

Ramaul Limited

Abbeyrose House

Inspection report

1 St Michaels Road
Maidstone
Kent
ME16 8BS

Tel: 01622762369
Website: www.abbeyrosehouse.co.uk

Date of inspection visit:
20 December 2016

Date of publication:
19 January 2017

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 ●

Summary of findings

Overall summary

The inspection was carried out on 20 December 2016, and was an unannounced inspection.

Abbeyrose House provided accommodation and personal care for up to 29 older people some of whom were living with dementia. The accommodation is arranged over three floors which were served by stair lifts and a passenger lift to assist people to get to all levels. There were 29 people living in the service when we inspected.

There was a registered manager at the home. 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 and associated Regulations about how the service is run.

At our previous inspection on 19 October 2015, we found breaches of Regulation 9 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were stored securely. People were supported to take their medicines when required. However, staff had not followed the procedures for signing the MAR chart once medicines had been given. We made a recommendation about this. Health and safety risk assessments relating to staff had not been completed. Staff did not have suitable information and guidance to safely work with people. We made a recommendation about this. People were fully involved in the development and review of their care plans. The care files we saw did not contain an initial assessment prior to receiving support from the service although people were encouraged to visit the service. We made a recommendation about this. We asked the provider to submit an action plan by 28 February 2016. The provider submitted an action plan on 26 February 2016 which stated that the provider will meet the regulations by 30 May 2016. At this inspection, we found improvements had been made and the provider was meeting the requirements of the regulations.

During this inspection, we found that medicines were managed safely. The processes in place ensured that the administration and handling of medicines was suitable for the people who used the service. People had good access to health and social care professionals when required.

People's safety had been appropriately assessed and monitored. Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as falls, mobility and skin integrity. However, generally the risk assessments had not been reviewed regularly. We have made a recommendation about this.

People were involved in assessment and care planning processes. Their support needs, likes and lifestyle preferences had been carefully considered and were reflected within the care and support plans available.

Our observation on the day showed that people had a variety of activities. Activities were diverse enough to meet people's needs and the home was responsive to people's activity needs.

People had access to nutritious food that met their needs. We observed that people had choices of food at each meal time. People were offered more food if they wanted it and people who did not want to eat what had been cooked were offered alternatives

The provider and registered manager had suitable processes in place to safeguard people from different forms of abuse. Staff had been trained in safeguarding people and in the provider's whistleblowing policy. They were confident that they could raise any matters of concern with the registered manager, or the local authority safeguarding team.

There were sufficient staff, with the correct skill mix, on duty to support people with their needs. Staff attended regular training courses. Staff were supported by their manager and felt able to raise any concerns they had or suggestions to improve the service to people.

The provider and registered manager had robust recruitment practices in place. Applicants were assessed as suitable for their job roles. Refresher training was provided at regular intervals. All staff received induction training at start of their employment.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider and staff understood their responsibilities under the Mental Capacity Act 2005.

People knew how to make a complaint and these were managed in accordance with the provider's policy.

Staff were clear about their roles and responsibilities. The staffing structure ensured that staff knew who they were accountable to. Staff meetings were held frequently. Staff told us they felt free to raise any concerns and make suggestions at any time to the registered manager and knew they would be listened to.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken. The registered manager and provider regularly assessed and monitored the quality of care to ensure standards were met and maintained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff were informed about safeguarding adult procedures, and took appropriate action to keep people safe.

The registered manager carried out individual risk assessments to protect people from harm or injury.

Accidents and incidents were monitored to identify any specific risks, and how to minimise these.

Staff were recruited safely, and there were enough staff to provide the support people needed.

Is the service effective?

Good ●

The service was effective.

Staff received on-going training in subjects identified by the provider as key areas. One to one supervisions took place as planned and yearly appraisal meetings were planned.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

Staff were knowledgeable about people's health needs, and contacted other health and social care professionals if they had concerns about people's health.

People's human and legal rights were respected by staff. Staff had the knowledge of the Mental Capacity Act and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Good ●

The service was caring.

People felt that staff provided them with good quality care. Staff kept people informed of any changes relevant to their support.

Staff protected people's privacy and dignity, and encouraged

them to retain their independence where possible.

Staff were aware of people's preferences, likes and dislikes.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

Is the service responsive?

Good ●

The service was responsive.

People were supported in line with their needs. People's needs were assessed and care plans were produced, identifying how support needed to be provided.

People and their relatives were involved in decisions regarding their care and support needs.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good ●

The service was well-led.

There was an open and positive culture which focused on people. The registered manager sought people and staff's feedback and welcomed their suggestions for improvement.

