

Executive Health Care Limited

Abbeyvale Care Centre

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

This inspection took place on 26 January 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting. The home had a registered manager in place. A registered manager is a person who has registered with 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 2008 and associated Regulations about how the service is run. The registered manager was not present during our visit however the deputy manager was present and was acting as manager at the time of the inspection.

Abbeyvale Care Centre was last inspected by CQC on 11 March 2014 and was compliant with the regulations in force at the time.

Abbeyvale Care Centre is registered to provide personal care and accommodation for up to 56 people. The home is located in Blackhall near Hartlepool and is owned and run by Executive Health Care Limited. Accommodation is provided across two levels within four units. There are two general residential units, Brockwell and Granary, a unit for people with dementia-type illnesses, Beechwood and Cavendish, a unit with fourteen apartments for

Summary of findings

people who have acquired brain injuries. On the day of our inspection there were 41 people using the service. The home comprised of 42 bedrooms, all of which were en-suite and 14 apartments. Facilities included several lounges, dining rooms and kitchenettes, a hair salon and an enclosed garden area.

People who used the service and their relatives were complimentary about the standard of care at Abbeyvale Care Centre. We saw staff supported and helped to maintain people's independence. People were encouraged to care for themselves where possible. Staff treated people with dignity and respect.

The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. There were sufficient numbers of staff on duty in order to meet the needs of people using the service.

Training records were up to date and staff had regular supervision meetings and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and most areas of the home were suitably designed for people with dementia type conditions.

The service was working within the principles of the Mental Capacity Act 2005 and any conditions on authorisations to deprive a person of their liberty were being met.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. Care records contained evidence of consent.

People were protected against the risks associated with the unsafe use and management of medicines.

People had access to food and drink throughout the day and we saw staff supported people to eat at meal times when required.

People who used the service had access to a range of activities in the home.

All the care records we looked at showed people's needs were assessed. Care plans and risk assessments were in place when required and daily records were up to date. Care plans were written in a person centred way and were reviewed regularly.

We saw staff used a range of assessment tools and kept clear records about how care was to be delivered and people who used the service had access to healthcare services and received ongoing healthcare support.

The registered provider had a complaints policy and procedure in place and complaints were fully investigated.

The registered provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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?

The service was safe.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff had completed training in safeguarding vulnerable adults and knew the different types of abuse and how to report concerns. Investigations had been carried out in response to safeguarding incidents or allegations.

The registered provider had procedures in place for managing the maintenance of the premises.

Good



Is the service effective?

The service was effective.

Staff were properly supported to provide care to people who used the service through a range of mandatory and specialised training and through supervision and appraisal.

People had access to food and drink throughout the day and we saw staff supported people to eat and drink when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and most areas of the home were suitably designed for people with dementia type conditions.

Good



Is the service caring?

The service was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their relatives to provide individual personal care.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

Good



Is the service responsive?

The service was responsive.

Care records were person-centred and reflective of people's needs.

People who used the service had access to a range of activities in the home.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Good



Is the service well-led?

The service was well-led.

Good



Summary of findings

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff we spoke with told us they felt able to approach the registered manager and felt safe to report concerns.

The service had policies and procedures in place that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions.

Abbeyvale Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 26 January 2016 and was unannounced. This meant the staff and the registered provider did not know we would be visiting. The inspection was carried out by an adult social care inspector, a specialist adviser in nursing and an expert by experience. The expert by experience had personal knowledge of caring for someone who used this type of care service.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted

professionals involved in caring for people who used the service, including commissioners, safeguarding and infection control staff. No concerns were raised by any of these professionals.

During our inspection we spoke with six people who used the service and three relatives. We also spoke with the deputy manager, operations manager, five care staff, the maintenance worker and a kitchen assistant.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as audits and policies.

We spoke with the deputy manager and the operations manager about what was good about their service and any improvements they intended to make.

Is the service safe?

Our findings

People who used the service told us they felt safe. They said, “I feel very safe indeed. They cannot do enough. I am safer than being at home.”, “My things are safe” and “I have a key for my room so I can lock the door so my things are safe”. A relative told us “They are pretty good in here. I never feel that she is unsafe”.

