Abbeyfield Society (The)

Abbeyfield House - Stockport

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We undertook a comprehensive inspection at Abbeyfield House on 7 September 2016 and the inspection was unannounced. The home was previously inspected in December 2013 and at the time was meeting all regulations assessed during the inspection.

Abbeyfield House is a large extended detached house prominently positioned approximately one mile from Bramhall Village in Stockport. Local community facilities are located nearby, with good public transport links to shops and a post office. The home provides accommodation for older persons who require nursing or personal care for a maximum of 16 people over two floors. There is a passenger lift to the upper floor. The lounge and dining room are situated on the ground floor where there is a conservatory leading to the garden areas. At the time of our inspection there were sixteen people living at the home.

Abbeyfield House had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had processes and systems in place that identified and mitigated risks to people and the environment. However, we found the registered provider had not always taken appropriate steps to identify and mitigate the risk from harm that could be caused to people by the use of bed rails. Other risk assessments associated with people's environment had not always been completed or reviewed in line with the registered provider's guidance.

The registered manager completed audits and quality assurance checks. However, these checks were not always effective in their purpose and had failed to identify where policies, procedures and systems had not always been implemented or completed to identify reduce or minimise risks to people.

Systems and processes in place were not robust in seeking and acting on feedback from relevant persons and others for the purpose of continually evaluating and improving the service people received.

People were supported by sufficient numbers of care workers who had completed pre-employment checks that helped to ensure they were of suitable character to work with vulnerable people. Care workers had completed generic training considered by the registered provider to be mandatory and additional training to meet people's individual needs and were supported in their role with regular one to one support and supervisions with their manager.

Care workers had received up to date training to recognise signs of abuse and harm to people and they understood how to raise their concerns in line with the safeguarding policies and procedures that provided them with guidance.

Safe systems and processes for the management of medicine were in place and we saw that care workers had received appropriate training and competency checks that helped to ensure people received their medications safely in line with how it was prescribed.

The registered provider had policies and procedures in place to record investigate and learn from accidents and incidents and we saw from records that this system was effective.

Care workers had received some training and understood the requirements of The Mental Capacity Act 2005. The registered manager was aware of their requirements under the act to ensure applications to deprive someone of their liberty were submitted to the local authority for assessment should the need arise.

People or their representatives were involved in their care planning and where people had capacity, consent had been sought that confirmed they agreed with the care and support provided. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests. The registered provider submitted referrals to advocacy services that enabled people to express their views and concerns and promoted their rights and responsibilities.

People were supported to maintain a healthy diet and any dietary requirements were recorded. Where required the registered provider had requested clarification of diets that were appropriate to people's needs from a GP and the response was documented. People were supported to access a range of health professionals who provided additional care and support to meet their individual needs and health requirements.

The home had a dining room that was easy to navigate around and linked to the living area. People could choose where they dined which included the dining room or their own bedrooms and meal times were not restricted. Food was freshly prepared in the kitchen and people's dietary requirements and choices were catered for.

We found care plans were centred on the individual and information on how people wanted to be supported at different times of the day with different activities was documented. People had been consulted on their wishes for the future, which included a person's preferences for end of life care and information on who should be contacted should the person be unable to make a decision.

Care workers understood how to respect people's privacy, dignity and human rights. We observed care workers addressing people how the wished to be addressed and we saw care workers knocking on doors before entering people's rooms, speaking with people politely and asking or explaining what they would be doing before carrying out any care interventions.

People were supported to undertake activities that were of interest to them and this information was documented and reviewed. We saw they were signed by the person or their representative to show their views had been recorded.

People were supported to complain and to raise any concerns they had. The registered provider showed us a complaints policy and procedure. Information on how to complain was available in the home in leaflet format and there was a booklet available with additional information.

We found two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Risk assessments in place for people, equipment and their environment had not always been completed or reviewed for their effectiveness in keeping people safe from harm.

Staffing was adjusted to reflect people's needs and activities.