The registered manager maintained quality assurance and monitoring procedures in order to provide an on-going assessment of how the service was functioning; and to act on the results to bring about improved services.

Records were clear and robust.

Abbeyrose House

Detailed findings

Background to this inspection

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

This inspection took place on 20 December 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports, actions plans and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection, we spoke with five people, three care assistants, the chef, the registered manager and the co-owner. We also spoke with visiting GP, district nurse and a visiting relative.

We looked at records held by the provider and care records held in the home. These included three people's care records, people's medicines records, risk assessments, staff rotas, three staff recruitment records, meeting minutes, quality audits, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including training records, quality assurance reports and recruitment information. The information we requested was sent to us in a timely manner.

Is the service safe?

Our findings

At our last inspection on 19 October 2015, we found that people were supported to take their medicines when required. However, staff had not followed the procedures for signing the MAR chart once medicines had been given. Health and safety risk assessments relating to staff had not been completed. Staff did not have suitable information and guidance to safely work with people. At this inspection, we found improvements had been made and the provider was meeting the requirements of the regulations.

One person said, "Absolutely, I feel safe. There is always someone to help you".

A visiting relative said, "My mother is safe here".

People were protected from the risks associated with the management of medicines. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained to them. We observed a trained staff member administering people's medicines during morning medicine round. The staff member checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. Medicines were given safely. Staff discreetly observed people taking their medicines to ensure that they had taken them.

Medicines were kept safe and secure at all times. They were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. There was a system of regular audit checks of medicine administration records and regular checks of stock. We completed a stock check of medicine which was boxed, this was correct. These contained information and a photograph of the person and of the medicine they had been prescribed. MAR sheets we looked at had been completed correctly. Medicines were stored correctly and audited at every administration. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

Within people's care plans we found risk assessments to promote and protect people's safety in a positive way. The registered manager identified risks to the individual, assessing the risk and how to manage it. For instance, moving and handling risk assessments recorded the activity and what measures needed to be put in place to carry out the task safely. Individual risk assessments were comprehensive with step by step guidance for people and staff. We saw evidence that risk assessments had been reviewed and changed in response to a change in circumstance or an incident. However, generally the risk assessments had not been reviewed regularly when not prompted in this way. This meant that the registered manager was not evidencing that she was checking that the information remained valid. We spoke to the registered manager about this who agreed and said she would immediately action reviewing risk assessments every month.

We recommend that the registered manager review practices in relation to reviewing risk assessments in the home.

Records showed that incidents and accidents were monitored in order to ensure that preventative measures

were put in place if required. Accident records were kept and audited by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of the quality assurance system. This record showed incidents of falls for example were clearly audited and any actions were followed up and support plans adjusted accordingly.

Staff were aware of how to protect people from abuse and the action to take if they had any suspicion of abuse. Staff were able to tell us the different types of abuse and how to recognise potential signs of abuse. Staff training in protecting people from abuse commenced at induction, and there was on-going refresher training for safeguarding people from abuse. Training plans sent to us confirmed that all staff had completed safeguarding training. All staff spoken with said they would usually contact the registered manager immediately if abuse was suspected, but knew they could also contact the Social Services safeguarding team directly. Staff also had access to the updated local authority safeguarding policy, protocol and procedure dated April 2016. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. A member of staff said, "I will tell the manager if I observe bad practice." This showed that the provider had up to date systems and processes in place that ensured the protection of people from abuse.

The registered manager told us there was adequate staffing to meet people's needs. Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and training to meet the needs of the people who used the service. The records we looked at such as the rotas and training files confirmed this. The provider had a dependency tool in place to assess the hours of support each individual required each week. This in turn helped the registered manager to assess the numbers of staff she needed to have available on the rota each week to be able to provide the support hours required.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Employment procedures were carried out in accordance with equal opportunities. Interview records were maintained and showed the process was thorough, and applicants were provided with a job description. Successful applicants were provided with the terms and conditions of employment. This meant that people could be confident that they were cared for by staff who were safe to work with them.

People had personal emergency evacuation plans (PEEP's) that were individual to the person and their specific support needs in the event of an emergency evacuation of the premises. The PEEP's had been agreed and signed either by the person themselves or their relatives.

There was a plan staff would use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

Is the service effective?

Our findings

People said, "I do like it here, they do just as I want them to", "I like the food and can ask for something else if not happy with what is on the menu" and "I am happy here."

A relative said, "It seems fine. They are doing a great job."