We saw the home was clean, well decorated and maintained. It was warm and comfortably furnished. The en-suite bathrooms, apartments, communal bathrooms, shower rooms and toilets were clean, suitable for the people who used the service and contained appropriate, wall mounted soap and towel dispensers. Grab rails in toilets and bathrooms were secure. All contained easy to clean flooring and tiles.

We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

Equipment was in place to meet people’s needs including hoists, pressure mattresses, shower chairs, wheelchairs and pressure cushions. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We saw windows were fitted with restrictors to reduce the risk of falls and wardrobes in people’s bedrooms were secured to walls. Call bells were placed near to people’s beds or chairs and were responded to in a timely manner.

Hot water temperature checks had been carried out and most readings were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. Where readings were not within the recommended temperature there was evidence of remedial action being taken to address. We looked at the records for portable appliance testing, gas safety and electrical installation. All of these were up to date.

We looked at the registered provider’s accident reporting policy and procedure, which provided staff with guidance on the reporting of injuries, diseases and dangerous occurrences and the incident notification requirements of CQC. Accidents and incidents were recorded and the

registered manager reviewed the information monthly in order to establish if there were any trends. We saw a fire emergency plan in the reception area. This included a plan of the building. We saw a fire risk assessment was in place dated 13 August 2015 and regular fire drills were undertaken. We also saw the tests for fire fighting equipment, fire alarms and emergency lighting were all up to date.

We saw a copy of the registered provider’s business continuity management plan dated 11 June 2015. This provided the procedures to be followed in the event of a range of emergencies, alternative evacuation locations and emergency contact details. We looked at the personal emergency evacuation plans (PEEPS) for people. These described the emergency evacuation procedures for each person who used the service. This included the person’s name, room number, impairment or disability and assistive equipment required. This meant the provider had arrangements in place for managing the maintenance of the premises and for keeping people safe.

We saw a copy of the registered provider’s safeguarding adult’s policy dated November 2015, which provided staff with guidance regarding how to report any allegations of abuse, protect vulnerable adults and how to address incidents. We saw that where abuse or potential allegations of abuse had occurred, the registered manager had followed the correct procedure by informing the local authority, contacting relevant healthcare professionals and notifying CQC. We looked at four staff files and saw that all of them had completed training in safeguarding of vulnerable adults. The staff we spoke with knew the different types of abuse and how to report concerns. This meant that people were protected from the risk of abuse.

People who used the service and their relatives told us there were enough staff on duty to meet their needs. For example, “There is enough staff”, “I think that there is enough staff on here” and “Yes there seems to enough, they never seem rushed”. We discussed staffing levels with the deputy manager and looked at staff rotas. The deputy manager told us that the levels of staff provided were based on the dependency needs of residents and any staff absences were covered by existing home care staff. We saw there were eleven members of care staff on a day shift and

Is the service safe?

eight care staff on duty at night. The home also employed an administrator, a cook, a kitchen assistant, domestics and a maintenance worker. We observed sufficient numbers of staff on duty.

We looked at the recruitment policy dated June 2014 and the recruitment records for four members of staff. We saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, birth certificates and driving licences. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. We looked at the disciplinary policy dated June 2014 and from the staff files we found the registered manager had disciplined staff in accordance with the policy. This meant the service had arrangements in place to protect people from harm or unsafe care.

The service had generic risk assessments in place, which contained detailed information on particular hazards and how to manage risks. Examples of these risk assessments included the use of equipment and machinery, slips and trips and work related stress. The deputy manager also told us how she planned to make the risk assessment file more accessible to staff along with a read receipt document for staff to sign once they had read and understood the contents. This meant the service had arrangements in place to protect people from harm or unsafe care.

The registered provider's medicines policies were dated December 2015 and covered all key aspects of medicines management. There was also a copy of the British National Formulary, which is a pharmaceutical reference book produced by the British Medical Association and the Royal Pharmaceutical Society of Great Britain, available for staffs reference. The service used individualised medicine supplied by a national pharmacy chain. Staff told us it was a good service. There were clear procedures in place regarding the ordering, supply, reconciliation and disposal of medicine. A signature verification sheet to identify staff initials who were approved to administer medicine was available at the front of each Medication Administration Record (MAR) chart file.

