Amesbury Abbey Limited

Amesbury Abbey Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Amesbury Abbey Care Home provides accommodation which includes nursing and personal care for up to 45 older people, some of whom are living with dementia. At the time of our visit 37 people were living at the service. The bedrooms were arranged over three floors. There was a communal drawing room for people to use. On the ground floor there was a communal dining room and conservatory and a central kitchen and laundry.

We carried out this inspection over two days on 20 and 22 September 2017. The first day of the inspection was unannounced.

There was a registered manager in post. 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 manager was available throughout the inspection.

Not all risks to people's safety had been adequately identified and addressed. For example, consideration had not been given to mitigate the risks associated with the shape and sturdiness of the radiators. One person had choked on their food but their care plan had not been updated to minimise the risk of further occurrences. Another person had a thickener for their drinks to minimise choking, but this was not clearly detailed in their care records. Documentation did not always show people's food was of a consistency, which had been recommended to them, by specialised services. These shortfalls were of particular concern, as there had been two significant incidents, involving such risks.

Improvements had been made to the contents of people's care plans but more work was required. For example, one person required staff intervention to minimise their risk of pressure ulceration but this was not clearly detailed in their care records. People's clinical needs were clearly identified and there was information about people's preferences and their chosen routines. Records showed people's food and fluid intake was monitored if they had been assessed as being at risk of malnutrition or dehydration. However, some monitoring records contained limited detail and staff had not always signed the record at the end of the day, to show they had assessed the amount consumed.

There were a range of audits, which monitored the quality of the service. However, the audits had not identified the shortfalls related to risk management, which were found during this inspection.

Staff promoted people's rights and there was a strong person centred ethos. People were encouraged to make decisions but records did not always show these were made in line with the principles of the Mental Capacity Act 2005 (MCA). People were supported to maintain their independence and follow their preferred routines. They were able to participate within a range of social activities such as historical talks and coffee mornings. People knew how to make a complaint and were encouraged to give their views about the

service. People's medicines were safely managed.

People were offered a good choice of quality foods. There were many positive comments about the meals provided. People were able to receive silver service in the dining room or have the meals in their room. Drinks were served throughout the day.

People were supported by staff who were well trained. There was a detailed training programme, which covered topics deemed mandatory by the provider and those that were "person specific". Staff were well supported and received meetings with their supervisor to discuss their performance. Systems were in place, including detailed handovers, to ensure staff had the information they required about people's needs. Staff were aware of their responsibilities to identify and report any suspicion of abuse.

There were positive comments about the registered manager and the overall management of the home. There were sufficient staff to support people effectively. New staff had been recruited and had undertaken an organised induction. Recruitment was well managed overall. A discrepancy with a Disclosure and Barring Service (DBS) check was being addressed.

During this inspection, we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made two recommendations about ensuring decision making was in line with the MCA and people's support plans were an accurate reflection of their needs and the support required. You can see what action we told the provider to take at the back of the full version of the 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.

Not all risks to people's safety had been properly identified and appropriately managed.

Staff were aware of their responsibilities to identify and report poor practice or abuse.

There were sufficient staff to support people effectively.

Medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were encouraged to make decisions but records did not always show these were made in line with the principles of the Mental Capacity Act 2005.

People were supported by staff who were well supported and committed to their role.

Staff received a comprehensive induction and a range of training to help them to do their job effectively.

People received good quality meals and a positive dining experience.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and respectful.

Staff promoted people's rights and were committed to their wellbeing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements had been made to the content of people's support plans. However, further work was required to ensure each plan reflected the person's needs and the support they required.

People and their relatives were happy with the care provided.

People were able to join in with various organised social activities.

There was confidence any complaint would be addressed and satisfactorily resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Whilst there were a range of audits to monitor the quality and safety of the service, shortfalls found during this inspection had not been identified.

There were many positive comments about the registered manager and the overall management of the home.

There was a strong, person centred ethos which was adopted throughout the staff team.

Amesbury Abbey Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced on 20 September 2017 and continued on 22 September 2017. The inspection was carried out by two inspectors, a specialist advisor in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke to ten people who used the service and seven relatives. We also spoke with the registered manager and nine members of staff. We looked at people's care records and documentation in relation to the management of the service.

