Athena Care (Ormskirk) Limited

Abbey Wood Lodge Care Home

Inspection report

173 County Road
Ormskirk
L39 3LY
Tel: 01695767778

Date of inspection visit: 21/04/2015
Date of publication: 01/10/2015

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**

Overall summary

Abbey Wood Lodge is situated on a main road position in a residential area of Ormskirk. It is a purpose built care home, which is a brand new facility, opened in November 2014. It is on the outskirts of well-kept parkland. Accommodation is provided for up to 60 adults, who require help with personal care needs and who are living with various degrees of dementia. Some parking spaces are available to the front of the home, but on road parking is also permitted. Public transport links are within easy reach and the local towns of Ormskirk, Skelmersdale, Wigan, Liverpool and Preston are a short drive away. A variety of amenities are close by, such as pubs, shops, a day centre and churches.

This was the first inspection of this location, conducted by the Care Quality Commission (CQC), as it was a newly registered service. This unannounced comprehensive inspection was conducted on 21st April 2015.

A senior care worker and the administrator made themselves known to the inspection team on our arrival.

Summary of findings

In addition we noted there was a full compliment of staff on duty. The registered manager was scheduled to work a later shift on the day of our inspection, but attended the home earlier to assist the inspection team. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We found that recruitment practices were, in general satisfactory. Induction records for new staff were not always maintained. Although a wide range of training was provided, it was evident that staff did not have sufficient knowledge and were not aware of how to manage people who had challenging behaviour and were living with moderate to severe dementia.

We found the planning of people's care and support could have been more detailed and person centred. Detailed assessments of need had not always been conducted and although some risk assessments were in place these did not always outline how identified risks were to be best managed. However, people were helped to maintain their independence with their privacy being respected at all times.

The staff team were confident in reporting any concerns about a person's safety and were seen to be kind and caring towards those who lived at the home.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. A contingency plan provided staff with guidance about what they needed to do in the event of an environmental emergency, such as power failure or severe weather conditions. Systems and equipment within the home had been serviced to ensure they were fit for use.

The management of medications could have been better. Although we found the senior care worker, who was administering the medications to be knowledgeable and efficient we did note that she dispensed the medications with her fingers without washing her hands first. There were some gaps on the Medication Administration Records (MAR's), where signatures were missing. Therefore, we could not establish if on these occasions medicines had been administered or omitted.

The environment was clean and hygienic throughout. There were no unpleasant smells and clinical waste was being disposed of appropriately.

The layout of the home was well designed and furnishings and fittings were of good quality. However, the décor was not in accordance with specific guidance around environments for people who live with dementia, so that those who lived at the home could experience a meaningful and tenacious life style.

The fire doors were not regulated to close gradually, but on activation of the fire alarm they slammed shut, which could have potentially caused serious injury to those who lived at Abbey Wood Lodge.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment, good governance, person centred care and premises and equipment.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

This service was not consistently safe.

Risk assessments had been conducted, but these were not always person centred and were not consistently reflected within the plan of care. On activation of the fire alarm the heavy bedroom doors 'slammed' shut. This had the potential to cause serious injury to those who lived at the home.

At the time of this inspection there were sufficient staff deployed to meet the needs of those who lived at Abbey Wood Lodge. Recruitment practices were, in general satisfactory to ensure only suitable staff were appointed to work with this vulnerable client group.

Staff were confident in responding appropriately to any concerns or allegations of abuse. However, we felt the staff team were not sufficiently trained to manage challenging behaviour or to support people who were living with moderate to severe degrees of dementia. People who lived at the home were protected by the emergency plans implemented at Abbey Wood Lodge.

Medicines were not consistently well managed and therefore people could be at risk of unsafe medication practices.

Is the service effective?

Requires improvement

This service was not consistently effective.

We noted people were able to move around the home, as they pleased, without any undue restrictions being placed on their freedom.

We were told that new staff completed an induction programme when they started to work at the home. However, this was not recorded in one staff member's file and the record in other files was basic.