People were protected against the risks of bullying and harassment. They felt safe and care workers had a good knowledge of safeguarding procedures.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Care workers had access to relevant training and courses to keep their knowledge and skills up to date.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act (MCA) (2005) guidelines were being followed.

People were supported to maintain a healthy diet and any dietary requirements were recorded.

Is the service caring?

Good

The service was caring.

Feedback showed the service provided care and support that was centred on the person. It was clear care workers knew the people in the home and put their needs first.

Privacy and dignity was consistently maintained and care workers were respectful when providing care and support to people.

People were encouraged to maintain their independence and to make their own decisions.

Is the service responsive?

Good

The service was responsive.

People using the service were encouraged to be involved in the home and care plans contained information that was responsive to people's needs.

People received personalised care and support which reflected their personal preferences and lifestyle choices.

People had the opportunity to participate in a wide range of activities that included walks in the garden, day trips, activities and celebrations in their own home.

People were supported to complain and to raise any concerns they had and there was information available to assist people with the process.

Is the service well-led?

Requires Improvement

The service was not always well led.

Despite audit and review systems and processes in place we found these were not always effective in their purpose.

Systems and processes in place were not robust in seeking and acting on feedback from relevant persons and others for the purpose of continually evaluating and improving the service people received.

There was a warm friendly atmosphere and care workers spoke of a positive culture where the registered manager promoted strong values and a person centred culture, which was supported by a committed staff group.

Abbeyfield House - Stockport

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 7 September 2016 and was unannounced. The inspection team included one adult social care inspector.

We did not ask the provider to complete a Provider Information Return (PIR) before the inspection. 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. However, providers are required by law to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we spoke with four people who used the service, the relatives of two people in the home, three care workers, a health visitor and the registered manager. We looked at care plans for three people and other records relating to their care.

A selection of documentation relating to the management and running of the service was looked at. This included, four staff recruitment files, training records, the staff rotas, minutes of meetings with staff, accident and incident records, quality assurance audits and maintenance of equipment records. We observed the medication round, the midday meal and the interactions between people and care workers in the home.

Requires Improvement

Is the service safe?

Our findings

The registered provider had processes and systems in place that identified and mitigated risks to people and the environment. For example, where people were at risk from falling out of bed the registered provider had purchased low-rise beds and pressure mats that alerted care workers when a person required assistance. However, we saw the beds had bed rails in place and the registered provider had not completed risk assessments in people's files for their use. A care worker told us, "People don't use their bed rails but they can be a useful aid when providing people with personal care, as they prevent them rolling from the bed." The registered manager told us, "The low profile beds come with bed rails but they are not used." We looked at the bed rail policy and procedure dated November 2014, this included templates for initial risk assessments, checklists, a register of who had bed rails installed and an assessment of staff competency for using bed rails and we saw that this information had not been completed. This meant the registered provider had not taken appropriate steps to identify and mitigate the risk from harm that could be caused to people by the use of bed rails and had failed to ensure equipment used was safe and used in a safe way.

Other risk assessments associated with people's environment included quarterly visual assessments for people's rooms, health and safety and daily living activities. Whilst we saw evidence of these checks documented in people's files, actions and outcomes had not always been completed or reviewed in line with the registered provider's guidance. People's care plans included risk, personal care and support for people. Some reviews were completed but these were not always in line with the registered provider's guidance. For example, one person had a risk assessment in place for moving and handling and associated control measures had been implemented in April 2016 as a result. We found that monthly reviews had not been completed in line with procedure, to evaluate the control measures for their effectiveness. We spoke with the registered provider about our concerns and they told us, "Paperwork should be routinely updated and the evaluations should be documented monthly, it's an area that needs some improvement."

The above concerns were a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Additional measures to help keep everybody safe in the home included a health and safety file. This contained generic risk assessments for meal preparation, gas safety checks, portable appliance tests for electrical items, showerhead disinfecting, water temperature checks, passenger lift inspections and hoist checks. A fire safety file included a fire risk assessment for the home completed in April 2016 by an external fire officer, a fire precaution logbook and fire extinguisher, lighting and alarm checks.

