Lotus Care 2 Limited

Abbas Combe Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 January 2017 and was unannounced.

Abbas Combe Nursing Home is registered to provide accommodation and nursing care for up to 25 people with a variety of needs including those living with dementia. At the time of our inspection, there were 18 people living at the home all of whom were over 65 years of age and had varying needs such as those associated with old age, frailty and dementia. Abbas Combe Nursing Home is a detached property close to the A27 on the outskirts of Chichester. Communal areas include an entrance hall, lounge with a conservatory and a dining room. Approximately half the rooms have en-suite facilities. The property has gardens at the rear, with seating areas.

The service did not have a registered manager in post as the previous registered manager had left the service. There was a new manager in post who has applied to be registered with the Commission. 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.

The last inspection took place on 27 and 28 October 2015. At that inspection we made legal requirements for two breaches of our regulations; these were regarding the lack of adequate maintenance of the premises and inconsistency in records for needs such diet and management of pressure areas on people's skin. The provider sent us an action plan to say how these legal requirements would be met. The action plan, however, did not include a date to say when these would be completed but said the action plan was 'ongoing.' At this inspection we found improvements and redecoration to the premises had been made and this regulation was now met. We also found care records were generally accurate and consistent; this regulation is also now met.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed.

Medicines were safely managed although we have made a recommendation regarding 'as required' medicines to ensure there is clear guidance for their use.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured suitable staff were employed.

Staff were trained and supervised so they provided effective care to people. This included induction training

for newly appointed staff and access to nationally recognised training such as the Diploma in Health and Social Care.

People were consulted about their care. Records showed people's consent was obtained regarding the care and support they needed.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and applications made to the local authority where people's liberty needed to be restricted for their own safety.

People were looked after by kind and caring staff who knew them well. People and their relatives said people were treated with respect and dignity. Staff were observed to support people well and to respond to their emotional needs.

People's needs were assessed before they were admitted. Care plans gave staff guidance on how to support people. A range of activities were provided and the provider was planning to extend these.

The service had a complaints procedure and people knew what to do if they were not satisfied with the service they received. Records were kept of any complaints which showed they were looked into and responded to.

There were a range of systems to measure the quality of care provided. People, their relatives, staff and other professionals were asked for their feedback on the service; these were mainly positive. Residents' meetings were held where people were able to express their views on the service.

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 always safe.

Procedures for when 'as required' medicines needed to be administered were not clear.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

Improvements have been made regarding the maintenance and decoration of the premises.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised so they could provide effective care to people.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People were looked after by kind and friendly staff and they were treated with dignity and respect.

Care was personalised to reflect people's preferences and needs. People were consulted about their care and were able to choose how they spent their time.

People's privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed. Care plans were individualised and reflected people's preferences.

A range of activities were provided to people.

The service had an effective complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Good

The service was well led.

People, their relatives, staff and other professionals were asked for their views about the service so that any improvements or action could be taken.

The provider was proactive in making plans to improve the service and carried out regular audits of the service provision.

There was a new manager in post who had applied for registration with the Commission.

Abbas Combe Nursing 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 10 and 11January 2017 and was unannounced. The inspection was carried out by an inspector and a Specialist advisor in nursing care.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with five people and to three relatives. We spoke with the manager and five staff, which included the chef, a housekeeper, care staff and a registered nurse. We also spoke to the provider and the provider's regional manager. We obtained the views of the local authority who commissioned services from the home and carried out their own audit visits. These professionals gave

permission for their comments to be included in this report.

