the provider and they acknowledged that the information required updating and should clearly identify the steps required. They further advised us that this would be addressed. The care plans that we reviewed focussed on the person's whole life and reflected how people would like to receive their care, treatment and support. We saw within a care plan we reviewed that there was information that detailed what was important to the person, their daily routine and what activities they wanted to be involved in. For example in this person's care plan it detailed how the condition they suffered from affected their thinking, what they could still do, what they found difficult and how specifically staff could help them individually. People's changing care needs had been identified promptly. We saw evidence of this where someone who was at risk of falls had been referred to the falls prevention team, People's needs were regularly reviewed with the involvement of the person and or their relatives.

Care plans contained guidance for staff which described the steps they should take when supporting people who may present with distressed reactions to other people and or their environment. Our observations and conversations with staff demonstrated that guidance had been followed. We observed occasions when one person presented as distressed and could only make noises to attract staff attention. Staff responded in a calm, comforting manner, allowing the person time to respond. Staff we spoke to were able to tell us about this person and it was evident they knew them very well. They were able to interpret the sounds made to what he needed, for example, food, to go to the toilet, when they were irritated and upset. We saw this in action throughout the day.

People and their relatives told us that they felt the service met their needs and they were satisfied with the care and support they received. They had been given the appropriate information and opportunity to see if the service was right for them, and could respond and meet their needs appropriately prior to moving in. People also told us they had had the opportunity to be involved in their care planning. One person told us, "[staff member] has talked to me about my care. I don't see all they write down but they discuss everything." And "I do feel involved." Additionally all the relatives spoken to agreed that they had had an input into care plans and were consulted and kept up to date with any issues. They also felt at ease with raising issues or

concerns and talking to the staff about their relatives. A healthcare professional we spoke with stated, "I've been here about six times and people seem happy and settled."

Staff knew the people they cared for well, this included their preferences, care needs and hobbies and interests. Staff described how they encouraged people to maintain their independence and to get involved in daily activities of their choice. Whilst there was not a rigidly structured schedule of activities, staff told us that people were supported with a variety of activities that they were interested in, and supported to maintain any hobbies and interests they had. For example, when we arrived one person was painting by numbers. We saw they were concentrating on this task and were enjoying it. They told us that staff had given them the set and they were, "giving it a go." They went on to say, "I am not sure I am doing it right though." We replied saying with art there was no right or wrong, and the painting looked very good. One staff member told us that this person enjoyed doing creative things.

Staff told us that they tried to support people to maintain their hobbies and interests, in line with their own choices. People were supported with a variety of activities that they were interested in and supported to maintain their hobbies and interests. This was partially confirmed from our discussions with people and their relatives. One person we spoke with told us they did not like to do much but did get asked if they wanted to participate in the planned bingo game. We saw an activities board displayed which showed photos from the Christmas just gone and documentation reviewed evidenced activities such as movie nights with popcorn, crisps, and drinks, the last one recorded was in November 2016. A shopping trip had also been offered but all had declined and this had been documented. Additionally on the day of inspection we observed a bingo game taking place where people won small confectionary bars as prizes. Other activities included people having a chat and board games, however the last one documented was in December 2016. The cook/carer ran a small in house shop, selling chocolates, sweets and bottled drinks to residents and visitors upon request. The small profits went to the residents fund to pay for entertainments and activities. Similarly we were told they held fetes and summer/christmas parties where raffle ticket sale profits also went towards a resident's fund.

People told us they could choose to spend time alone in their rooms or the quiet communal areas as well if they preferred. A new quiet lounge area had been developed since the last inspection, however was unused on the day of inspection. Staff told us it was hard to plan structured activities as most people wanted different things. For example one person spent a lot of time in their room by choice, and whilst we acknowledge that people made their own choices around which activity they participated in and staff made efforts to encourage meaningful pastime, this seemed limited and infrequent. Most of the people we spoke to were quite happy with their choices of activity when we spoke to them.

We recommend that the provider looks at ensuring additional activity provision is encouraged regularly and people are able to fulfil their chosen preference of daily activity at all times, and that this is clearly reflected in their plan of care.

All of the people we spoke with told us they were content with the service they received and would speak to the manager or other staff if they needed to. People told us that if they had raised any concerns this had been dealt with. People told us they had daily access to the management team and that they were approachable. Those people who were able also told us they had opportunities to express their views about the care they received through care reviews, residents meetings and surveys.

One formal complaint had been received by the CQC regarding the service since the last inspection in January 2016. We discussed this with the registered manager and how they had responded to the same, and clarified that most of this had been unsubstantiated. This complaint had been responded to appropriately.

We were told that any complaints received would be acted upon and learning from the same was used to improve the service. Feedback would be given to people explaining clearly the outcome and any actions taken to resolve any concerns. Staff were aware of the actions that they should take if anyone wanted to make a complaint. There was a complaints procedure in place which was displayed in the service for people to refer to.