Records showed the staff team completed a range of mandatory training modules and this was confirmed by staff members we spoke with. However, from our observations and from speaking with staff it was clear that they were not knowledgeable about the needs of those who were living with moderate to severe dementia. Regular supervision and annual appraisals were not yet introduced, as the care home had only recently been opened.

The décor of the home was not in accordance with specific guidance around environments for people who live with dementia, so that those who lived at the home could experience a meaningful life style.

Systems were not in place to support people to select their choice of menu and people's dietary preferences had not been taken into consideration.

Is the service caring?

Good

This service was caring.

Summary of findings

Staff interacted well with those who lived at the home. People were provided with the same opportunities, irrespective of age or disability. Their privacy was consistently respected.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

People were treated in a respectful way. The staff were seen to be kind and caring. People were supported to remain as independent as possible.

Is the service responsive?

Requires improvement

This service was not consistently responsive.

Detailed assessments of need had not always been conducted before a placement was arranged.

Care plans were found to be completed, but these could have been more person centred in some instances.

People we spoke with told us they would know how to make a complaint should they need to do so and staff were confident in knowing how to deal with any concerns raised.

Is the service well-led?

Requires improvement

This service was not consistently well-led.

Records showed that surveys had been conducted for those who lived at the home and their relatives.

Records showed that meetings had not yet been arranged for those who lived at the home and their relatives. A comments and suggestion box were available in the reception area of the home for relatives, residents and staff to utilise, should they wish to do so.

Systems for assessing and monitoring the quality of service provided had not been fully implemented. Audits around the management of medications had been introduced, but we were told no others had yet been started.

Evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community professionals.

Abbey Wood Lodge 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 21 April 2015 by two Adult Social Care inspectors from the Care Quality Commission, who were accompanied by a specialist dementia care advisor. At the time of our inspection of this location there were 26 people who lived at Abbey Wood Lodge. We spoke at length with six of them and seven relatives. We also spoke with six staff members and the registered manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of six people who used the service and the personnel records of five staff members.

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 'pathway tracked' the care of four people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us and we asked local commissioners for their views about the service provided. We also requested feedback from 11 community professionals, such as medical practitioners, community nurses, mental health teams and a dentist. We received one response, which provided us with positive information.

Requires improvement

Is the service safe?

Our findings

Risk assessments were evident in the care files we looked at and although the level of risk was usually identified the process did not always outline how the risk was to be best managed. The risk assessments included areas, such as risk of falls, pressure ulcers, malnutrition and choking. Plans of care did not always follow on from a risk management framework. Therefore, potential risks were not always incorporated into the care planning process and clear strategies of action were not always evident to reduce the possibility of harm.

Following lunch we observed three people left unsupervised in one of the communal areas of the home. When we entered we saw a male resident trying to help a female resident into a wheelchair. She stumbled before landing in the wheelchair. The male then dragged her feet across the floor whilst pushing the wheelchair without footrests being in place. We immediately sought assistance from staff, who were all in another communal area of the home, with the majority of those who lived at Abbey Wood Lodge.

We observed another incident where one person was agitated and shouting. The incident escalated as three members of staff all tried to intervene simultaneously, which confused and distressed the individual further. The senior care worker at that time failed to give direction to staff about how to deal with the incident in the most effective and safe way. This clearly demonstrated a lack of basic knowledge and behaviour management training for staff members.

We spoke with one person and her husband, who was visiting. This person was not living with dementia, but had a cognitive impairment, due to complex medical needs, which resulted in episodes of forgetfulness and confusion. She told us that she wanted to remain on this particular unit at the home because she enjoyed the view from her window across the park.

We found that the registered person had not protected people against the risk of harm, because potential health care risks had not always been appropriately managed. This was in breach of regulation 12(1)(2))(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that environmental risk assessments and audits of the premises had not been implemented at the time of our inspection. The premises were maintained to a good standard. However, on the day of our inspection a fire alarm test was conducted. We observed that on activation of the fire alarm all electronic door guards automatically released, allowing the doors to close. However, the doors were sturdy and slammed shut with some force. At this time one person was standing in his bedroom doorway and was almost knocked over with the force of the door, which could have potentially caused injury to this individual. We advise that the quick release of fire doors could also potentially cause injury to people due to entrapment of fingers or limbs.