We looked at the care records for 11people and the medicines administration records (MARs) for people accommodated on the ground floor. Staff training, induction and supervision records were looked at. We also looked at records such as complaints and quality assurance checks.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 27 and 28 October 2015 we found the provider was in breach of Regulation 15 as the premises were not safely maintained. The provider submitted an action plan to say the issues with the premises were being addressed and ongoing maintenance work was being carried out. At this inspection we found improvements had been made to those areas highlighted in the previous inspection report as requiring attention. Redecoration had taken place in the dining room and communal areas. Bedrooms were clean and decorated to a good standard. Since the last inspection we received a complaint that a bedroom had odours caused by urinary incontinence. However, at this inspection there were no unpleasant odours. There were areas still in need of attention such as worn and dirty carpets, marks on walls in corridors and the occasional damaged paintwork. The provider confirmed these were included in future redecoration plans. Checks were made by suitably qualified persons of equipment such as the passenger lift, hoists, fire safety equipment and alarms and electrical appliances. The risks of legionnaires disease was checked by a suitably qualified contractor. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. Temperature controls were in place to prevent any possible scalding from hot water. This regulation was now met as the provider had taken sufficient steps to ensure the environment was safe, well maintained and plans to carry out ongoing redecoration.

People and their relatives told us care was provided in a safe way and people said they felt safe at the service. For example, one person said, "I feel safe here, it's like living with a family." People considered there were enough staff and that staff responded when they asked for help by using the call points in their rooms. One relative, commented, "On the whole the response time of staff is satisfactory," but added there were the occasional delays. We observed call points were in easy reach of people so they could ask for assistance.

Staff were trained in procedures for reporting any suspected abuse and for safeguarding those at risk. Staff said they would report any concerns to their line manager and knew the procedures for contacting the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of adults, including a copy of the local authority safeguarding procedures. We identified one person had developed a pressure sore which should have been notified to the local authority safeguarding team. This was completed immediately after the inspection and a notification about this was also sent by the manager to the Commission.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on how to support people to reduce the risk of injury or harm. These included the risks of falls, the risk of pressure areas developing and risks when moving people. Risk assessments and care plans gave staff clear guidance on how to support people to mobilise safely. Where people had specific safety issues, such as the use of bed rails to keep them safe these were assessed for any risks. Equipment was in place to reduce the risk of pressure areas developing on people's skin such as air mattresses and cushions. Charts showed that people were turned at intervals as set out in the care plan to reduce the pressure on people's skin due to immobility. We observed staff supporting people to mobilise safely, which included explaining to people the most appropriate and safe way to get up. Care plans, including risk assessments, were reviewed on a regular basis so any changes in people's needs regarding risks could be identified.

Sufficient numbers of staff were provided to meet people's needs. This judgement was based on our observations, how the management assessed the staffing levels needed to safely care for people and what people and staff told us. The service used a dependency assessment tool to assess the levels of staff to meet care needs. We saw the staffing levels exceeded what the dependency assessment said was required to meet people's care and nursing needs. At the time of the inspection there was a Registered General Nurse (RGN) on duty from 8am to 8 pm with four care staff 8am to 2pm. From 2pm to 8pm three care staff were on duty. The staff rota showed these staffing levels were provided and on some mornings there were two RGNs on duty. At night time there were two care staff and a RGN on duty.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC).

We looked at the service's procedures for the handling, storage and administration of medicines. Stock checks were carried out and recorded as well as records for any medicines received. A monthly stock check and regular audits of medicines had taken place. The medicine administration records (MARs) were completed each time medicines were administered and showed medicines were given as prescribed. Stocks of medicines also indicated medicines were administered as prescribed. Where people administered their own medicines this was subject to an assessment to determine if the person could do this safely themselves. Checks were made regarding blood sugar levels where medicines for diabetes were administered as well as blood checks by the NHS to determine the amounts of warfarin needed. There has been one medicine error in the 12 months preceding the inspection. This was looked into by the local authority safeguarding team and the provider. Additional measures had been put in place to ensure a reoccurrence did not take place, such as additional staff training.