The registered manager told us that staff had appropriate training and experience to support people with their individual needs. Staff completed an induction course that was in line with the nationally recognised 'Care Certificate' by Skills for Care. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively and that staff understood their roles in delivering care.

Staff training was mainly through online training. Staff told us they were happy with this and that it suited them well. One member of staff said, "I like it as I can go at my own pace and time. It was a bit scary at first as I was not used to computers but definitely good now". Staff received training in a variety of topics, which included health and safety, fire safety, safeguarding, food hygiene, diabetes, deprivation of liberty safeguards (DoLS) and pressure care. Our discussions with staff confirmed they understood people's care needs. For example, staff could describe who needed additional staff to assist when they were moved using equipment like a hoist and which people were on specialised diets. Staff also described which people needed staff support at meals times to help them maintain their health and wellbeing through eating and drinking enough.

Staff were being supported through individual one to one supervision meetings every three months. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Records confirmed that supervision had taken place. A member of staff also confirmed training needs were discussed as part of supervision and they could ask for training that would be of benefit to them in their role. They said, "I receive supervision with the manager and I can discuss freely."

Yearly appraisals were carried out and reviewed. The last time this took place, development & training needs were identified. Tasks to be carried out were also identified with timescales for completion. For example, one member of staff was identified to benefit from additional training. This was actioned and planned for by the registered manager. This would enable staff to improve on their skills and knowledge which would

ensure effective delivery of care to people. Records confirmed that annual appraisals were being carried out by the registered manager.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. 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. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave examples of how they supported people who did not verbally communicate to make choices. Care staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed, the statutory principles underpinning the MCA and related this to people that were subject to DoLS.

The registered manager had gained consent from people for staff to assist with care tasks such as personal care or administering medicines when they moved into the home. Some people had been assessed as not having the capacity to give informed consent. In this case, discussions had taken place with family members who had signed to confirm their involvement.

Capacity assessments had been carried out where appropriate, ensuring people had the capacity to make any decisions that were required. Sometimes important decisions needed to be made and a person had been assessed as lacking the capacity to make that particular decision. There was evidence that relevant people, such as family members, had been consulted with to make sure any decisions were made in the person's best interests. For example, if a person required bed rails to keep them safe and prevent them falling out of bed.

Where family members had legal responsibilities to make decisions on people's behalf, such as a lasting power of attorney, this was recorded in the care plan. This meant that staff understood the responsibilities and relationships in people's lives when they were planning their care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People in the service were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People had access to nutritious food that met their needs. They had a choice of at least two different meals at dinner time and could ask for another option if they wished. People were supported to make cold and hot drinks when they wanted them. The kitchen of the service was well stocked and included a variety of fresh fruit and vegetables. Food was prepared in a suitably hygienic environment and we saw that good practice was followed in relation to the safe preparation of food. Food was appropriately stored and staff were aware of good food hygiene practices. A pictorial food guide was on the notice board for people to understand healthy eating. Weights were regularly monitored to identify any weight gain or loss that may indicate a health concern.

The chef spoke to each person every morning to ask what they wanted for lunch and tea from the menu. People were able to ask for something different if they did not like either of the choices available. Following the meal, the chef asked people if they had enjoyed their meal or what the problem was if they had not. He recorded the responses given in order to improve where necessary and to establish further people's likes and dislikes. The vast majority of the comments were positive, such as, 'very good', 'quite good', 'perfect', 'lovely pudding'.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. People had a health action plan in place. This outlined specific health needs and how they should be managed. People received effective, timely and responsive medical treatment when their health needs changed.

Records confirmed that staff encouraged people to have regular health checks and where appropriate staff accompanied people to appointments. Staff told us that each person was supported to see or be seen by their GP, chiropodist, optician, dentist or other health care professionals, including well men and women clinics. People were regularly seen by their treating team. During our inspection, people were visited by both the GP and the district nurse. The visiting healthcare professionals commented "The manager knows everything. She has her finger on the pulse, knows all the facts about every person" and "The registered manager is excellent. I trust her judgement. If she says she is worried you take note. If she says you don't need to come out but I think you should know ...I trust her with that". Health appointments were documented in people's care plans and there was evidence that the service worked closely with health and social care professionals to maintain and improve people's health and well-being.

Is the service caring?

Our findings

One person said, "Yes, in the main, I am looked after. They do attend to all our needs."

People we spoke with told us that they were able to receive visits from their family members and friends at any reasonable time. They also said family members and friends were always made to feel welcome and there was always a nice atmosphere. One person said, "My son and family do come to visit me" and "My niece and nephew do take me out."

A health care professional said, "It is very lovely here, very caring".