We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication policies and procedures were in place at the home. We observed the senior care worker administering medications. Although this took all morning we found her to be very efficient and knowledgeable whilst distributing the medication. However, we noticed she had not washed her hands prior to commencing the medication round. She did not wear disposable gloves and used her fingers for dispensing and distributing the medication. The Medication Administration Records (MAR's) were completed correctly during our inspection. However, we observed several blank entries on previous occasions. This meant we were unable to establish if people had received their medications on these occasions, or if they had been omitted.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures were in place in relation to safeguarding vulnerable adults and whistle-blowing. Records showed staff had completed training in this area. A system was in place for recording and monitoring any safeguarding concerns. However, no safeguarding incidents

Requires improvement

Is the service safe?

had occurred or been recorded in the previous five months. Staff we spoke with knew what action they needed to take, should they be concerned about the safety of someone in their care.

We looked at the staff off duty rotas. People we spoke with did not report any staff shortages and we observed that call bells were answered within a reasonable length of time. Relatives we spoke with thought there were enough staff on duty and this information appeared accurate from our observations.

During our inspection we looked at the personnel records of five members of staff. We found that recruitment practices were, in general satisfactory. Although two references had mostly been obtained before people started to work at the home, one reference had been obtained shortly after one person had commenced employment. Staff personnel records showed that telephone interviews were conducted for prospective employees. We discussed this with the registered manager, who assured us that face to face interviews were conducted for those who successfully passed the telephone interviews. This was confirmed by the staff members we spoke with and was recorded within the personnel records we saw.

Prospective employees had completed application forms, including health questionnaires and had produced acceptable identification documents, with a photograph. The disclosure and barring service (DBS) had been consulted before people were employed. The DBS checks criminal conviction records, so the provider can make an informed choice about employment in accordance with risk. Staff talked us through their recruitment and told us this was thorough.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations, so that they were fit for use and protected people from harm. A contingency plan was in place, which provided staff with guidance about action they needed to take in the event of an environmental emergency, such as a power failure or severe weather conditions.

Although Individual Personal Emergency Evacuation Plans (PEEPS) had been developed in a generic way, which grouped people together in accordance with their mobility and assistance needed, it would be beneficial if people had individual PEEPS, specific to their needs. These could then identify if people may display challenging behaviour or become anxious if evacuation was needed. Some people could have medical conditions, which could be exacerbated with the stress of evacuation procedures, such as asthma. The provider has subsequently informed us that individual PEEPS have been prepared.

During the course of our inspection we toured the premises. We found the home to be clean and hygienic throughout without any unpleasant smells. An infection control policy was in place and we noted that clinical waste was being disposed of in accordance with current legislation and good practice guidelines. The registered manager told us that she was planning to appoint an infection control lead member of staff, who would take on the responsibility of ensuring that infection control policies were followed and that staff received appropriate training.

Requires improvement

Is the service effective?

Our findings

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. The building was found to be well maintained and comprised of three floors, although at the time of our inspection only the first two were in use.

The home overlooked an enclosed garden and beautiful area of parkland to the rear. We found the environment to be very attractive with good quality fittings and co-ordinated furnishings. The layout of the home was suitable for those who lived at Abbey Wood Lodge. Private accommodation at Abbey Wood Lodge was arranged over three floors. At the time of our inspection the upper floor was not operational. The ground floor accommodated people who did not have a diagnosis of dementia or those who had early onset dementia. People who lived on the first floor were those who required a slightly higher level of dementia care. The second floor was intended for people with more complex dementia care needs. The décor and design varied for each level of the home. However, we found that the needs of people who lived with dementia had not been completely taken in to consideration during the design of the internal décor. We did not see evidence of dementia friendly resources or adaptations in the communal areas, corridors or bedrooms. People had little chance to explore their surroundings. The lack of dementia friendly amenities resulted in lost opportunities to stimulate exercise and to relieve boredom, as well as enabling people to orientate themselves to their environment.