Where people had medicines prescribed to be taken on an 'as required' basis when people had specific symptoms there was lack of guidance recorded to show staff what the symptoms would be and the procedures for administering these. This was discussed with one of the registered nurses and the manager. It was not clear from discussion with one of the nurses what the specific circumstances were to indicate when 'as required' medicines should be given. The lack of specific recorded guidance regarding 'as required' medicines means there is a risk staff may not recognise when this is needed, especially when agency staff are involved in the administration of medicines. We recommend the provider takes action where people have 'as required' medicines so staff have clear guidance on the circumstances when this medicine is needed.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff knew people's needs well and were conversant with information recorded in the care plans. Staff were motivated and enjoyed their work. People and their relatives described the staff as helpful and responsive.

Staff confirmed they had access to a range of training courses and were encouraged by the management to develop their skills. One of the registered nurses told us how they maintained their nursing skills and NMC registration by updating training in subjects such as catheterisation and venepuncture (the process of obtaining intravenous access for blood or treatment).

The management maintained a staff training matrix which allowed the manager to monitor when staff had completed training considered to be mandatory. These included health and safety, dementia awareness, fire safety, food hygiene, first aid and moving and handling. This training was either provided in a 'classroom' setting, such as for first aid and moving and handling, or, by an internet interactive training programme. Staff who handled medicines were trained in this, which included a staff competency assessment.

The service employed five RGNs plus the manager who was also an RGN. Fourteen care staff were employed. The manager Staff said there had been an improvement in the numbers of permanent RGNs and care staff which has led to less agency staff being used. Five of the 13 care staff team were qualified to National Vocational Qualification (NVQ) levels 2 or 3 or had the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Newly appointed staff underwent an induction which involved a period of shadowing more experienced staff. The induction included direct observation and assessment of staff to determine if they were sufficiently skilled to work without direct supervision. Records of staff induction were maintained and newly appointed staff registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff confirmed they received an induction which prepared them for their role.

The local authority contracts and commissioning team has had input to the service to assist in developing staff skills and competence. The staff contracts and commissioning team said staff were motivated to attend additional training.

Staff told us they felt supported in their work and could ask for advice when they needed it. Records of staff supervision were maintained and the manager acknowledged some staff had received more frequent supervision than others and would be addressing this. For example, one of the RGNs had a record of four supervision sessions in 2016 whereas other staff had just one. Records also showed staff appraisals took

place although not all staff received an appraisal in 2016. Again, the manager was planning to address this.

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). At this inspection we found the provider had taken action to ensure the capacity of people was assessed where needed and prior to any DoLS application. At the time of the inspection two people were subject to a DoLS authorisations. Where people did not have capacity to consent to their care and treatment appropriate arrangements were made for decisions to be made on behalf of people called 'best interests' decisions.

Staff were trained in the MCA and were aware of the principles of the legislation. Care plans and care plan reviews showed people were consulted about their care and had signed to agree to the arrangements for their care and treatment. People said they were consulted about their care and that their views were incorporated into how they received their care. Staff were observed to ask people what they wanted to do and how they wanted to be helped.

People had a choice of food and said they were asked in advance what they would like to eat for the meals ahead. People and their relatives said the food was good. Two people said how they enjoyed the cooked breakfast. A relative said the food is "lovely" and said pureed food was presented "beautifully" with each meal component pureed separately rather than together.

We observed staff were generally attentive to people at lunch time to ensure their nutritional needs and food preferences were met. The meal was homemade and looked appetising with plenty of fresh vegetables. People were supported by staff to eat. Where people were not eating staff asked people if they would like something else.

We identified some of the meal routines were in need of improvement. The main course was served at the same time as the dessert. This was confusing for one person who ate their dessert before the main course. We spoke to the manager and provider about this who said the dessert should not have been served to people at the same time as the main course and was an error made by staff. We also saw where one person was reluctant to eat, that staff offered the person an alternative and the person decided to have an omelette. However, the omelette was not served to the person until 30 minutes later. Staff were overheard to say it had been left on the kitchen counter as staff had forgotten to serve it. These were two isolated incidents and did not reflect the overall meal experience for people, which was positive. The manager and provider said these would be looked into and addressed with staff.