Appropriate arrangements were in place for the management, administration and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. Medicine administration was observed to be appropriate. Medicines were stored appropriately and clinic rooms displayed a good standard of housekeeping. We saw that temperature checks for refrigerators and the medicines storage room were recorded on a daily basis and were within recommended levels. Staff who administered medicines were trained and competency assessments were in place. We saw that medicine audits were up to date and included action plans for any identified issues. This meant that the provider stored, administered, managed and disposed of medicines safely.

Is the service effective?

Our findings

People who lived at Abbeyvale Care Centre received care and support from trained and supported staff. A relative told us, “It would seem that they are trained. I don’t think that I would have my sister in here if they weren’t”.

We saw that all new members of staff received an induction to the Abbeyvale Care Centre, which included information about the provider, a tour of the home and an introduction to the people who used the service, health and safety and policies and procedures. Staff were also provided with an Employee Handbook and a copy of a Code of Conduct for Employees.

We looked at the training records for four members of staff. The records contained certificates, which showed that the registered provider’s mandatory training was up to date. Mandatory training included moving and handling, fire safety, medicines, health and safety, first aid, infection control and safeguarding. Records showed that most staff had completed either a Level 2 or 3 National Vocational Qualification in Care or a Level 2 in Health and Social Care and the Care Certificate. In addition staff had completed more specialised training in for example, equality, diversity and inclusion, customer service and dignity in care, dementia awareness and oral healthcare.

We saw evidence of planned training displayed in the home. For example, fire safety was booked for six staff on 1 April 2016, first aid was booked for nine staff on 11, 12, and 13 April 2016, moving and positioning was booked for eight staff on 25 April 2016 and twenty seven staff were booked for customer care training on 1 April 2016. Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. This meant that staff were properly supported to provide care to people who used the service.

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

only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the acting manager, who told us applications had been submitted to the local authority for those people who required DoLS but no authorisations had been received yet. Records we looked at confirmed this. We looked at a copy of the provider’s MCA/DoLS policy dated November 2014, which provided staff with guidance regarding the Mental Capacity Act 2005, the DoLS procedures and the involvement of Independent Mental Capacity Advocates (IMCAs). This meant the provider was following the requirements in the DoLS.

Mental capacity assessments had been completed for some people and best interest decisions made for their care and treatment. We saw consent to care and treatment was documented in the care plan documents. Staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The deputy manager told us that she was currently sourcing additional staff training through Sunderland City Council.

People had access to a choice of food and drink throughout the day and we saw staff supported them to eat in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. We saw daily menus displayed on dining tables which detailed the meals available throughout the day. We observed staff giving residents a choice of food and drink. We saw staff chatting with people who used the service. The atmosphere was calm and not rushed.

People who used the service and their relatives told us, “You get a choice and there is enough. I’m not a big eater”, “I like cooked meals, like a roast and I like puddings. The food is alright, you get a choice. Today it was lamb curry or a chicken dinner. I do get enough and I get a jug of juice. They always say to just ask for a cup of tea or anything”, “You get enough. Breakfast is cooked or toast”, “The food has been lovely today”, “I have had a meal and they are very nice”, “We have sat with mam whilst she has had her

Is the service effective?

meals and they seem alright” and “I’ve seen the meals and they seem to be ok”. From the staff records we looked at, all of them had completed training in food safety and diet and nutrition.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GP’s, speech and language therapist, dietician, optician, advanced nurse practitioner, community district nursing, dentist and chiropodist. This meant the service ensured people’s wider healthcare needs were being met through partnership working.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and most areas of the home were suitably designed for people with dementia type conditions. The deputy manager told us about the improvements planned for the home which included replacing the flooring in the Granary unit dining room and a refurbishment of the Cavendish Unit in April 2016.

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at Abbeyvale Care Centre. People who used the service and their relatives told us, “The staff are exceedingly good. They are very happy and accommodating”, “I am happy and they are very kind”, “I am happy, the staff could not be nicer. They are kind. They always try to help you” and “It is nice here”.