We observed that staff respected people's privacy. All bedrooms doors were closed. For example, when we arrived, we observed that staff were supporting people with personal care in the privacy of their rooms with doors shut. Staff knocked on doors before they entered. Staff treated people with dignity and respect. Staff were attentive, showed compassion and interacted well with people. The environment was well-designed and supported people's privacy and dignity. People were able to personalise their bedrooms. Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care for a person. We found the staff team was committed to delivering a service that had compassion and respect for people.

Staff respected confidentiality. People's information was treated confidentially. People's individual care records were stored securely in lockable filing cabinets in the office, but were available to people and staff. We saw evidence that people were asked before information was shared with people.

Staff were kind, caring and patient in their approach. Staff supported people in a calm and relaxed manner. They stopped to chat with people, listening, answering questions and showing interest in what they were saying. We observed staff initiating conversations with people according to their mode of communication in a friendly, sociable manner and not just in relation to what they had to do for them. We found that staff knew the people they were supporting well.

We saw many examples throughout our visit of quietly caring exchanges between people and staff. There was a calm and pleasant atmosphere in the home where staff went about their work without rushing. Staff were sitting chatting to people and making sure people had everything they needed. Many conversations took place with people asking staff about themselves and vice versa. One member of staff said, "This is a very caring home, it's like having another family. We get to know people so well. When you see them deteriorating it can be upsetting". Another said, "We get to know families well too. They often ask us what their relative wants or doesn't want as we know them so well".

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People and their family members had the opportunity to make it clear what their wishes were at the end of their life and these were recorded in the care plan. The registered manager had a plan in place for each person who health care professionals had

determined was approaching the end of their life. A colour coded system identified clearly the stage that each person was at and what this meant. This helped people, their loved ones and staff to understand and prepare appropriately.

There was evidence that people who required help to make decisions and did not have family involvement had been referred to independent advocacy services. This made sure that people had the support to make important decisions from an independent agency, helping them to speak up for themselves. The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Staff told us they were aware of how to access advocacy support for people. Advocacy information was on the notice board for people in the service.

Is the service responsive?

Our findings

At our last inspection on 19 October 2015, we found a breach of the regulations. People were not involved in any planned activities during the morning and the activities we observed were unorganised and did not fully involve people who participated. Also, we found that care files did not contain an initial assessment prior to receiving support from the service. We made a recommendation about this. At this inspection, we found improvements had been made and the provider was meeting the requirements of the regulations.

People said, "I would like to get my glasses repaired. I informed the manager and she responded by inviting professionals to the home to repair it" and "I go out on Fridays to see my friend in Maidstone, which I always look forward to."

There was evidence that people's needs were assessed prior to admission and continually throughout their stay at the service. The registered manager undertook thorough assessments of people's needs before accepting them and a structured introduction took place. Each person had an initial referral which included a full case history, as well as a pre-admission assessment. The assessment covered all medical history, any challenging behaviour, and care needed to manage and safely support the person's needs. The assessment was used to determine whether or not the service could meet the person's needs, and if any specialised tools or professional's assistance would be required. This showed that people's needs were assessed in detail to ensure they could be safely supported at the service.

Each person's detailed assessment, which highlighted their needs, led to a range of care plans being developed. We found from our discussions with staff that the plans met people's needs. We saw evidence that people and their relatives had been involved in making decisions about their care and support and developing their support plans. We reviewed care plans which contained detailed assessments that provided information on how staff should support each person. Changes to the care plans were made whenever people had been seen or assessed by external health professionals.

Personal and caring details were included in people's care plans. Such as when people had difficulties understanding or remembering what was said at times. Care plans included how to help, for instance by writing little notes and by giving plenty of time for people to process the information given. People's likes and dislikes were recorded, for example what drinks people preferred and how they liked these.

There was an emphasis on supporting people to maintain their independence throughout the care plans. For example, a section entitled 'The things I can still do myself' detailed those things, such as people being able to choose their own clothes, dressing themselves or washing themselves. Another section, 'The things I find difficult and need assistance with' recorded such things as people's mobility, if they needed an aid such as a frame, or if staff needed to walk alongside them.

People's care plan described what circumstances may make them upset and what staff could do to support them. For instance, people living with dementia who may not always be able to understand what is being said to them. The care plan clearly stated this and guidelines for staff included making sure they always

spoke slowly and clearly.