An emergency 'Grab File' was available which contained emergency contact information a disaster recovery action plan; in the case of an emergency and individual personal emergency evacuation plans (PEEP). People had been assessed to indicate the support they required in an emergency and a PEEP completed. A PEEP is a document, which advises of the support people need to leave the home in the event of an evacuation-taking place. These measures helped to ensure the home was safe and people would be helped to maintain their safety in the event of an emergency.

The registered provider had a robust programme in place that helped control the associated risks to people from infection. A thorough investigative audit into infection control practices across the home had been completed by the local authority health protection and control of infection unit in May 2016. The report had identified some areas that required improvement and we saw the registered provider had documented and completed those associated actions, which helped to keep people free from infections.

People told us they felt safe with the care and support they received in the home. One person told us, "One of the reasons that persuaded me to move into a residential home was to enjoy the feeling of safety and that's what Abbeyfield House provides me with; at all times of night and day someone is available which makes me feel very safe." Another person said, "If I wake up at night and feel vulnerable I only have to push the buzzer and someone comes and in the morning someone will bring me a cup of tea which I find personally reassuring that I am not on my own." A relative told us, "Dad is in good hands, if he wasn't I would move him elsewhere; I know he is safe here."

The home had sufficient qualified care workers to meet people's individual needs. We observed people were never left alone for long without a reassuring word from a care worker. However, comments about staffing were mixed. Care workers told us, "It can be difficult at busy times but I think overall we manage with the numbers of staff on duty.", "If we lose long term staffing then there is a big impact, we lose their experience and we have to take time to shadow a new employee." A volunteer told us, "Recruitment into care services in the area is difficult; we need to get it right so we don't rush the process and we try and focus on staff retention." We looked at rotas for care workers and the registered manager confirmed there was a team leader, two care assistants, a volunteer, the cook and an additional senior covering training for care workers during the day of our inspection. The registered manager added, "We adjust staffing dependant on people's needs and any activities that are on." The rotas confirmed this.

We looked at the recruitment files for four care workers. We saw that the dates references and Disclosure and Barring Services (DBS) checks had been received were recorded. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. It was clear on records that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. A care worker said, "DBS and reference checks have to be returned and you can't start work until this information has been provided." This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

The registered provider had a safeguarding adults and whistleblowing policy and procedure that provided care workers with good practice guidelines to help keep people safe from harm and abuse and report their concerns. These documents had been recently reviewed and updated. The registered manager was able to discuss safeguarding referrals they had made. Care workers we spoke with told us they had undertaken safeguarding training and understood what was meant by whistleblowing. Training records we looked at confirmed this. Care workers said, "We are people's advocates, they depend on us to help keep them safe." "Our training in safeguarding is very good and of course I would report any concerns to the manager." "There are signs of abuse we are trained to look out for and there can be bad practice that can happen at any level." "If we had concerns we might have to undertake whistleblowing to the local authority or the Care Quality Commission [CQC], it's all about keeping people safe."

Safe systems and processes for the management of medicine were in place. Medicines were administered safely by care workers who had received appropriate up to date training. We observed care workers signed the medicine administration records (MAR) after the person had taken their medication. The registered provider maintained an up to date documented list of care worker signatures for those who signed the MAR sheet. MAR charts were completed correctly and any errors or omissions had been documented. Medicines

were stored, received and disposed of securely. The temperature of the medicine fridge and storage room was regularly checked to ensure that medicines were being kept at the appropriate temperature. However, we observed one fridge had recordings in excess of the recommended temperature. There were no medicines in the fridge at the time of our inspection and the registered manager told us they had recently moved the fridge to a cooler location but this had not proved effective. They advised us they would purchase a fan and would continue to monitor the temperatures to ensure they were following best practice and guidance for the storage of medicines.