Before our inspection, we looked at notifications we had received. Services tell us about important events relating to the care they provide using a notification. In addition, we looked at the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned on time and completed in full.

Requires Improvement

Is the service safe?

Our findings

Not all potential risks to people's safety had been identified. There were large radiators on the landing and in the drawing room. Each radiator was sturdy and had prominent edges, which meant there was a risk of injury if a person fell against them. The radiators had not been covered to minimise this risk. This was particularly of concern, as a person fell against a radiator, last year. Action had not been taken to minimise further occurrences. Records showed the risk of sustaining a burn type injury from the hot surfaces had been considered. However, the shape and form of the radiators had not been identified in the assessment. The registered manager told us they would review this. There was a large, ornamental, marble type bath on the landing, which posed a similar risk if a person fell against it. Records did not show measures to minimise this risk had been considered. The registered manager told us the possible removal of the item would be investigated. After the inspection, the registered manager told us the risks associated with the feature had been assessed.

One person had been assessed as being at risk of choking. They had been seen by the speech and language team and guidance to promote the person's safety whilst eating had been given. These factors were clearly stated in the person's support plan. However, at the very back of the plan, records showed the person had choked on their food and needed hospital treatment. The support plan had not been updated in response to this incident. This did not show staff had taken steps to prevent a recurrence. The discharge notes from the hospital advised staff should "review with regards to diet. If a known choke risk, why was [person's name] given chicken today?" There was no evidence to show the person's diet had been reviewed or that another review from the speech and language team had been requested. On the day of the inspection, records showed the person had eaten the same meal as other people using the service. It was not reflective of the moist, soft diet the speech and language therapist had recommended. Staff told us the person's food had been pureed but this was not reflected in the records. This was particularly of concern as there had been a recent death of a person that related to a choking incident, which was being investigated by the coroner.

Staff told us another person required a thickening agent, to minimise the risk of them choking whilst drinking. Staff were aware of the amount of thickener to be used and the required consistency of the person's drinks. However, instructions for the use of the thickener were not clearly identified in the person's care plan. This did not ensure all staff, including those less familiar with the person such as agency staff, were fully aware of its use. It was identified the person needed to be supervised at every meal but it was not clear what this meant in practice. One member of staff told us the person did not want them in the room whilst they were eating, so they observed "from a distance". Another staff member said they "hovered" and kept returning to the person to make sure they were ok. There was not an agreed approach to ensure the person's safety. Records showed the person did not always want meals of a consistency, which had been recommended. A meeting to discuss this had been held but details of the discussions and any agreements reached, were not evidenced.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information within other support plans showed how people were supported to stay safe. For example, one care plan stated the person's medical condition could affect their mobility and impact on their independence. Staff were directed to assess the person on a daily basis because of this. Another plan showed the person was at risk of choking whilst eating. There were clear measures in place to minimise this risk. These included ensuring the person was sat completely upright, had a "fork mashable" diet and regularly took small sips of fluid, to promote swallowing.

People told us they felt safe at the home. One person told us "I am very happy here. It is a very good care home. I am treated very well and I have no complaints, I do feel safe here". Another person told us "It couldn't be better. I have no worries about my safety at all". Relatives gave us similar views about their family member's safety. One relative told us "I have no concerns at all with X being here. They look after him perfectly". Other comments were "X's very happy here and would say if there was anything they were not happy about" and "I have no concerns about X's safety. In fact, it puts my mind at rest with them being here".

Staff were aware of their responsibilities to identify and report any poor practice or suspicion of abuse. They said they would immediately report any concern to the registered manager or director. One member of staff said "I am happy to speak up and I know the directors would listen to me". Another staff member said "There are a range of people to go to if needed, nurses, manager, provider, it would be up to you". Staff were confident any concerns would be appropriately managed. If this was not the case, they said they would inform external agencies, such as the local safeguarding team. Following a recent safeguarding investigation, the registered manager had displayed information about safeguarding on a notice board in the corridor. The information gave details of abuse and what to do if this was suspected. There were contact numbers, which anyone could use to report potential abuse or the risk of harm. One leaflet was titled "Are you being abused or neglected?"

