Millennium Care Homes Limited

Abbey House 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

Abbey House Nursing Home is a care home. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Abbey House Nursing home provides accommodation for up to 48 older people who require nursing care. A small number of people using the service were living with dementia or other mental health problems. The home provides a rehabilitation service for up to nine people under contract with the NHS. These people were accommodated temporarily at the service for between two and six weeks and were being supported to regain their independence following their discharge from hospital. At the time of the inspection there were 48 people using the service.

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

Improvements were needed to ensure that all aspects of medicines were managed safely.

Overall there were a range of systems and processes in place to identify and manage risks to people's wellbeing and environmental risks, but we have made some recommendations about the frequency with which people cared for in their room are checked and identified that many of the tools and charts used to monitor people's needs and risks were not being completed consistently.

Overall, the home was clean but we did identify some infection control concerns that could present risks to people.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

There were suitable numbers of staff deployed to meet people's needs. Appropriate checks had been made to ensure that new staff were suitable to work in the home.

Accidents and incidents were investigated and action taken to reduce the risk of further harm.

Improvements had been made to ensure that staff were provided with opportunities to develop their skills and knowledge and performed their role effectively.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. Staff worked in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were applied appropriately.

People were supported to have enough to eat and drink. People were able to choose the meals they wish to eat and alternatives were provided.

Abbey House was not a purpose built nursing home and we did find that some aspects of the premises and of the equipment within it were in need of attention. We have made a recommendation about this.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning peoples support to ensure their health care needs were met.

People were cared for by kind and compassionate staff. Staff were very motivated and spoke with enthusiasm about providing person centred care. People were treated with dignity and respect.

Improvements had been made to people's care plans which contained a more detailed record of people's individual needs. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs.

There was evidence that staff provided compassionate care to people reaching the end of their life.

The service was well led. Staff were positive about the leadership of the service and felt well supported in their roles. Staff morale was good and staff worked well as a team to meet people's needs.

The registered manager and provider had been proactive in making improvements to the governance arrangements within the service to improve the quality and safety of care for people. The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

The registered manager demonstrated knowledge, passion and enthusiasm for their role and to the people in their care and the staff team.

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.

Improvements were needed to ensure that all aspects of medicines were managed safely.

Overall there were a range of systems and processes in place to identify and manage risks to people's wellbeing and environmental risks, but we have made some recommendations about the frequency with which people cared for in their room are checked. Many of the tools and charts used to monitor people's needs and risks were not being completed consistently.

Overall, the home was clean but we did identify some infection control concerns that could present risks to people.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

There were suitable numbers of staff deployed to meet people's needs. Appropriate checks had been made to ensure that new staff were suitable to work in the home.

Accidents and incidents were investigated and action taken to reduce the risk of further harm.

Is the service effective?

Good

The service was now effective.

Improvements had been made to ensure that staff were provided with opportunities to develop their skills and knowledge and performed their role effectively.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support.

People were supported to have enough to eat and drink.

Abbey House was not a purpose built nursing home and we did find that some aspects of the premises and of the equipment

within it were in need of attention. We have made a recommendation about this.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning peoples support to ensure their health care needs were met.

Is the service caring?

Good

The service remained caring.

People were cared for by kind and compassionate staff. Staff were very motivated and spoke with enthusiasm about providing person centred care. People were treated with dignity and respect.

Is the service responsive?

Good

The service was now responsive.

Improvements had been made to people's care plans which contained a more detailed record of people's individual needs. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs.

There was evidence that staff provided compassionate care to people reaching the end of their life.

People's complaints and comments were listened to and responded to appropriately.

Is the service well-led?

Good

The service remained well led.

The service was well led. Staff were positive about the leadership of the service and felt well supported in their roles. Staff morale was good and staff worked well as a team to meet people's needs.

The registered manager and provider had been proactive in making improvements to the governance arrangements within the service to improve the quality and safety of care for people. The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

The registered manager demonstrated knowledge, passion and

enthusiasm for their role and to the people in their care and the staff team.