We spoke to the chef who said meals were home made from fresh ingredients, and, if needed were fortified with ingredients such as cream to increase the calorific value. Meals were prepared according to a menu plan. Food stocks included fresh fruit and vegetables.

People's nutritional needs were assessed regarding any risks of malnutrition and each person's weight was monitored. Where needed people had a nutrition care plan, which gave staff guidance on how to support people with eating and drinking. Charts were completed by staff to monitor people had sufficient food and drink. Referrals were made to specialist health services where people were at risk of malnutrition or had

difficulties swallowing. Advice from these specialists was recorded in the relevant care plans so staff had guidance to support people. A drinks trolley of tea, coffee or biscuits was brought round to people in the morning and in the afternoon to ensure people had enough to eat and drink. People had soft drinks in their rooms.

People's health care needs were assessed and monitored. Records showed eyesight, hearing, dental and oral care needs were assessed. Observation charts demonstrated each person's pulse, body temperature, blood pressure and respiration was monitored. People and their relatives said staff contacted the GP when any medical need arose. Records showed staff referred people for medical assistance when it was identified people needed medical input. This included contacting community nursing services and people's GP. Records of any appointments people had with health care services were recorded.

Good

Is the service caring?

Our findings

People were treated with kindness and respect by the staff. Positive comments were made by people and their relatives about the attitude and approach of the staff. For example, a relative told us, "The staff are really caring, I can't fault them. It is really refreshing to see how much the staff care for the residents." Another relative described the staff as, "kind and friendly" and formed good relationships with people. People said they were consulted about their care and were able to make choices in how they spent their time, such times for getting up and going to bed. For example, one person said, "Staff respond to any queries or questions. I get up when I'm ready, usually at 7am and choose what I want for breakfast."

We also received positive feedback from relatives who said, "Care is provided with dignity and respect," and, "Carers knock the door before they come into her room, they give care in a person centred way. The staff know mum and they listen to what she wants, for example they will put her to bed when she asks. They always offer choice. The call bell is always answered in good time. I feel included in her care."

Each person's care plan was personalised to reflect how people's needs were to be met. These included details about people's preferences as well as psychological and social needs such as how to support people with bereavement. Care plans showed people were consulted and had agreed to the arrangements for their care. Emotional needs were assessed and included in care plans with details about how to support people who needed specific support. We observed staff responded appropriately to those who experienced distress.

Staff were observed to treat people with kindness and respect. We observed the lunch time meal and saw staff spoke to people politely, asked them what they wanted and responded to any requests. Where staff supported people to eat this was carried out calmly with staff making good eye contact and spoke to people as they supported them.

Staff demonstrated they had values of compassion towards people and were focused on people's needs. For example, when we asked a staff member what they enjoyed about their job, they replied, "The residents." Staff told us how important it was to treat people with kindness and one staff member said this was the most important aspect of providing care. Staff also said it was important to carefully listen to what people said and to be patient. The values of providing care to people had been discussed at a recent staff meeting and this included reference to 'the mum test': that the care being provided is good enough for a close relative.

Staff promoted people's privacy by knocking on bedroom doors and waiting for a response before entering.

The provider confirmed that where applicable people had end of life care plans and that staff were registered for training in end of life care with a local hospice.

Good

Is the service responsive?

Our findings

At the inspection of 27 and 28 October 2015 we found the provider was in breach of Regulation 17 as information in people's care records was not always consistent or accurate. The provider submitted an action plan to say this was being addressed to ensure care plans and records of care were accurate and up to date. At this inspection we found improvements had been made in this area and the regulation was now met.

People and their relatives told us care needs were met. One relative told us how their mother's skin had improved since being admitted to the service. Another relative contacted us to say they would like to praise the staff for the "excellent care." One relative, however, had contacted us to say the staff provided a "high standard of care" but that staff had not encouraged their relative to get out of bed enough. This was looked into and responded to by the previous registered manager.