There was a clear recruitment procedure in place. However, whilst a Disclosure and Barring Service (DBS) check had been undertaken for one member of staff, it did not include whether they had been placed on the Adult Barring list. This did not ensure the staff member was safe to work with vulnerable people. The registered manager told us they would look into this, as the check was not part of the provider's policy for recruiting this particular group of staff. After the inspection, the registered manager told us they had looked in to this and were not eligible to request the check. This was because the staff member's role of waitress did not match the required criteria. They said senior management were looking at ways to address this.

Records showed all applicants were required to complete an application form and attend a formal interview. There was evidence of the applicant's identity and information about their previous work performance and character. However, one application form identified an employment history from 2015 but there was no information prior to this. This was not explored further, which did not verify the applicant's past. The registered manager told us they would investigate this. Records showed other applications demonstrated a robust procedure. Staff confirmed this. They said they were asked about their knowledge of topics such as safeguarding and undertook a literacy and maths test. One member of staff told us they felt they had been "grilled" at their interview and were exhausted afterwards.

People's medicines were safely managed. When administering medicines, the member of staff informed each person what their tablets were for and asked if they were happy to take them. They ensured the person had swallowed their medicines before signing the medicine administration record (MAR). The member of staff asked people if they needed any additional medicines, such as pain relief. They were knowledgeable about what medicines people were prescribed and the reasons for them. However, people's preferences regarding how they liked to take their medicines were not stated. There was no information to show how

staff gave one person their medicines covertly. This is when medicines are disguised, usually in food and administered without the person's knowledge. The registered manager told us they would address this area. They had completed this by the second day of the inspection.

Staff had completed the MAR charts appropriately. This demonstrated people had received their medicines as prescribed. There were up to date photographs of people at the front of the records. This enabled staff, especially agency staff who were not familiar with people, to clearly identify each individual. People's allergies had been documented and there was information about the administration of "as required" medicines. Staff had documented when these medicines had been administered and the reasons why. Some people had been prescribed topical creams. There was clear information to inform staff of their application. Records showed the creams were applied as prescribed. Regular audits were undertaken to ensure the safety of the medicines systems.

People or their relatives did not raise any concerns about the numbers of staff on duty and their availability. Staff confirmed there were enough staff although one comment was that an additional member of staff was "sometimes" needed on the ground floor. Other comments were "Yes, we have enough staff, definitely" and "I do think we have enough staff". One member of staff told us there were enough staff but sometimes they felt the skill mix could be better. They felt this would be improved by registered nurses working directly alongside care staff more often.

Requires Improvement

Is the service effective?

Our findings

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.

The principles of the Mental Capacity Act 2005 (MCA) had not been consistently followed. This was because signed consent forms for all aspects of support were not always in place and assessments, to assess people's capacity to consent, had not always been undertaken. Bed rails and sensor mats were being used to promote safety but records did not show whether less restrictive options had been considered. Mental capacity assessments or any evidence of best interest meetings to agree the use of such equipment, were not always in place. One consent form had been completed stating the person's next of kin had verbally agreed to the use of bedrails. There was no capacity assessment or evidence of a best interest decision meeting taking place. Records showed another person had agreed the initial use of a sensor mat but it was to be discussed again at a later date. This was because the person wanted to reconsider their decision, if they fell again. The records stated "very unsteady on feet, so sensor mat put in place". There was no consent form, to show the person had agreed to its use.

We recommend that the service reviews the documentation in place to ensure any decisions made are in line with the principles of the MCA.

Another person was receiving their medicines covertly. An assessment of the person's ability to consent to this had been undertaken. The person lacked capacity and the decision to administer medicines this way had been made in the person's best interests. This was clearly documented and showed the person's GP, pharmacist and advocates had been involved in the decision making process.

People told us they consented to their care and were encouraged to sign their care plan. One person told us "My health records are regularly brought up to date for me to sign off, as agreed". Relatives told us staff were very good at enabling people to direct their care and be in control of their lives. One relative told us "X [family member] signs his care plan regularly to show he agrees with its content".