People we saw were well presented and looked comfortable. We saw staff talking to people in a polite and respectful manner. Staff interacted with people at every opportunity. We saw staff knocking before entering people’s rooms and closing bedroom doors before delivering personal care. People who used the service and their relatives told us, “It’s very good in here. You hear laughter, it’s not just the staff, it’s the residents also”, “I think that people have individual attention. Staff have the right approach”, “They are generally good and ask people” and “She is happy enough. They treat her very respectfully”.

We saw people were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people’s individual needs. We saw staff assisting people, using walking frames and in wheelchairs, to access the lounge, bedrooms and dining room. Staff assisted people in a calm and gentle manner, ensuring the people were safe and comfortable, often providing reassurance to them. This meant that staff treated people with dignity and respect.

A member of staff was available at all times throughout the day in the areas occupied by people who lived at the home. We observed people who used the service received help from staff without delay. We saw staff interacting with people in a caring manner and supported people to maintain their independence. A person who used the service told us, “I’ve been a bit lazy lately, I can have lie ins

and naps if I want”. Relatives told us, “My mam has a pad and sensor and they are always making sure she is alright” and “They do ask her and give options. I think that they promote independence”.

All the staff on duty that we spoke with were able to describe the individual needs of people who were using the service and how they wanted and needed to be supported. A member of staff told us, “I am proud working here. We are a good team and all work hard together. I like to see the residents happy especially when you see you can put a smile on someone’s face. This meant that staff were working closely with individuals to find out what they actually wanted.

We saw the bedrooms were individualised, some with people’s own furniture and personal possessions. We saw many photographs of relatives and occasions in people’s bedrooms. All the people we spoke with told us they could have visitors whenever they wished. The relatives we spoke with told us they could visit at any time and were always made welcome.

We saw Do Not Attempt Resuscitation (DNAR) forms were included in care records and we saw evidence that the person, care staff, relatives and healthcare professionals had been involved in the decision making. This meant that information was available to inform staff of the person’s wishes at this important time to ensure that their final wishes could be met. We saw staff had received training in end of life care.

We saw people were provided with information about the service in the registered providers ‘statement of purpose’ and ‘service user guide’ which contained information about privacy, dignity, independence and choice, the staff team, fire/emergency procedures, social activities, spirituality, and complaints. Information about local services was also prominently displayed on notice boards throughout the home including, for example, safeguarding and the local authority.

Is the service responsive?

Our findings

We found care records were person-centred and reflected people's needs. We looked at care records for four people who used the service. We saw people had their needs assessed and their care plans demonstrated regular review, updates and evaluation.

The home used a standardised framework for care plans and these were person centred to reflect people's identified need. We saw evidence of a range of care plans that included: physical and emotional wellbeing, mental health, breathing, continence, end of life, capacity, infection control, environmental safety, communication, skin integrity, personal care and hygiene, activity, sleep, nutrition and hydration, mobility and medicine. Care plans contained people's photographs and recorded their allergy status. Personalised risk assessments were in place relating to people's assessed needs. This meant risks were identified and minimised to keep people safe.

We observed people and their relatives being actively involved in discussions regarding care planning issues and we saw evidence of this recorded within their care plans. People and their relatives told us "I have seen my care plan, I was part of it", "We have been involved in meetings about her care" and "I have been involved in the care plans".

We saw staff used a range of specialist assessment and monitoring tools and kept clear records about how care was to be delivered. For example, Malnutrition Universal Screening Tool (MUST), which is a five-step screening tool, were used to identify if people were malnourished or at risk of malnutrition and Braden Scale assessment was used to determine the risk of people developing skin pressure damage. Nutritional monitoring documents were in use on a daily basis where there had been an identified need and Body Maps were used where they had been deemed necessary to record unusual skin marks or physical injury.

The service employed two activities co-ordinators. We saw daily planned activities were displayed on the notice

boards which included a quiz, bingo, ball games, armchair exercises, discussion group, singing and music, film and television, newspapers and books, tea and coffee mornings and trips out. On the day of our visit we saw the home hosted a coffee morning and we saw people watching television in the lounges or in their bedrooms, reading books and completing puzzles. Later in the day we saw people getting ready to go the pantomime, Dick Whittington, at the local community centre.