Abbey House 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 checked 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 was an unannounced inspection which took place over two days on 5 and 8 January 2018. On the first day of our visit, the inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. On the second day, the team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 17 people who used the service and the relatives of a further six people. We spoke with the registered manager, the operations manager, training manager two registered nurses and four care workers. We reviewed the care records of four people in detail and aspects of another five people's care plans. We also looked at the records for four staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

During and following the inspection we sought feedback from five health and social care professionals about the care provided at Abbey House Nursing Home.

The last inspection of Abbey House Nursing Home was in September 2016 when the service was rated as requires improvement. This was because we found that some of the legal requirements were not being met as people had not always received safe care, staff had not been received effective supervision, some of the records relating to people's care were not always fit for purpose and the governance arrangements were not

being effective at ensuring the safety and quality of the service. Overall, this inspection found there had been improvements and the legal requirements were now being met, although in some cases, further work was needed to ensure that the improvements were consistent, embedded and sustained throughout the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Abbey House Nursing Home. For example, one person said, "Yes very much so". A relative told us they felt their family member was safe saying, "Yes, there's always someone around to help".

We looked at how the service managed people's medicines. Controlled drugs were stored and administered safely. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. Staff administering medicines had received training and had their competency to administer medicines safely assessed on an annual basis. Homely remedies were available within the service. Homely remedies are medicines the public can buy over the counter to treat minor illnesses like headaches and colds. The use of these medicines had been agreed with the GP and protocols were in place for their administration. Each person had a medicines administration record (MAR) which contained the information needed to support the safe administration of medicines and people told us they received their medicines on time and in a manner of their choosing. The temperature of the fridge and treatment room was monitored.

However, we did identify some concerns with regards to how some aspects of people's medicines were managed. During a medicines round we noted that a bottle of tablets had been left on the top of the medicines trolley and not locked away; the trolley was unattended in the corridor for at least six minutes. Six bottles of liquid medicines had been opened but no date of opening had been recorded on the bottle; this is not in line with best practice guidance as medicines should only be kept for a limited time after opening. One medicine was in use but had passed its expiry date. Our checks showed there was a great deal of excess stock of medicines and topical creams. When checked, one of these medicines had also passed its expiry date of September 2016. We recommended that the excess stock was fully audited and this matter was addressed by the second day of the inspection.

It was the provider's policy that products used to thicken food and fluids for people who experienced problems swallowing fluids were kept in locked cupboards. We found containers of thickener stored in an unlocked cupboard in a kitchenette accessible to people. Guidance from NHS England on patient safety recommends careful risk management of thickeners as they can present a risk of asphyxiation to people. The product was moved to more secure storage. Topical medication administration records (TMAR's) were not being fully completed and therefore we could not be reassured that people were having their topical creams as prescribed. We spoke to the registered manager and the operations manager who were aware of this ongoing problem. They told us they had addressed the matter in staff meetings and supervisions and were frustrated this was an ongoing problem.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing but also environmental risks. Maintenance staff completed a range of health and safety checks, for example, the lift was regularly serviced and checks were made of the safety of electrical and gas appliances, the call bell system and window restrictors. Regular checks were undertaken of fire safety within the service and there was evidence to show that faults identified were repaired as soon as possible. People had personal

emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies. Regular checks were also made of the water safety. We did note that whilst a legionella risk assessment had been completed in May 2017, some of the recommendations from this were yet to be completed. The provider has, since the inspection, confirmed that these are to be completed on the 22 January 2018.

Each person had a range of individual risk assessments which helped to ensure their safety. For example, people had moving and handling risk assessments and assessments were in place which helped predict whether people were at risk developing pressure ulcers or becoming malnourished. Where people were at risk of choking, risk assessments had been completed and a choking care plan was in place. Bed rail risk assessments had also been completed. We did note that some of the risk assessments viewed had not been regularly reviewed. People who spent time in their rooms had access to call bells and in most cases these were seen to be readily accessible to the person. Some people were unable to use their call bells due to cognitive impairment. Where this was the case, records showed they were currently checked upon every two to three hours to ensure they were comfortable and safe and to carry out scheduled or required tasks. We felt some people cared for in their rooms might benefit from more frequent checks and we recommend that the registered manager review this to reassure themselves that each person is receiving attention on a regular basis according to their needs.