Staff said they had received training on the Mental Capacity Act. One member of staff told us "I understand that if we use any form of restraint, there needs to be an assessment and a best interest meeting". Another staff member said "I've had the training, but probably need some refresher training". On the second day of the inspection, records showed a request for further MCA training had been formally submitted.

During the comprehensive inspection in August 2016, we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records in relation to people's nutritional and hydration needs and the monitoring of effective intake, were poor. At this inspection, improvements had been made to this area. The registered manager told us to assist with this, additional training had been organised for staff. The training had included dysphagia (difficulty or

discomfort in swallowing, associated with the ageing process) and dining with dignity.

Information within support plans detailed the support people required to eat and drink. One plan stated staff were to "prompt" a person to drink on an hourly basis in the morning and two hourly for the rest of the day. This had been agreed with the person and was clearly evidenced within their records. Another record showed the person had been prompted to drink at similar intervals. Staff were monitoring those, who were at risk of malnutrition or dehydration. The monitoring charts showed people had been supported with meals and drinks regularly. These people were identified on the handover sheets, to remind staff of the additional support needed. However, some records were not specific and staff had documented "half of pudding" eaten rather than the actual dessert. This did not show the nutritional content of the food. Not all charts had been "signed off" at the end of the day and the recommended fluid intake for the person was not identified on the record. This did not show effective monitoring was always taking place.

The registered manager told us emphasis was given to high quality food. They said this was because food was important to people and "good food" encouraged people to eat, thus enhancing wellbeing. People and their relatives confirmed this. Specific comments included "the food is amazing", "I'm always amazed at the quality of the food and the variety" and "the food is excellent". One relative told us "I wouldn't mind living here for the food you get. There's an excellent choice of good quality meals. I'm always impressed with the food". A member of staff told us "We make very nutritious food and give plenty of variety at all meal times".

The menu consisted of meals such as puff pastry game pie, crispy shredded chilli beef and Thai green prawn curry. People were able to choose from two main dishes and further preferences were accommodated as required. The registered manager told us there was an additional menu for those people who preferred or needed softer foods. There was information about special food requirements, for staff reference in the kitchen. These related to people's health conditions or general preferences.

People were supported by staff that were well trained. Records showed there was a clear programme of training which included topics deemed mandatory by the provider, as well as "person specific" training. There was a training manager, who was responsible for all aspects of staff training and development. They said in addition to "day to day" training, all staff were encouraged to complete nationally recognised training programmes, related to their role.

Staff told us they were happy with the training they received. One member of staff told us "It's the best training I've ever had". Another member of staff told us "What I like is the training's related to people's needs so it's all really useful". They said they had recently completed training in dementia, Parkinson's disease, leg ulcers and catheter care. Another member of staff told us "There's a lot training which is e-learning so you can just add on the extras, you feel you need". Registered nurses told us they had on-going training and development to meet their professional registration requirements. One registered nurse told us "We had a catheterisation update yesterday" and "I did venepuncture recently". Another member of staff told us training in care planning had been organised, following the last inspection. The registered manager told us they encouraged discussions after a training session to ensure staff had understood the information they had been given. They said staff were monitored to ensure staff worked in the way they had been trained.

Staff told us they received a good induction when they started work at the home. One member of staff said they completed a range of training and worked "shadow shifts" with more experienced members of staff. Another staff member told us they needed to be "signed off" before working on their own with people. They said their competency with all tasks was assessed and they had to complete all training expected of them to pass their induction. Staff said they were asked if they were confident to work on their own and if not, additional support was given. Within their induction, each new member of staff was allocated a mentor. This

enabled a clear point of contact and support. One mentor told us "I wouldn't be doing my job properly if new staff were struggling. We all work as role models, so the new member of staff learns how we expect things to be done". The mentor confirmed the staff member's competence was assessed before they were able to work unsupported.

Staff told us they were well supported. However, there were some comments about morale being low at times and areas of teamwork, which could be improved upon. The registered manager told us they were working with staff to improve these areas. They said systems such as "Abbey Aces" were being used to recognise staff's work. This enabled staff to be nominated and recognised for their contribution to the service.