We found colour schemes to be neutral throughout the home, which did not help with orientation and the lack of prominent picture signage did not easily identify areas, such as bathrooms and toilets. Bedroom doors were not easily identifiable; to enable people to find their own private accommodation and staff we spoke with had no knowledge as to what made a dementia friendly environment. Making changes to the environment, in accordance with current guidance would help to provide reassurance and improve confidence and orientation.

We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design. This was in breach of regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent in various areas had not been obtained. For example, the daily notes for one person showed that staff checked on them every two hours during the night, but there was no evidence to demonstrate the individual concerned had agreed to this decision and the plan of care did not reflect this level of observation.

We noted that one person who lived at the home required blood pressure monitoring every day, due to a change in medication. We were told that initially this was difficult to facilitate because staff who worked at the home had not been trained to take people's blood pressure. However, we established that this issue had since been resolved. We examined this person's care records and found there was no consensual agreement for staff to take her blood pressure every day.

We found the registered person had not ensured that consent had always been obtained from people before care and support was provided. This was in breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many of the staff we spoke with and those we observed lacked considerable insight into the challenges and needs of individuals who lived at the home. We were told by the registered manager that there were three to four people living on the first floor, who were living with moderate to severe dementia and were waiting to be moved up to the second floor when it opened. We felt staff were not sufficiently trained to work with people who were living with moderate to severe dementia. For example, they were not aware of the impact which background noise could have on people living with dementia, such as a television being left on, which could cause a considerable amount of anxiety and distress. Other examples, included the inappropriate management of one person who became agitated and frightened, as reported under the 'safe' section of this report and people were seen to be struggling eating their breakfast whilst balancing their plates on their knees or arms of chairs, rather than eating at dining tables.

There was no induction record in one staff member's personnel file and those that were present in others were basic 'tick' lists, which did not provide details of topics

Requires improvement

Is the service effective?

covered at the time of employment. The registered manager told us that detailed induction booklets had since been introduced and these were to be used by any new staff appointed to work at the home.

We found that the registered person had not ensured those employed had the qualifications, competence, skills and experience which were necessary to provide appropriate care and support for those who were living with dementia. This was in breach of regulation 19 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Policies and procedures were in place in relation to the MCA, but not for DoLS. 'All care files we examined stated, 'No problem' with mental capacity. The registered manager told us that some people were living with moderate to severe levels of dementia. Records showed that one person had difficulty in making decisions and we observed another expressing his wish to go home to his family. However, it was not evident that people were under continuous supervision and control and therefore not free to leave, if they wished to do so.'

Records showed that staff were provided with an employee handbook when they commenced work at Abbey Wood Lodge. This covered areas, such as equal opportunities, discipline and grievance procedures, recruitment and selection, safeguarding, whistle-blowing and health and safety. This helped to ensure that all new employees were provided with sufficient information at the time of employment. Staff were provided with job descriptions relevant to their specific role and terms and conditions of employment, which outlined what was expected of them whilst working for the company and action which would be taken in the event of staff misconduct, as well as the appeals process.

Supervision records were seen in some staff files. These allowed employees to discuss their work performance and training needs with their line managers at structured and regular intervals. Annual appraisals had not been implemented at the time of our inspection, as the home had been opened less than a year and therefore the staff team had been employed for only a short time.

Records showed that staff members completed a seven week training programme at the start of their employment, which involved one day each week for seven consecutive weeks. This programme covered modules, such as catheter and stoma care, continence, dementia awareness, emergency first aid, end of life care, health and safety, infection control, moving and handling and the management of medications. Staff members spoken with told us they had received regular training. They felt enough training was provided to meet the needs of those who lived at the home. However,

People's dietary preferences were not always documented within individual plans of care. The care plan of one person referred to staff following local policy if there was no improvement in one person's nutritional screening. However, the local policy was not available to look at. We noticed at breakfast time people were balancing plates of food on their knees or on the arms of easy chairs in the lounge/dining room. This made it difficult for people to dine in a comfortable way.