We did note some areas where improvements could be made. One person who had regular falls over a three month period had no care plan in place which described how their risk of falls was being managed. We brought this to the attention of the registered manager who addressed this. A small number of people had fluid charts which were being used to monitor risks to their hydration however these had not always been consistently completed. Staff reassured us that people did have regular drinks and we observed a member of staff regularly visiting people in their rooms and supporting them to take drinks and milkshakes, however, the records did not always reflect this. Food charts often recorded what had been offered rather than what had been eaten. Repositioning charts did not consistently record whether the person had last been repositioned on their back, left or right side. Instead they were just ticked. This limited the effectiveness of the chart as a monitoring tool. We did not however, identify any concerns about people's skin integrity and this would appear to be a recording omission and not indicative of poor care.

Each of the people we spoke with felt that the home was clean. Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE). Suitable cleaning schedules were in place and followed in practice. The kitchen was clean and the catering team were completing appropriate food hygiene records. The service had recently been awarded the highest rating following a food hygiene inspection. We did note that in the case of one person, the bed rail bumpers being used were not suitable and were soiled in places and for another person, their mattress underneath the protective cover was also stained and no longer fit for purpose. We pointed out both of these concerns to the registered manager, who took immediate action to replace both items. However, we were concerned that the provider's own checks had not identified this. We also found that the surface on a stand aid was badly flaking. This would make it difficult to effectively clean. Hairdressing gowns were hanging beside a toilet presenting a cross infection risk and the flooring in one of the bathrooms was worn and would benefit from being replaced.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which made explicit links to the local authority's multi-agency safeguarding procedures. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to

taking action to ensure people's safety. Staff were aware of whistle-blowing procedures and were clear they could raise any concerns with the manager and other organisations if they were concerned about poor practice or abuse in the service.

People gave us mixed feedback about the staffing levels; for example, one person said, 'Yes, you push the bell and they come quickly', whilst another said, 'It's debatable. What is the right number? It could be tightened up a bit'. Staff were however, generally positive. One care worker said, "Yes there are definitely more than enough staff". This was echoed by health and social care professionals with one saying, "The staffing always seems adequate", and another, "When I am working at Abbey House I am sometimes in the office when staffing problems are identified and everyone works hard to ensure the right mix of professionals is available on the shift. Our NHS rehab beds are always well supported by appropriate staff". Our observations indicated that there were suitable numbers of staff deployed to meet people's needs in a timely and attentive manner and that care was delivered in an unhurried and person centred manner. Early shifts continued to be staffed by two registered nurses and 11 care workers. After 2pm, this reduced to seven care workers. Night shifts were staffed by one registered nurse and five care workers. The rotas showed these staffing levels were usually achieved. The home also employed a team of housekeeping and laundry staff, an administrator and reception staff, activities leads, chefs and kitchen staff. There were also two staff responsible for maintenance.

Recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised. These included identity checks, obtaining full employment histories, references and Disclosure and Barring Service checks. Checks were also made to ensure that the registered nurses were registered with the body responsible for the regulation of health care professionals.

The service had a system in place to report, investigate and learn from incidents and accidents. On a quarterly basis, the registered manager completed an analysis of these to identify any trends or patterns so that remedial action could be taken which might reduce the risk of similar incidents happening again. Following a safety incident at the service, the registered manager had appropriately reported the incident to a range of external agencies and fully investigated the potential causes of the event and introduced measures to prevent a reoccurrence.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us that they were suitably trained and skilled to meet their needs. For example, one person said, "Yes they are well trained, but if they are not certain, they go and ask". Another person told us how staff supported them with hoisting, they said, "They've got a special belt and a shoulder strap, they do that pretty well". One health care professional told us, "I see people who are cared for in a very friendly and professional way," and another told us, "They [staff] are knowledgeable and informed regarding care and treatment of the rehab patients".