People and their relatives told us, "In the summer we are out on the green. We sometimes play games and cards", "I usually do crosswords, they do bingo, I read, and they do seated exercise. We are going to the pantomime tonight and there are trips out", They have had a coffee morning and I go to the community centre on a Wednesday. I go to a social club and a women's centre with my support worker on a Tuesday", "She likes to embroider, knit, paint and crayon. She likes to wash up. She goes to the Haswell Mencap Day club. I have no concerns", "They play bingo and she sings along to the music" and "She likes to knit, she liked to bake and she was a homemaker". This meant the provider ensured people had access to activities that were important and relevant to them.

People were encouraged and supported to maintain their relationships with their friends and relatives. Relatives and friends could visit at any time of the day. This meant people were protected from social isolation.

We saw a copy of the complaints policy on display. It informed people who to talk to if they had a complaint, how complaints would be responded to and contact details for the local authority and CQC, if the complainant was unhappy with the outcome. We saw the complaints file and saw that complaints were recorded, investigated and the complainant informed of the outcome including the details of any action taken. The people who used the service and their relatives were aware of the complaints policy. A person told us, "If I had a complaint I would go to the manager". This meant that comments and complaints were listened to and acted on effectively.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post however we had been notified that they were on short term leave of absence from the home. The manager had been registered with CQC since 12 April 2011. The deputy manager was acting as manager in the interim. A registered manager is a person who has registered with CQC to manage the service. We discussed the management arrangements with the deputy manager and the operations manager. We found the arrangements to be satisfactory and supportive of the acting manager. The CQC registration certificate and most recent CQC inspection reports were prominently displayed in the home.

The deputy manager told us the home had an open door policy, meaning people who used the service, their relatives and other visitors were able to chat and discuss concerns at any time. Staff we spoke with were clear about their role and responsibility. They told us they were supported in their role and felt able to approach the registered manager or to report concerns. A member of staff told us “The registered manager and the deputy manager have been excellent in supporting me through a period of ill health, they are both very approachable, this is a good place to work”.

The provider had a quality assurance system in place to ensure people at the home received the best care. We looked at the registered provider's audit file, which covered areas such as health and safety, medicines, care plans, infection control, nutrition and catering. All of these were up to date and included action plans for any identified issues.

People who used the service and their relatives told us they were regularly involved with the service in a meaningful way. They told us they felt their views were listened to and acted upon and that this helped to drive improvement. We saw the service held regular residents and relatives meetings. We saw the minutes of a recent meeting held on 13 January 2016 which was attended by 18 residents and 2 relatives. Discussion items included menus, decoration, cleanliness, staffing and care.

We saw a 'You said, We did' notice board displayed in the entrance to the home dated 13 January 2016. The notice board demonstrated the registered manager had recently

sought views and comments, about the home, from people who used the service and their relatives. The responses received included that people were concerned about the staffing levels in the Brockwell unit, the colours of the corridor in the Beechwood unit and the choice of meals and snacks. The board displayed the actions taken by the registered manager to address the concerns. For example, staffing levels had been reviewed and an additional member of staff was made available in the Brockwell unit, people were now being consulted about future redecoration of the home, a better selection of fruit was being provided and the variety of dishes available for people with diabetes had improved.

We saw staff meetings took place regularly although attendance was low. The operations manager told us there were options being considered to address this. We found staff were able to discuss any areas of concern they had about the service or the people who used it. Discussion items included training and documentation. This meant that the provider gathered information about the quality of the service from a variety of sources and had systems in place to promote continuous improvement.

The service had close links with the local community centre. The deputy manager told us how the people who used the service visited the centre regularly for lunches and organised events.

The service had policies and procedures in place that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions. For example, the registered provider's nutrition policy referred to guidance from the National Institute for Health and Care Excellence and the infection control policy referred to guidance from the Department of Health. The deputy manager told us, “Policies are regularly discussed during staff supervisions and staff meetings to ensure staff understand and apply them in practice”. The staff we spoke with and the records we saw supported this.

On the day of our visit we found that storage of people's care files on the Granary unit was not sufficiently secure and could have led to a breach in confidentiality. We discussed this matter with the deputy manager who addressed it at the time of our inspection. Records were maintained and used in accordance with the Data Protection Act.