The registered provider had a policy statement that helped guide care workers in the management of medications. We saw this was updated centrally and had been reviewed in December 2015. At the time of our inspection, two people self-medicated. A care worker told us, "People undergo an assessment when they first arrive and we monitor their continuing ability to self-medicate; we wouldn't take that away from them," they continued, "The assessment is carried out by the lead in medication and the person signs to agree, we involve the GP who provides us with an agreement to the person self-administering." This meant that the registered provider had taken steps to ensure that risks in relation to people receiving medication were anticipated, identified and managed and people received their prescribed medication safely.

We looked at how the registered provider managed and recorded accidents and incidents. We saw accidents and incidents were recorded on a report form and included learning from the event. For example, we saw a medication error had been recorded and as a result an unplanned supervision had taken place to discuss the incident and learning was shared at a staff meeting. A policy and procedure was followed that provided guidance on good practice for incidents and other significant events. This meant the registered provider had appropriate policies and procedures in place to record, manage and learn from outcomes.

Good

Is the service effective?

Our findings

People told us that care workers had the appropriate skills and knowledge to meet their care and support needs. Comments included, "Staff seem be to be able to respond to anything that I ask for; they must receive good training here." "I don't have a problem with the staff at all, they are very understanding of my needs." It was clear from our observations that people responded positively, often smiling, when care workers approached them.

A care worker told us, "My induction to the job was really good; I worked with existing staff and shadowed them around the home which meant I got to know people and their needs." The registered manager told us and we saw from care worker files that they had completed an induction to the home environment and the basic standards required to undertake their role. The registered provider had implemented the care certificate and we saw people had completed or were in the process of this learning. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. This demonstrated how care workers were supported to understand the fundamentals of care.

Care worker files included confirmation about the training they had completed. This included general training for example, moving and handling, safeguarding, first aid, food hygiene, medication, mental capacity act 2005 and equality and diversity. Additionally we saw care workers had received training that was specific to a person's individual needs such as, continence, dementia and sensory impairment. A care worker told us, "There is always some training to do, [registered manager] seems to have a long list but it means we are well supported with our jobs." We asked the registered manager how they monitored training for care workers. They told us, "We use a training matrix; it does need some updating with recent training that has been completed and this will be done once we have information on all the people who have completed it [training]." This meant that the registered provider had a system in place to record and manage training for care workers. This helped care workers to keep their skills and knowledge up to date.

Care workers received regular documented supervisions with their manager. A care worker told us, "It sounds daft but I look forward to my one to ones as I can discuss anything that's bothering me and I receive reassurances, or not, that I am doing the job right and that people are happy." We saw files for care workers included information in a 'Supervision agreement' and planned supervisions had been recorded that included documented discussions about the practice, understanding of the philosophies of care and career development for the care worker. This meant the registered provider supported care workers to remain motivated and skilled to perform their role.

Care workers had received some training and understood the requirements of The Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of our inspection there was nobody residing in the home with a DoLS in place. A DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager was aware of changes (March 2014) in the case law around DoLS and that, additional DoLS authorisations may need to be submitted to the local authority should they be required.

We looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity consent had been sought that confirmed they agreed with the care and support provided. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests.

Assessments were documented that identified to what extent an individual required assistance with aspects of daily living and this helped people to maintain their health and wellbeing. Daily living activities included social activities, health and physical wellbeing, personal care tissue viability, mobility, nutrition and health.

People were supported to access a range of health professionals who provided additional care and support to meet their individual needs and health requirements. For example where people were at risk from bedsores we saw the registered provider had completed a risk assessment and documented a support plan for the prevention of sores. This included monthly records, activities to reduce the risk, a 'skin assessment' body map and additional intervention was recorded by the district nurse. We saw where people were at risk of falls, continence or diet appropriate records were maintained and evaluated and further action had been implemented to reduce the risk and re-occurrence.