Our last inspection found that the care and treatment provided to one person with a urine infection had not been provided in a manner that effectively met their healthcare needs. At this inspection we found that the required improvements had been made and we did not identify any concerns of a similar nature. Since our last inspection, staff had received a clinical supervision which included reference to a national quality standard and clinical pathway for the management of urine infections. Where required, people were seen to have suitable continence and catheter care plans which described their needs and how these should be met.

At our last inspection we found that staff had not been receiving regular supervision. Supervision is an important tool and ensures that staff fully understand their role and responsibilities. At this inspection we found that the required improvements had been made. Staff were now receiving regular supervision which they told us was helpful and assisted them to perform their role effectively. Appraisals were also taking place and discussed the staff members training and development needs.

People received their care and support from staff who had the skills and knowledge to meet their needs. Training and induction was now overseen by a training manager who had been in post a year and was based at the home. The induction programme was comprehensive and new staff were supernumerary for a period of two to three weeks during which they had opportunities to shadow the more experienced staff, completed a site specific induction and a range of essential training. The training manager met frequently with new staff members and completed assessments of their learning style to ensure that the training was being delivered in a manner suited to their needs. Inexperienced or staff new to care, completed the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Workplace observations were undertaken to provide reassurances that new workers were competent in a number of areas such as moving and handling.

An annual staff training plan set out the training each staff member was required to complete. This included subjects such as moving and handling, health and safety, fire training, infection control, safeguarding, food hygiene and first aid. Staff were able to complete additional training relevant to the needs of people using the service. For example, staff were completing training in caring for people living with dementia, diet and nutrition, tissue viability, falls awareness and mouth care. Staff had also become champions (experts) in a variety of areas such as nutrition and hydration, medicines, infection control and end of life care.

The provider was also committed to supporting registered nurses to gain their revalidation and provided

opportunities for additional training in a range of clinical skills such as male catheterisation, verification of death and wound management. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register. Staff told us the training provided was good. A registered nurse told us, "The presence of the training manager at the home has improved the care of clients, we are all more able and aware but also the effect has been an improved confidence from the [care staff], they feel more valued".

Before a person came to stay at the service, a comprehensive assessment of their care needs was carried out to gather information from the person and where appropriate from their relatives and any professionals involved in their care. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. These initial care plans were used as the basis for more comprehensive care plans which described the person's needs in a range of areas such as personal care, eating and drinking, mobility and social activity. Staff had a good knowledge of people's care plans and of how they liked their care to be provided. Where necessary people had condition specific care plans describing their needs in relation to conditions such as diabetes and pancreatic disease. There was evidence that care and treatment was being delivered in line with a range of evidence based guidance and clinical pathways. For example, a health care professional told us that staff effectively used NEWS (National Early Warning Score). This is a tool used to improve the detection of acute deterioration in people, potentially caused by life threatening conditions such as sepsis and is seen by NHS England as a key factor in improving health outcomes for people. Pathways were also being used for the treatment of wounds and the management of urine infections. Guidance was available on how to respond to outbreaks of flu and how to prevent other winter viruses.

A range of healthcare professionals including GP's, community mental health nurses, occupational therapists and physiotherapists had been involved in planning peoples support to ensure their health care needs were met. Each week, a GP attended a routine visit to the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. A visiting healthcare professional told us they saw each person on at least an annual basis, but also regularly reviewed people's medicines, their weights and general observations. Records were maintained of the outcome of medical appointments. Staff worked closely with a range of other health and social care professionals to deliver an effective rehabilitation service to people following their discharge from hospital. Information about people's needs and progress was shared effectively through a weekly meeting and the outcome for people using this rehabilitation service was positive.

People told us that staff sought their consent before providing care and that they were encouraged and supported to make decisions about their care and support. One person told us, "They do [ask for consent] they are very professional". People had signed consent forms in relation to their care plans and to having their photograph taken. Where people had appointed a legal representative to make decisions on their behalf, copies of the legal documents were maintained within the service. Two health care professionals told us that staff had a good understanding of mental capacity and positive risk taking saying, "Yes, this is evident when we are encouraging clients to improve their independence, take responsibility for their wellbeing, and have an informed say in their rehabilitation and discharge".