Care records showed people's needs were assessed prior to being admitted to the service. This allowed the staff and manager to make a decision as to whether the person's needs could be met. Assessments of care and care plans were comprehensive and included the following areas: dietary needs, physical well-being, personal care, mental health, medicines, continence and mobility. There was an abbreviated care plan so staff were able to see what someone's care needs were without looking at the whole file. The care plans were individualised to reflect each person's needs and preferences.

A copy of each person's care plan was held in their bedrooms along with any charts which needed to be completed on a daily basis such as charts when people were turned to alleviate pressure on their skin, food and fluid intake, night time observations and daily provision of personal care.

People told us they attended a range of activities and we observed people taking part in an afternoon craft session on one of the days of the inspection. There was a list of events displayed which included two or three per month such as parties, and mother's day celebrations. In addition to this were craft activities each Tuesday and quizzes on Wednesdays. Activities were also provided by external providers such as entertainers and reminiscence sessions. A record was kept of the activities undertaken by individual people. The provider confirmed the provision of activities was under review with plans to increase them, such as the use of a volunteer for one to one sessions with people.

The service had an effective complaints procedure with any concerns looked into and responded to. The complaints procedure was displayed in the home. People and their relatives said they knew what to do if they had a complaint and that they felt comfortable raising any complaints. For example, one relative said the staff and manager were open and approachable and listened and responded to any concerns raised.

The provider confirmed five complaints have been received in the 12 months before this inspection. The service maintained a record of complaints which showed complaints were looked into and a response made to the complainant. These included meetings with complainants and the creation of any action plan to address areas in need of improvement.

Good

Is the service well-led?

Our findings

People and their relatives gave examples of the service's management seeking and acting on their views. For example, one relative said they were able to give their views by completing a satisfaction survey questionnaire adding that the management were approachable and listened to what they said. We saw copies of survey questionnaires which gave generally positive comments about the service. Two of these stated there had been improvements in cleanliness in the home and that odours caused by urinary incontinence had lessened. Another questionnaire acknowledged concerns were dealt with. There was also a 'suggestions and comments' box in the hall, so that anyone could post their feedback on any aspect of the home and care provided. The views of stakeholder professionals were sought and were also positive about the service. For example, a GP commented, 'Staff are very of aware about needs and requirement of the residents. Good team work providing optimal care in conjunction with doctors.' People were also able to discuss the running of the home at the residents' meetings. Relatives' meetings were also held. This ensured the feedback of people and relatives were sought to promote continuous improvement of Abbas Combe.

The service focussed on meeting the needs and preferences of people. Staff were aware of their responsibilities and said they felt able to raise any issues with the manager. The provider and manager were open to suggestions as to how the service could be improved and the PIR showed plans were in place to develop the service. Staff were encouraged to develop their skills. Staff were motivated and said they worked well as a team. Staff and people described the service as being 'like a home' and provided a good standard of care.

Staff meetings were held and minutes of these showed the quality of the service was discussed along with incidents, accidents, providing good care and staff training. Staff meetings were also held for specific groups of staff such as the nurses or care staff. Staff said the manager was approachable and felt able to raise any issues they had.

The provider carried out regular audit checks of the service and the last one of these included checks on people's care records, any complaints made, the environment as well as discussions with staff and people. There were a range of other systems in place to monitor the quality of the service provided. These included audits of: care plans, medicines, air mattresses, completion of resuscitation authorisations made by a medical practitioner, the environment, infection control and accidents and incidents. An audit by an external body on infection control in the home was also carried out. Audits of untoward incidents were carried out each month but we noted these had stopped in September 2016. This was thought by the provider to be as a result of the change in manager.

Since the last inspection the registered manager had left and there was a new manager. At the time of this inspection the new manager had applied to be registered with the Commission. The new manager was committed to making improvement and to develop the service. The service had a system of line management which included a deputy manager and senior care staff.