People were supported to maintain a healthy diet and any dietary requirements were recorded. One care plan contained a 'Nutrition and Health' form, this included an evaluation of the person's required needs and further guidance on caring and supporting a person with diabetes. The registered manager told us, "People have a pre-assessment of their dietary needs and this is reviewed." We saw this had been updated in August 2016 and included people's individual dietary requirements. Where required the registered provider had requested clarification of diets that were appropriate to people's needs from a GP and the response was documented.

The home had a dining room that was easy to navigate around and linked to the living area. People could choose where they dined which included the dining room or their own bedrooms and meal times were not restricted. The registered manager told us, "Breakfast starts at 07:00 and continues until everybody has eaten." They said, "One person likes to get up a bit later, they come downstairs and have a late breakfast and often only a snack at lunch time; that is their choice, we keep an eye on them to make sure they eat regularly and offer a varied diet and drinks."

The dining area was colourful and had a homely feel. A daily menu was displayed on a blackboard and care workers discussed the available options with people. Fresh fruit and juice was available and sufficient care workers were on hand to support people with their food if they required assistance.

The cook told us, "Everything is made fresh, we don't serve food on plates, we use a silver platter and people can have as much or as little as they wish." They said, "On special occasions we let residents choose their meal and we prepare it; of course we make sure everybody is catered for and this includes family members; we can have a lot of guests which makes it very special for people." The kitchen had an environmental health officer food hygiene rating [FHRS] award of 5. The rating was awarded in August 2016. Ratings are

based on how hygienic and well-managed food preparation areas are on the premises. A food preparation facility is given "FHRS" rating from 0 to 5, 0 being the worst and 5 being the best. An FHRS rating of 3 is acceptable.

Good

Is the service caring?

Our findings

Everybody we spoke with was complimentary about how caring the care workers were. Our observations during the inspection confirmed that care workers knew people well and treated them with dignity and respect. We did not hear any raised voices and we saw attentive care workers who were patient and encouraging with people as they moved around the home. People told us, "They [care workers] are very helpful" and "I do feel cared for, they [care workers] can't do enough to make sure we are happy and have everything that we need."

We asked care workers how well they knew people as individuals and their needs. They told us "We have to make time and speak with people to get to know them." Another care worker told us, "There is always information [about people] in care plans, this might not always be up to date but is a useful source of information."

We looked at care files for three people. We found care plans were centred on the individual. They included a, 'What's Important to Me' section of the care plan, a photograph of the person, and information on how people wanted to be supported at different times of the day with different activities. Other information included information on people's life history and relatives' comments completed by the main care worker responsible with the person.

People had been consulted on their wishes for the future. A 'Preferred Priorities for Care' form had been completed. This included a person's preferences for end of life care and information on who should be contacted should the person be unable to make a decision. A care worker told us, "It can be a difficult subject to address and we try and encourage people with their families and representatives to document their wishes whist they have the capacity to do so."

People and their relatives were involved with their care planning. A relative told us, "[Parent] has a care plan and we attend all the reviews; they usually last about an hour but we are able to contribute and we are involved in putting forward ideas to help improve [parents] care." They continued, "What is good is how responsive they [registered provider] are; whenever we agree changes for [parent], as long as they are appropriate they are implemented; there's no delay." One person told us, "I don't really comment during reviews, I know they are important and I am asked to contribute but I am very happy with the care I receive."

People were supported to make decisions where they sometimes lacked the capacity to do so on their own. Independent advice and support was available. The reception area had leaflets about an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities. The registered manager told us, "It is clear when people need independent support; a good example is for managing their finances but there's a range of times when we need to bring in an advocacy."

Discussion with care workers revealed where people living at the service had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status,

race, religion and sexual orientation these needs were adequately catered for. We were told that some people had religious needs and these were provided for within the service and by people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Care workers understood how to respect people's privacy, dignity and human rights. We observed care workers knocking on doors before entering people's rooms, speaking with people politely and asking or explaining what they would be doing before carrying out any care interventions. People who used the service were addressed by carers in their preferred way. People were appropriately dressed and care workers were mindful that any personal care should be offered in a way that promoted the individuals dignity.