Where there was doubt about a person's capacity to make decisions about their care, mental capacity assessments had been appropriately undertaken and documented in line with the Mental Capacity Act (MCA) 2005 which ensured that the person's rights were protected. The 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. Staff were well informed about the principles of the MCA 2005. One care worker said, "You should always assume someone has capacity…and act in their best interests". We did note that whilst the registered manager was aware that decisions made on behalf of people must be in their best interests and made in consultation in relevant persons, the best interest's consultations had not always been fully documented.

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). Only a small number of people required a DoLS. Relevant applications had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

People gave us mixed feedback about the food. One person told us, "The quantity is not a problem, sometimes, there's an issue with quality", whilst another said, "The fish and chips are nicely done, you have all your veggies with it". People told us they could have a cooked breakfast if they wished and most were positive about the amount of choices available and told us that an alternative would be provided if they did not like what was on the menu. We observed that the chef visited in person in turn to ask them what they would like to eat from the day's menu. They did this in a patient and good humoured manner, taking time to explaining the options available. One person praised the chef for this saying, "He takes the bother to make a satisfying explanation". A selection of hot and cold drinks and milkshakes were available throughout the day and each person we visited had water or juice in their rooms.

We observed people having their lunch on the first day of our inspection. The meal time service began at 12.30pm with staff supporting people who chose or needed to eat in their rooms first. The meals were presented attractively and where people required a pureed diet, each of the elements of the meal had been pureed separately so that people could still taste the different flavours. Where people needed support to eat and drink, our observations indicated that this was provided in a way that was safe, dignified and respectful of the individual. People confirmed this with one person saying, "They are always there to help" and a relative saying, "They make sure she doesn't choke, they keep an eye on her". We did note that the hot pudding was served at the same time as the main meal, we were concerned that this would mean that it was no longer hot when the person came to eat it. The registered manager told us that this should not have been happening and advised that staff would be reminded to use the heated trolley which had been purchased specifically to keep the puddings hot during service.

Six people came to the dining room to eat their lunch. One of the tables was sat for 20 minutes waiting for their lunch to be served. Whilst waiting, they were surrounded by staff collecting and distributing meals to those eating in their rooms. We felt it may have been more relaxing for these people to be assisted to the table once staff had finished serving those eating elsewhere. Some people chose to eat their meal in the sun lounge. Staff readily chatted with people whilst serving the meals and clearly explained to people what the meal was and offered to fetch ketchup for one person, although we did note that there was no salt and pepper available. Drinks were readily topped up.

Overall the design and layout of the premises met people's needs. There were four separate lounges where people could choose to spend their day or entertain visitors. In addition there were three adapted shower rooms, one of which had recently been fitted with a ceiling track hoist and a further two assisted bathrooms. There were landscaped and fully accessible gardens which included a variety of areas for people to enjoy including sensory plants and seating areas. People and their relatives had recently fundraised and purchased a summer house for the garden. The registered manager told us this had been well used and greatly enjoyed by people in the summer.

However, the premises were not purpose built and therefore presented some challenges. For example, some of the floors in people's bedrooms were sloping and we were concerned that this could present risks to people due to furniture toppling over. The provider was taking action to address this by ensuring all wardrobes were secured to the wall. We noted that the dining area would not have been big enough to accommodate each person, but a number of people chose or needed to eat their meals in their rooms and so this was not problematic on the day of the inspection but would need to be kept under review. We observed, and staff told us, that some of the shared rooms would benefit from being converted into single rooms as their size meant that it was difficult to effectively use moving and handling equipment such as hoists. We recommend that the provider review the shared rooms to ensure that these are suitable for people's needs and large enough to accommodate required equipment.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and compassionate staff. One person said, "Indeed they are [caring]. They must be happy in their work, they're always cheerful". Another said, "The care is amazing, every single one of them [care workers] is kind and caring". Relatives were also positive about the caring nature of the staff team and of the friendly and welcoming nature of the home. One relative told us, "The nurses are very friendly and happy". Health care professionals were positive about the caring nature of the service and told us people's dignity was respected, for example, one said, "During the visits there I have observed the staff ensuring the dignity and respect of the residents are protected. For example ensuring doors are closed during personal care or knocking on door before entering".