The meal choices for the day were written on a very small chalk board, which would be difficult to decipher by any aging person. We were told that anyone requiring assistance to make menu choices, then this would be provided. However, it would have been beneficial for those who lived at Abbey Wood Lodge and who were able, to consult the menu of the day at their leisure. Picture menus would be more beneficial for those unable to interpret written information. The main course was evidently very hot, as we could see the steam rising from the food. The plates were placed in front of people without any warnings that the food was hot. There were no explanations given about what food was on their plates.

A few of those who lived at the home and their relatives were unhappy that evening meal was served at 16:30, as they felt this was for the convenience of the kitchen staff and not the residents.

Requires improvement

Is the service effective?

Staff we spoke with knew very little about people's likes and dislikes. One plan of care informed the reader that the person could only tolerate brown bread due to a medical condition. However, this individual's relative told us, "My mum is always being given white bread, which she cannot eat and tomatoes, which she hates." We recommend that the registered person assesses and monitors the management of meals, so that those who live at the home experience pleasant and comfortable meal times and are provided with the opportunity to select their choice of food in accordance with their dietary preferences.

The registered manager told us that a wide range of community professionals were involved in the care and treatment of those who lived at Abbey Wood Lodge, such as community nurses, psychiatrists, GPs, dentists, opticians, and psychologists, which helped people to receive the health care they needed. We saw a medical practitioner and a district nurse visit on the day of our inspection.

Good

Is the service caring?

Our findings

We spoke with people about the care and support they received. In general, we received positive comments. One person commented, "The staff are very, very friendly." A relative of this person told us that they had no concerns about the service provided. However, another visitor told us that she called to the home on the morning of our inspection to find her relative dressed in a shirt and sweater on top of his vest and pyjama top. She said he was very hot and she had to 'sort out his clothes for him and get him cooled down.'

We saw that a Service Users' Guide had been developed, which provided information about the services and facilities available at the home, including the complaints procedure. The administrator told us that she sent this document to people who were interested in the possibility of living at Abbey Wood Lodge, so that they could make an informed choice about accepting a place.

Care plans outlined the importance of promoting people's privacy and dignity and promoting their independence. Staff spoken with were fully aware of the need to respect those in their care. We observed kind and patient care being afforded to those who lived at Abbey Wood Lodge. People were well presented and looked comfortable in the presence of staff members.

Interactions we observed between staff members and those who lived at the home were all pleasant, polite, friendly and unhurried. Staff expressed their genuine concern about individual people when talking with us.

One member of staff said they enjoyed working at the home and they felt people received good care and support. Another commented, "It is a good place to work."

We noted that privacy, dignity and independence were integral parts of the care planning process, particularly during the provision of intimate personal care and the promotion of people's abilities. We conducted a SOFI, which is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw that staff regularly interacted with people in a positive way. They were kind and caring, approaching people who lived at the home in a gentle and sensitive way. However, Some relatives we spoke with expressed concerns that on occasion personal care was not being delivered effectively. They felt that if their loved one had declined personal care then it was not being re-offered a little later when their mood had improved. We did not observe any instances of this whilst we were at the home.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions. Most relatives we spoke with said they were informed of any changes in the needs of their loved one and the care provided was discussed with them. We found that records were retained in a confidential manner, so that people's personal details were secure.

Requires improvement

Is the service responsive?

Our findings

Records showed that needs assessments did not furnish the staff team with a clear picture and understanding of what people required and how their needs were to be best met. The care records we saw provided basic information only. They lacked person centred awareness and did not demonstrate a good level of detail about people's preferences, wishes or social history. One plan of care stated, 'Promote communication skills and maintain independence where possible.' However, there was no guidance provided for staff, to enable them to follow these instructions. Another stated, 'Staff to be aware of (Name removed)'s likes and dislikes (in relation to dietary preferences).' However, these were not recorded. Vague statements were also often used such as, 'Arrange regular dental check ups'. This information did not provide staff with specific guidance about the dental needs of this person.