Care workers told us they understood what was meant by 'confidentiality'. One person told us, "I never talk about a person to anybody except the people directly involved, those who need to know" they said, "If I had any concerns about their wellbeing I would discuss it with the person and tell them that if appropriate we may need to contact the safeguarding team."

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs. A care worker told us, "It's quite a small compact home which I really like because we are never far from people and we can always respond to their individual needs." A relative told us, "It's a lovely home; it provides a service for each person and we, as family members are also involved." The registered manager told us, "We try and get as many family members involved as possible, we include them in celebrations, meals and they get involved in the garden." They continued, "A family member has been involved in developing the raised beds and is going to come in and paint the gazebo."

The registered provider told us that all new people coming into the home were allocated a key worker. The key worker was responsible for welcoming new residents into the home, which helped people to settle into their new environment. One person we spoke with told us, "My move into the home was a difficult decision for me but the registered manager has let me come in for a few weeks at a time to help me adjust to the new surroundings." They said, "I keep going back to my home but I think I am just about ready now to move in permanently." Another person said, "I have been able to maintain my independence which is encouraged here; I still go out with my friends for a coffee and visit the hairdressers which is important for me."

We saw people were supported to undertake activities that were of interest to them. One person said, "There is usually something to do and they [care workers] are very flexible." The registered manager told us, "We don't like to just undertake structured activities; we try and focus on individuals and groups who have a common interest in doing something." They continued, "Some people like to remain in their rooms, that is their choice but we make sure we encourage them where ever possible and undertake regular checks to make sure they are ok." An activity sheet in the living area included; garden walks, a quiz, nails and pampers session, and a relaxed church service. Care plans included information on social contacts and activities that included people's wishes, and preferences. We saw they were signed by the person or their representative to show their views had been recorded.

People were treated as individuals and the registered provider acknowledged Abbeyfied House was their home. The registered manager was keen to receive feedback and share information about the home with people. An activity used to promote open communication was a coffee evening in the communal lounge. This included attendance of the registered manager or a senior care worker and family members were also invited. The purpose of the meeting, around a coffee, was to provide families and people living in the home with an informal opportunity to have their say, discuss any concerns and receive updates on the service and any changes. Minutes from a meeting documented information discussed that included, menus, staffing changes, special events, school visits and a canal day trip. People had requested plain fish alongside battered, bread-crumbed options, and we saw this had been actioned by the cook with additional choices on the menu. The registered manager told us. "We involve the people who live here with everything that's going on; it's their home after all." "We are re-decorating the dining room and people have been involved in the colour schemes and discussions about the new carpet." One person said, "It is like being at home really, I am still involved with decisions that are made." This meant the registered provider had systems in place to involve people and their families in decisions about their home and that resulting outcomes and actions

were implemented wherever possible.

People were supported to complain and to raise any concerns they had. The registered provider showed us a complaints policy and procedure. Information on how to complain was available in the home in leaflet format and there was a booklet available with additional information. We looked at the complaints file and saw this included information that related to all complaints raised, the date it was responded to, an outcome and any actions implemented as a result. The registered manager told us, "We receive more compliments than we do complaints; we share everything back with staff, it's all important to us." People we spoke with told us, "I would speak with [registered manager] if I had a complaint, they are very good." "I don't have much to complain about, I know how to complain and I am sure I could find something if I tried but I am quite happy with everything." The registered manager told us, "We try to provide for people's needs in the home and seek interventions from a range of health professionals to make that possible." "Sometimes people do go into hospital and we will work with families and others to move people to a new service should we be unable to meet their continuing needs."

Care plans included interventions from GP's, health visitors, therapists and a community nurse. A care worker told us, "We discuss people's needs at handover after each shift and along with any appointments the information is recorded." Handover notes we looked at confirmed this. A family member told us, "[Relative] has been in the home many years, the service has met with all their needs and adaptions and even a room change has meant [relative] will hopefully remain here much longer." This meant people were supported to remain in the home or to transfer between services if required.