Staff were confident that all of their colleagues were kind and caring and were clear that if this was felt not to be the case, they would raise their concerns and this would be addressed. Prior to and during the inspection we received a significant amount of positive feedback about the caring nature of the staff team. One relative's feedback to us said, 'Every worker there works as part of a huge caring family and this is reflected in the happiness of those being cared for'. There was also a folder containing a large number of thank you cards from people, and relatives of current and past residents of the home. A central theme to many of these was the kind and caring nature of staff. Comments included, 'To us you are all extended family', and, 'Abbey House was truly mums home and she loved your friendship'. A registered nurse who was leaving the service had written, 'The care, compassion, dignity and respect I have witnessed whilst on duty has been outstanding'.

Staff spoke fondly about the people they supported and it was clear that they had developed meaningful relationships with them. For example, one care worker said, "If you can put a smile on a residents face, it's really rewarding". We saw a considerable number of warm and friendly exchanges between staff and people. For example, we saw that staff bent down to speak with people at their level and spoke in a calm and reassuring manner. We saw a registered nurse enter one person's room and greeted the person cheerfully; the person smiled. Staff used humour to interact with some people and we observed some banter which people appeared to be enjoying. A member of the domestic staff also knew people well and interacted with them whilst completing their tasks. We observed that staff spent time with people even when they were busy; overall people seemed relaxed and contented. A care worker told us they were, "Actively discouraged from rushing around" by the registered manager.

Staff were very motivated and spoke with enthusiasm about providing a family environment where people and their relatives felt safe, valued and cared for. A registered nurse told us, "The clients are our extended family….I like to think we provide friendly efficient care". One care worker told us there was a culture of caring and of family values. This was echoed by a relative who told us, "[family member] has a good rapport with staff. They have nice conversations, he's relaxed with them".

Staff told us how they tried to promote people's independence wherever possible. For example, one staff member said, "I always say would you like to wash your own face". Another staff member told us that one of the best parts of her job was "Seeing [people] go home independent after their rehabilitation".

People told us they were treated with dignity and respect and when staff spoke with us, they referred to people in a respectful and dignified way. One person said, "Oh yes, they tap on the door". Another person told us how she had been asked how they would like staff to address them when they first came to the home. This information was also clearly recorded in people's care plans. Our observations indicated that care was provided in a discreet manner and that staff were mindful of people's privacy and dignity when providing care. For example, when people were being hoisted in the communal areas, privacy blankets were used to protect people's dignity and screens were used in the shared rooms.

People were provided with opportunities to follow their religious beliefs. A Christian service was held on a monthly basis and people were supported to attend coffee mornings at the local church. The registered manager was also aware of the importance of after death rituals for people from other faiths. Information about advocacy services was available within the service user guide.

Good

Is the service responsive?

Our findings

People, their relatives and health and social care professionals told us that staff provided care that was responsive to people's needs. One person said, "It couldn't be better, it's like a private luxury hotel, they notice every single thing". Another said, "They [staff] treat people as people". A relative had contacted us to say, 'The staff are responsive and really gentle with each other and every service user I observed. Their approach when a service user became agitated was far far more that I would have expected to see and I was genuinely impressed with the individuality of their approaches'. Professionals told us the service was focused on providing person centred care, for example, one said, "I have seen the interaction of the staff with residents on a number of occasions. These appear to be caring and person centred".