We spoke at length with the relatives of a person, who we 'pathway tracked'. They told us that they were very unhappy with the service. They said that their relative was admitted to the home for EMI care. They told us this was because she had moderate to severe dementia. However, on admission they realised the second floor was not open. They were told it would be another eight weeks before it opened. Meanwhile their relative was accommodated on the second floor. They told us that the manager of the home had since told them that they needed to look elsewhere for their relative's care, as the staff at Abbey Wood Lodge were not trained to manage their relative's behaviour. However, the provider has since informed us of the home's understanding of this situation and it seems there is some conflicting information surrounding the circumstances. Therefore, it is difficult to judge the accuracy of the information provided by either party.

There was little information about individual preferences, wishes or choices, which did not demonstrate that people had been given the opportunity to decide how they wished their care and support to be delivered. Another care plan talked about promoting past hobbies and interests and looking at the individual's social history. However, these were not recorded and therefore staff would not be aware of people's past leisure activities or social histories. The plan of care for one person had been updated with additional information in relation to the individual's hobbies.

The plan of care for one person recorded, 'Document dietary intake for three days', but this record could not be located at the time of our visit. The plan of care for another stated, 'Use chair of appropriate design and height for the patient'. This lacked person centred information and guidance about the type of chair was not recorded. We saw this person to be sitting on what appeared to be a regular lounge chair during the day.

There was no evidence to suggest people had been given the opportunity to make some decisions about the way their care and support was delivered. There was very little information about people's religious needs or emotional well-being, despite some being anxious or confused. However, the plans of care had been reviewed every month or more often if required and any changes in needs had been recorded, although this information was brief and lacked detail. Some elements of the plans of care we saw did not have any objectives in place and did not record any actions necessary, in order to meet people's needs. We found the care received by people to be task focused and not person centred.

We found that the registered person had not ensured people's needs were always met, because the care planning process was not always sufficiently person centred and potential risks had not always been managed well. This was in breach of regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a person who was sitting in one of the lounges. She was thoroughly enjoying watching the activities in the park, such as ducks on the lake and groups of school children on nature walks. She said, "I love sitting here. There is so much going on and so much to watch. It is very pleasant."

We sat in a communal area of the home, when one person entered with her daughter, who was visiting. This individual took an interest in the piano situated in this lounge, as she had enjoyed playing previously and she told us she used to have a piano at home. However, it was discovered that some keys were missing and the piano was out of tune,

Requires improvement

Is the service responsive?

which was disappointing for the individual. This was a missed opportunity for the individual concerned. Some people helped to set the tables for lunch and others helped with light chores around the home.

The records of one person, who lived at the home, showed she went to a day care centre four days a week, which promoted community links and supported her independence. We were told another person enjoyed visiting the garden centre, as he had been a keen gardener. This person had also been a walk in the park with a relative on the morning of our inspection. His relative told us about activities he liked, such as bingo and dominoes. She said the home had arranged a good Easter celebration with games, tombola, music and a visiting musician. We saw that family photographs adorned the bedroom of one person, which helped with reality orientation.

A hairdressing salon was available and we were told that a stylist attended the home once a week. A satellite kitchen was provided for the use of those who lived at the home, so that they could make beverages and simple snacks. This also enabled people to do some domestic duties, if they wished to do so. Relatives could also use this kitchen area for making drinks during their visits.

We viewed a number of bedrooms during our inspection. Some we found to be very personalised with objects and pictures displayed that were clearly personal and important to those who lived in these rooms. This promoted individuality and maintained people's interests.

Each had a 'Memory Box' outside the bedroom door. The use of these boxes varied greatly, some holding personal photographs, memorabilia and a brief resume of people's likes and dislikes. However, others were left completely empty. The provider subsequently informed us that although relatives were encouraged to use this facility; some chose not to do so.