Requires Improvement

Is the service well-led?

Our findings

We asked the registered provider about the methods they used to question practice that helped to improve the quality of the service for people. The registered manager told us, "We have had external audits by the local authority that has included medication, infection control and our own internal audit." "We use the feedback to improve practice." We were provided with copies of recent audits that confirmed actions had been implemented as a result. However, despite the measures in place we found these were not always effective in their purpose. Our findings included areas of identified risks to people that had not been updated for their care, support and their environment and measures in place to reduce or minimise risks had not always been implemented or completed that included the installation and use of bed rails.

We looked at how the registered provider gathered feedback from people, their families and care workers about the services provided and if they used the information to evaluate and improve the services for people at the home. The registered provider gave us information relating to their participation in a national survey but this did not focus specifically on the home. The registered manager told us, "We are constantly including people in decisions about the home, their care and support and we gather some feedback to make improvements, such as at coffee meetings, resident meetings and we support staff through regular supervisions and one to ones." This information did not evidence how the provider consistently gathered and evaluated feedback that measured improvement of the service. We asked the registered provider for a copy of their annual consultation or survey for people families and care workers but this was not provided.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. The registered manager was on duty and supported us during the inspection. There was positive feedback from everyone we spoke with about the leadership and there was a high degree of confidence in how the service was run. Comments from people who lived at the home included, "Staff can be very busy but [the registered manager] will always step in, they are very good." "[Registered manager] keeps on top of the home and gets things done." "I always recommend the home and the manager to everybody but I think there is a waiting list." A relative told us, "I am updated by [registered manager] about my relatives care and support at every visit." A district nurse said, "The [registered] manager always knows what is happening with each individual person and can always discuss their individual needs, any changes and what they are doing to maintain people's health and wellbeing."

The registered manager knew about their registration requirements with the Care Quality Commission (CQC) and was able to discuss when they needed to submit a notification, which was in line with conditions of their registration.

Care workers told us the home had a positive culture. They told us the registered manager had an open door policy and they would not hesitate to undertake whistle blowing. One person said, "I would not hesitate in raising concerns to protect people" and "The manager's door is always open; I know any concerns I have would be dealt with in a professional and confidential manner."

The registered provider had a statement of purpose that had been updated in July 2016. We saw this included an overview of the 'Abbeyfield Society' provision of care services, a philosophy of care, organisational values, what residents can expect and their mission statement; 'To enhance the quality of life for older people.' We asked care workers what they thought the registered provider did well. They told us, "We work well as a team to provide a good service for people as individuals." "We ensure the care, and support we provide for residents is the best we can." Care workers told us that regular staff meetings, one to ones and supervisions ensured that the mission statement was upheld.

A volunteer we spoke with told us they had been the chairperson for the home since it first opened. They told us, "We work hard to uphold high values of care and best practice." They said, "I recently attended talks at local hospitals on coronary care and Alzheimer's disease; I fed this back to staff at staff meetings to improve their knowledge and understanding." They continued, "Along with the registered manager we meet quarterly with other managers in the organisation to share best practice and we discuss innovative ways to work." They told us the local authority had used their work to help other organisations in the area with similar problems. We saw a copy of a report from the local authority that confirmed this. This showed us the registered provider worked with external organisations and local authorities to help the service to improve.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not always been completed or reviewed to identify and mitigate such risks in a timely manner. Checks were not always completed to ensure equipment was suitable for its purpose, properly maintained and used correctly and safely by competent staff. Regulations 12 (1) (2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place were not always effective in their purpose and had failed to identify where policies, procedures and systems had not always been implemented or completed to identify reduce or minimise risks to people. Systems and processes in place were not robust in seeking and acting on feedback from relevant persons and others for the purpose of continually evaluating and improving the service people received. Regulation 17 (1) (2)(a)(b)(e)(f)