At our last inspection we found that records relating to people's care and treatment had not always been fit for purpose. At this inspection we found that improvements had been made but that further work was needed to ensure that the improvements in relation to some aspects of record keeping were consistent, embedded and sustained throughout the service. We discussed this with the registered manager who had told us how frustrating it was that this was still a problem. In response they told us they planned to continue to pass on at every handover, staff meetings and through supervisions that all relevant charts must be completed. They also planned to review the charts to establish if there was a common theme emerging, such as the same staff members concerned. They told us that the findings would be reviewed and actioned to include additional training and mentoring by the training manager if required. We did find that improvements had been made to the quality of wound care plans, those viewed were suitably detailed and demonstrated that the wound was being regularly evaluated. Short term care plans were now in place for people with acute health care needs and where required people had care plans which described how chronic pain was to be managed. Where people may display behaviour which might challenge staff or others, a suitable detailed and person centred care plan was in place which described the strategies staff could use to deescalate this.

There was evidence that people and those important to them had been involved in planning their care and support. For example, people's care plans contained some information about their individual preferences and choices and were written in a manner that was respectful of people and of their individuality. For example, staff were prompted to 'ensure [the person] looks nice' and 'offer a choice about what clothing she would like to wear'. Each person's care plans addressed areas such as their ability to give consent and staff were prompted to make sure they explained all care interventions to the person in a way they could understand. Staff told us they could refer to the updated care plans in order to understand people's needs and it was evident the care plans had been read by the staff. People had social activity plans which included some information about their life before coming to live at the home and about how they liked to spend their time. This enabled staff to understand the person and the things that were important to them. There was evidence that care plans had been evaluated on a monthly basis and were generally up to date and reflected people's current needs. Whilst some of the daily records seen were still task centred in nature, there was evidence of improvements with regards to this and each person's care plan now contained a prompt sheet which encouraged staff to think about how they might have helped provide person centred care and use this to enhance the care provided and the records they were keeping.

There was evidence that staff recognised if people were unwell and sought medical advice. For example, we saw a care worker check with a person whether they were feeling well, the person said no. The care worker told a nurse who then also came and checked the person and administered some cough medicine. People were being referred to the GP is they had signs or symptoms of chest infections. Staff documented visits by to GP's or other healthcare professionals so that a record was maintained of changes to treatment pathways. Relatives told us they were kept fully informed about their family member's wellbeing and there was evidence that family members were promptly told about falls and the outcome of health appointments.

People had access to planned activities between Monday and Friday for four hours each afternoon. The planned activities were advertised and included craft sessions, bingo, music for health sessions and pampering. A cat visited most weeks for cuddles and strokes and also visited people in their rooms. Records showed that in 2017, people had taken part in trips to the local country park and to local garden centres. In the summer all those that wished to had been supported to vote. A summer fete was held and a Christmas pantomime with some people getting involved in writing the script. People also took part in a gardening club. Efforts were made to provide one to one activities with people cared for in their rooms such as playing dominoes. A staff member said, "People in their rooms don't miss out". We received mixed feedback about the activities provided, some people were positive, for example, one person told us, "Yes they are good, sometimes we have a singer or a quiz or a singalong, yes there are enough, sometimes we have a session in the evening also" and a relative told us, "[family member] has been out on boat trips and a trip to the garden centre". However, another person told us, "It's monotonous" and another said, "I don't think there is much happening". A number of people told us they would like to get out in the gardens more. The registered manager assured us that people frequently enjoyed the outdoor spaces and that this would again be facilitated once the better weather returned.

The registered manager told us that where necessary information was provided in a format according to people's needs. For example, people were able to access a specialist computer with a large key board and touch screen to play games and to stay in contact with family and friends. The whole building was covered with Wi-Fi accessible to people. Audio books were obtained for people with a visual impairment. A local vicar was providing training in specialist communication techniques and we were advised that pictorial menus were in place although we did not see these in use during the inspection. We look at this to ensure that the service is complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Information about how to complain was readily available within the service and within the service user guide. Records showed that when issues or complaints had been raised, these were investigated promptly and appropriate actions taken to ensure similar complaints did not occur again.