During the course of our inspection we looked at the care records of six people who lived at Abbey Wood Lodge and 'pathway tracked' the care of four of them. We established that a 'key worker' system had been implemented. This allowed people to identify with a specific member of staff, so that they developed a good relationship and became able to trust them and to discuss any concerns they may have had. The key worker was also responsible for ensuring those in their care had everything they needed and to liaise with their loved ones, as necessary, so that important information could be passed on to families, with the agreement of the person who used the service.

A complaints policy was in place at the home and a system was in place for recording and monitoring complaints. Each step of the process was clear, which enabled a distinct audit trail to be followed. A relative we spoke with told us she would not hesitate to contact the registered manager if she had any concerns and she felt issues would be dealt with appropriately. All the people we spoke with said they knew the manager. Everyone said they had no complaints, but if they had they would be happy to tell the staff.

Requires improvement

Is the service well-led?

Our findings

We asked for a range of records and documents to be provided. These were made available as far as possible, although it did take some time before some were produced and this was after several times of asking. However, the registered manager and administrator told us that they could not access some records on the computer because they had been 'encrypted' The organisation was dealing with this situation.

A quality monitoring system had not been fully implemented at the time of our inspection. There were only audits available for medications. We did not see any in relation to care planning, recruitment, infection control, the environment or record keeping. We were told that iPads had been ordered, so that staff could complete computerised care records in the day rooms whilst observing people; instead of the present method of sitting in the office at a desk top computer.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been in post since the home opened five months previously. She was able to discuss the needs of people well and evidently wanted to provide a good service for those who lived at Abbey Wood Lodge. People we spoke with and their relatives were all aware of who the registered manager was and felt they could approach her if they had a problem or concern. We saw the registered manager interact politely with people who lived at the home and they responded to her well.

All staff we observed were polite and attentive towards those who lived at Abbey Wood Lodge. They enjoyed their work and provided us with positive feedback about the registered manager, describing her as 'friendly' and 'approachable.'

One relative told us, "I am very impressed with this service. I was when I first came, but I was advised to go and have a look at some other places to compare them with Abbey Wood Lodge, but I didn't need to. The staff are lovely, very friendly, kind and caring. I am very happy my dad is here."

We established that the Responsible Individual (company representative) visited the home prior to its opening, but has not visited since. This did not demonstrate a good support network for the registered manager. However, we were told that the director of the company did visit each week.

Formal group meetings had not been established at the time of our inspection because the home had only been open a short period of time. However, we were told staff meetings were going to be organised in the near future. We recommend that meetings for those who live at the home and their relatives are also introduced. Records did show that some meetings with individual staff members had been commenced. This allowed staff to discuss any concerns they may have with their line manager and to identify any training needs.

We established that surveys for those who lived at the home and their relatives had been circulated and we did see one person with the questionnaire. This meant that people were encouraged to submit their views about the service and facilities provided.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We noted we had been told about things we needed to know in accordance with The Care Quality Commission (Registration) Regulations 2009.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These covered areas, such as safeguarding adults, whistle-blowing, complaints, the Mental Capacity Act, infection control and advocacy. However, we did not see any information leaflets on display for people to take in relation to advocacy support.

One community professional wrote on the feedback, 'I thought that Abbey Wood Lodge was a great place. The Staff were all kind and helpful. The manager Gay could not have been more accommodating and clearly enthusiastic about her work. We had a bit of a difficult situation requiring tact and understanding and the staff have all been most helpful. I would give them full marks as far as our dealings with them.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Proper steps had not always been taken to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment. This was because risks relating to their health had not always been well managed. Regulation 12(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with the unsafe use and management of medicines. This was because appropriate arrangements had not been made for the obtaining, recording, using and safe administration of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found the design of the internal premises to be unsuitable for the purpose for which they were being used. Regulation 15(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured those employed had the qualifications, competence, skills and experience which were necessary to provide appropriate care and support for those who were living with dementia. Regulation 19 (1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not ensured that people's needs were always met, because the care planning process was not always sufficiently person centred and potential health risks had not always been managed well. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided had not been fully implemented.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not ensured consent had always been obtained from people before care and support was provided. Regulation 11(1)
	Regulation 17(1)(2)