Staff told us they met with their supervisor on a more formal basis to discuss their work. They said the sessions were useful. The policy regarding support and supervision identified staff should receive six sessions a year. A schedule showed the service was on track to achieve this for most of the staff. The training manager told us staff appraisals were undertaken in December so they could be "signed off for the year". An appraisal enables the staff member's performance to be reflected upon. Areas discussed included what went well and what could have been improved upon. A development and training plan for the following year was developed and agreed, as a result of the discussions.

People were supported to access a range of services to meet their health care needs. Records showed these included the GP, Tissue Viability Nurse, speech and Language Therapists and foot care specialists. One person told us they were having lots of physiotherapy. People had Treatment Escalation Plans (TEP's) in place. TEP forms are a way of a doctor recording people's individual treatment plans. These focus on which treatments may or may not be most helpful in the future. Areas considered are resuscitation and admission to hospital if the person is acutely ill. Whilst people had TEP forms in place, staff were not readily aware of the content. For example, one person was transferred to hospital, despite their TEP form stating emergency hospital admission was inappropriate. The receiving doctor at the hospital had raised this issue and documented "Clear TEP in place – not for acute admission". These comments had not been included in the investigation of the incident.

Good

Is the service caring?

Our findings

Staff spoke to people in a professional but very caring way. Staff addressed people according to their preference and used people's titles such as "Captain" or "General". This showed respect and recognition of the person's status. They asked people "how can I help?" and used pleasantries such as "you are most welcome". Staff took their time with people. When coming across individuals in the corridor, they stopped to have a conversation. The atmosphere was friendly and relaxed.

Staff were attentive whilst supporting people. This included engaging in conversation whilst walking with a person. One member of staff opened a door for a person and said "after you sir". Those people, who needed assistance to eat, were supported in a caring and sensitive manner. One member of staff was talking to the person whilst assisting them. They were asking questions such as "is that nice?" and "would you like some more?" Another person asked a member of staff to arrange the items around them, so they were nearer. The member of staff said "of course, how's that. Is that better?" They asked if there was anything the person needed before leaving them.

The dining room at lunch time was calm, quiet and relaxing. There was silver service to enhance the experience. Flowers were on each table, which gave a pleasant feel to the room. Condiments were readily available. Staff told us people generally preferred to have their breakfast served in their room and use the dining room for their midday and evening meals. They said people's wishes were always adhered to and fully respected.

People told us their rights were fully promoted and staff treated them well. Specific comments were "We are always treated with respect and dignity" and "I am always treated with kindness and respect". Relatives confirmed this. They were very positive about the care their family member received. One relative told us "X is incredibly well looked after. The staff are fabulous and are very fond of him. They know him as a person and are very concerned about his wellbeing". Another relative told us "I watched the staff the other day and they did a task for X [family member] beautifully. They were so sensitive and so caring". Other comments were "the care is fabulous", "they are so caring", "staff go out of their way for people", "they are very caring but the care is genuine" and "nothing is too much trouble". One relative told us "The staff go well beyond the call of duty. They are exceptional". Another relative said "Mum is well cared for and the staff are very good with her, very respectful".

Staff told us they received training in promoting people's rights. They said this area was given high priority and rights to privacy and dignity, for example were always promoted. Staff said personal care was always delivered in private, behind closed doors. Whilst supporting people, staff said they placed a "peacock" sign on the outside of the door, to show they were not to be disturbed. Staff respected the signs, as the member of staff administering medicines said "It looks like they're having a wash or getting dressed, so I'll come back later". If there were no signs on the doors, staff knocked and waited to be invited in. Staff called out as they entered and said "good morning X, it's X [staff' name]. How can I help?" Staff told us one person chose to eat all of their meals in their room, as they were embarrassed about the difficulties they had with eating. Staff told us their wishes were "fully respected". Another member of staff told us they ensured attention was given

to a person's hair to ensure dignity. They said "Even if a person is nursed in bed, we ensure their hair is washed regularly. It's important to make a person feel better about their presentation, especially if this was important to them when they were more able".