The home had an end of life care lead nurse who liaised closely with the local hospice to develop their skills and knowledge and share these with their colleagues in delivering end of life care. Care plans were in place that contained basic information about the care the person would, and would not, like to receive at the end of their lives, including under what circumstances they wished to be admitted to hospital and whether they should be resuscitated. Nursing staff ensured appropriate medicines were available to people nearing the end of their life to manage their pain and promote their dignity. A health care professional told us, "On weekly rounds I see clients who are possibly approaching end of life to discuss plans and anticipate needs. We will organise an end of life care pathway. . ...I think palliative care here is excellent".

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well led. One person said, "[the registered manager] is wonderful, most understanding", and another said, "Yes its well-managed, everything seems to run nicely". A health care professional told us, "[The registered manager] is working hard to improve standards". Whilst another said, "[The deputy manager] has revitalised leadership at Abbey House, particularly from the point of view of the rehab beds". Staff were positive about the leadership of the service and felt well supported in their roles. They told us morale was good and that they worked well as a team to meet people's needs. One care worker told us, "Yes it is definitely [well led], she knows her stuff, if I had a situation I could go to her about it…she comes rounds and talks to family and checks we are alright".

Our last inspection had found a failure to ensure effective governance and quality assurance processes were in place. This inspection found that improvements had been made and there were now more effective systems in place to monitor and improve quality and safety within the service. A range of audits were undertaken on a monthly basis including care documentation, infection control, catering, wound care and medicines management. Clear action plans were drafted in response to these audits and each month progress with these was reviewed as part of a quality meeting with the operations and business managers. It was evident from these audits that some of the concerns we had identified in relation to the completion of records and charts had already been identified by the service and that plans were in place to try and address this. The leadership team completed daily walk arounds which assessed areas such as staffing levels and aspects of the care being provided. Each week both the operations manager and the provider visited the service to undertake checks and speak with people and staff and the registered manager sent a weekly report to the provider detailing issues such as admissions, incidents or accidents and complaints. This helped to ensure that the provider retained oversight of quality or risks within the service.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service. 'Residents and relatives meetings' were held approximately every six months but there were plans to increase this frequency to quarterly. These meetings gave people and their relatives the opportunity to hear about developments and changes within the service. The provider undertook annual surveys with people and their relatives. The most recent surveys were completed in November 2017 and the results were mainly positive, with many people commenting on the friendliness of staff and the family orientated nature of the home, but also raising some concerns about staffing levels. The registered manager told us that they constantly kept staffing under review and discussed this at quality assurance meetings. Twilights shifts had been added in on some nights to address this. Staff surveys had last been undertaken in February 2017 and so were due to be repeated shortly. Staff meetings were being held on a more regular basis and staff told us they felt encouraged to contribute their ideas for developments and that if possible these were listened to and acted upon. For example, we saw that the doorway to one room had been widened to enable better access for staff and equipment. A care worker told us, "[The registered manager] gives an opportunity for each and every one of us to have our say".

The registered manager demonstrated a passion and enthusiasm for their role and had a clear vision for the service underpinned by key values which included treating people as individuals and ensuring their safety

and wellbeing. They explained that it was important that people were given an opportunity to improve and develop their independence which they told us also had a positive impact on staff who felt they were supporting people to attain their goals. They said they felt highly honoured when people chose the home and that their biggest reward was receiving positive feedback from people commenting on the family atmosphere of the home. Our inspection and the feedback we have received since, has indicated that both the registered manager and staff worked in a manner that was in keeping with these values and objectives. The registered manager spoke knowledgeably about the people living at the home and of the staff team that provided people's care. We observed that they spent time interacting with people, providing reassurance when this was required. They told us that communication within the service had improved and that all staff were now joining in discussions about how to improve care and follow best practice guidance and care pathways. A health care professional commented on the registered manager's commitment to drive improvements saying, "The manager was always willing to discuss areas that were going well as well as areas of improvement. The unit appears to take on new ideas well…..They continue to challenge themselves to improve services". The registered manager had a good understanding of the future challenges facing the service which included embedding the improvements with documentation and managing the increasingly complex needs of people being admitted to the service.