People's care plans recorded what people's interests were and what they liked to do through the day. Some people preferred their own company and did not like joining in group activities and instead like to read or listen to music. We saw many people who had a newspaper delivered each day and were sitting reading the news. Others preferred the company of other people and liked to sit in a busier lounge, joining in any group activities on offer. We saw the registered manager asking people in the lounge if they wished to have music on or the TV. People chose the TV and she checked that everyone was happy with this. People were engaged in watching the TV, discussing the programmes with each other.

Although the home had no activities coordinator as the registered manager was in the process of recruiting to this position, staff had a plan of activities they followed. The registered manager told us that they were in charge of the activities until a new person could be recruited. People had the opportunity to join in the activities of the day if they wished. The provider had subscribed to a daily 'magazine' that provided instructions and guidance to follow activities of the day. For example, a member of staff was engaging people in an exercise programme when we visited. Some people told us that they would like to get the opportunity to go out, either to take part in activities or just for a walk but at the moment they could not. We spoke to the registered manager about this and she agreed this would be beneficial for those who would like to spend time in the community. She said she would start to plan this avenue with people. A visiting healthcare professional said, "They get people involved in activities in the afternoon which is good."

There were systems in place to receive people's feedback about the service. The provider sought people's and others views by using annual questionnaires to people who used the service, staff, professionals and relatives to gain feedback on the quality of the service. Family members were supported to raise concerns and to provide feedback on the care received by their loved one and on the service as a whole. The summary of feedback received showed that people were happy with the service provided. The completed questionnaires demonstrated that all people who used the service, families and those that worked with people were satisfied with the care and support provided.

The provider had a complaints and compliments procedure. The complaints procedure was clearly detailed to people within the 'service user guide'. The complaints policy available in the office showed expected timescales for complaints to be acknowledged and gave information about who to contact if a person was unhappy with the provider response. This included The Care Quality Commission (CQC) the Local Government Ombudsman (LGO). The complaints procedure gave information about how long it would take for the provider to respond to complaints. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction.

We saw complimentary messages sent to the registered manager and staff. One of these comments was, 'We have all felt very confident in the fact that our mum has been safe and well looked after in a lovely homely atmosphere with the feeling of a large family'.

Is the service well-led?

Our findings

At our last inspection on 19 October 2015, we also found a breach of the regulation. Risks to the environment had not been assessed or recorded. At this inspection, we found improvements had been made and the provider was meeting the requirements of the regulations.

People said, "The registered manager and the co-owner make a good team" and "The manager is good. I would like to go to Scotland and she is looking into this."

A visiting relative said, "The managers are very friendly. They do respond. Very approachable."

Visiting healthcare professionals said, "The manager knows everything. She has her finger on the pulse, knows all the facts about every person" and "We (our team) rank this as a very good home, the top of the pile. It's a very good home with a very good manager."

Our discussions with the registered manager and staff, including our observation when we inspected showed us that there was an open and positive culture that focused on people. The service had a culture of fairness and openness, and staff were listened to and encouraged to share their ideas. Staff commented, "My manager and deputy are approachable. The organisation is very quick to act regarding service users."

Staff told us the morale was good and that they were kept informed about matters that affected the home. They told us that team meetings took place regularly and they were encouraged to share their views. They found that suggestions were warmly welcomed and used to assist them to constantly review and improve the service. Staff meeting records confirmed that staff views were sought.

The mission statement of the service said "We are committed to providing our residents a life that is as normal as possible, given their individual health and needs in a homely and safe environment." At this inspection, we found that these values had been fully implemented in the service. Relatives told us that Abbeyrose was a lovely home from home. We observed this practice during our visit. People and staff were cordial in their approach to each other.

The registered manager continually monitored the quality of the service and the experience of people in the service. They regularly worked alongside staff and used this as an opportunity to assess their competency and to consider any development needs. They were involved in all care reviews. We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the service. The registered manager had effective systems in place for monitoring the service, which were fully implemented. They completed quarterly audits of all aspects of the service, such as medicine, care plans, nutrition and health and safety, risk assessments for staff. They used these audits to review the service. Audits routinely identified areas for improvement and the registered manager produced action plans. These clearly detailed what needed to be done and when action had been taken.

Communication within the service was facilitated through team meetings. We saw that this provided a

forum where areas such as risk assessments, safeguarding, staff handover, infection control and people's needs updates amongst other areas were discussed. Staff told us there was good communication between staff and the management team.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated that the registered manager understood their legal obligations.

The service worked well with other agencies and services to make sure people received their care in a cohesive way. Health and social care professionals reported that staff within the service were responsive to people's needs and ensured they made appropriate referrals to outside agencies. The registered manager told us that they worked in a joined up way with external agencies in order to ensure that people's needs were met.