Is the service well-led?

Our findings

At the last inspection in January 2016 the provider's audit and governance systems to assess, monitor and improve the quality and the safety of the service were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2016, we asked the provider to take action to make improvements to the quality and monitoring processes and oversight of the service. At this inspection, whilst we found improvements had been made, we found some additional issues which required addressing.

At this inspection we found the management of the service had improved. Additional systems to monitor the quality of the service and seek people's views had recently been implemented. However, these had only recently been put in place. We saw that a weekly environmental and cleanliness audit had been implemented since the last inspection. This had recently identified that a new blind and radiator cover were to be replaced and a new bed was required for one person. There were actions from this audit and these actions were in progress. However as these processes were only in their infancy we were not fully assured that these would be continually effective. We will continue to monitor the outcome of audits to ensure they are continually monitored.

People and their relatives were encouraged to give their views on the service through day to day discussions with staff and management, care plan review meetings, monthly resident and relatives meetings, and the provider's annual satisfaction survey. Relatives told us they were made welcome when they visited and management and staff actively encouraged their involvement and views. For example, one person told us, "I know all about [relative]." And had been involved with their relatives care from day one.

Monthly monitoring was now taking place by the registered manager. The registered manager told us that they had restructured the quality monitoring of the service which meant they had a better oversight. Audits we reviewed reflected that any shortfalls identified had been addressed within an acceptable time scale however there had not been many issues identified and most of the reports stated things like, 'Nothing identified this month.' This still needs to be monitored more closely to ensure that the service was continuously improving and people's views had been taken into consideration.

The registered manager was asked to notify us monthly of the audit processes they had completed. Whilst we acknowledge the provider has done this each month, the reports we have received have been brief and non-specific in places. We will continue to monitor these reports until we are confident that the auditing systems are effective at identifying and managing risks and issues.

The registered manager told us, recent reviews with other professionals and the local authority had been positive. A recent visit from the local authority in January 2017 identified that the service had met the improvement plan set in full. It stated that quality assurance policies and procedures were in place and regularly reviewed and updated in light of changing legislation. It also confirmed that audits were completed regularly, trends and themes analysed and actions as result were recorded.

The registered manager was confident staff were all aware of their roles and responsibilities. Staff told us the senior carers and the manager led the shifts and that everyone understood their respective roles and responsibilities. Staff were motivated and focussed on meeting people's care and support needs. Decisions about people's care and support were made by the appropriate staff at the appropriate level. For example, care staff told us they always reported any issues or concerns to the district nurses. If they noticed any changes in people's needs they noted these in the person's daily care records and then brought this to the attention of health care professionals if required. One care worker told us, "Sometimes the manager can have very fixed ideas but we still tell him if we need something and he takes on board our views."

The registered manager told us that they had received positive comments from people and their relatives and survey results showed an improvement in overall standards at the home. A recent survey undertaken in November 2016 identified teamwork as an area for improvement. The results of these surveys were displayed in a, 'you told us.' and a, 'This is what we will do.' format.

A monthly auditing system was in place and contained the following audits, safeguarding, complaints, quality assurance, surveys, infection control, medicine audit (storage, record and document audit), staffing levels and levels of dependency of people receiving a service. The manager told us, if specific shortfalls were found these were discussed immediately with staff at the time and further training could be arranged if necessary. Staff confirmed that they were aware of the importance of the various audit tools in place. This meant that staff and management of the service were making efforts to ensure the monitoring of the quality of service delivered, to ensure that people who used the service were having a good quality of service at all times.

The registered manager who is also the provider was visible around the service and provided leadership. One person described the manager as a, "very nice man" and one staff member said, "Once you get to know him, he's fine and very approachable." Additionally we were told, "Staff get on with the registered manager but know how to take them. They can sometimes be difficult, but as a staff group we support each other."

We saw the registered manager directed and supported care staff and senior carers to support people appropriately. For example, care staff were asked to assist people when they appeared to be getting anxious or distressed or required assistance.

The provider told us they promoted honesty, learned from any mistakes and admitted when things went wrong. They stated the last inspection had 'opened their eyes' and they intended to continue to monitor the service, and this had been hard work. Staff additionally told us the culture of the service had changed and things were better now with the changes that had been made. One member of staff told us, "There have been lots of improvements since the last inspection the house is now looking nicer and it was really shabby before." This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. For example, to the best of our knowledge, the registered manager had notified the Care Quality Commission and other statutory authorities of all significant events and notifiable incidents, in line with their legal responsibilities.

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 | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person has failed to ensure care and treatment must be provided in a safe way for service users and that this is provided by persons who have the skills and experience to do so safely</p> <p>This was a further breach of regulation 12.</p> |