Staff told us they encouraged people to follow their own routines. One member of staff told us "It's fine if someone wants to go out and come back late. They can have their meal when they come back. It's not a problem". Another member of staff told us "If a person wants to stay up really late, eat crisps and drink fizzy pop, who am I to judge?" Staff told us people were encouraged to get up and go to bed when they wanted. One member of staff told us "We are here to help people with what they want. We work around people and their wishes". One relative told us "X has a cup of tea, almost the minute he opens his eyes in the morning. They know what he likes and they provide it for him".

Each person was encouraged to furnish their room as they wished. Rooms contained personal items and photographs, which reflected the person's identity. People were encouraged to have visitors when they wanted them. Relatives confirmed this by saying "There are no visiting restrictions that we are aware of" and "I come at all different times, depending what I'm doing. The staff are always very welcoming". One relative told us "They always offer me a cup of tea and a piece of cake". A member of staff confirmed this. They said "It's the first thing a person would do in their own home and as this is their home, it's no different". Relatives told us they were able to eat with their family member, if they chose to. One relative told us there was a flat, which could be rented. This enabled relatives, especially those who lived a long way away, to spend the weekend or week with their family member, if they chose to.

Staff told they enjoyed their work and spoke highly of the care they provided. Comments included "The care here is very good. We make sure people are cared for like they are our family" and "The care is superb here. The staff really care for the residents and show affection for them". One member of staff told us "Everyone is 100% here for the residents. We all really care. It's built in so it's really natural". Another member of staff said "We are here to please. We do what the residents want us to do. We ensure autonomy and take their lead". One member of staff told us "We encourage people to ring their call bell, as it's their contact with us. Some people may ring their emergency bell so we can move a glass or take a cup away. It might not be an emergency to us but it is to the person, so it's fine". Another member of staff told us "All the staff really care about people. We wouldn't dream of leaving a person to die on their own. If they had no family with them, we would take it in turns to sit with them to the very end, holding their hand, maybe stroking their hair and talking to them".

Requires Improvement

Is the service responsive?

Our findings

During the comprehensive inspection in August 2016, we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always receive care that was responsive to their needs. In addition, the quality of people's care plans was variable. Some were very comprehensive, others were not.

At this inspection, improvements had been made to the quality of people's care plans. However, information did not always show the action required to ensure people's safety. For example, one person had been assessed as being at very high risk of pressure ulceration. Staff told us of the support they gave to minimise the risk but this was not detailed in the person's care plan. Another person was at similar risk. Their care plan stated they needed staff to assist them to change their position "regularly". This instruction was not specific and did not ensure staff provided appropriate support in line with the risk identified. The person's care chart, where staff recorded the assistance they gave with repositioning, stated the person was able to reposition themselves. This gave conflicting information and did not reflect what was written in the person's care plan.

We recommend that the service reviews all information within people's care plans to ensure it is an accurate reflection of their needs.

Plans showing people's clinical needs were detailed and well written. There were wound care plans which showed clear information of the wound, including photographs. Dressing plans were clear and specialist input had been gained from the tissue viability nurse, as required. One person's support plan clearly showed details of their diabetes. This included how to monitor the person's blood sugar levels and the type of diet they required. There were also signs and symptoms of low blood sugar and what action should be taken, if identified.

People's dietary preferences and their preferred routines, such as what time they liked to get up and go to bed, were stated. However, there continued to be limited information about people's history and their lives before their admission to the home. This lack of information did not promote the person's identity or enable staff to make conversation about areas of importance. The registered manager told us, after the last inspection, additional training in terms of care planning had been arranged. They were aware improvements had been made but there was further work to do. A health care professional told us they supported staff with the review of people's care plans. They said the plans they had seen, were of a good standard and reflective of people's needs.

Care plans identified what people could do independently and what worked well. Information also identified support required and anything that had not been so good. This included deterioration in a person's mobility and general health. It had been noted one person was choosing to spend more time in bed. Their tissue viability care plan had been updated to reflect the potential risks of this. The plan informed staff to assess and respect the person's level of tiredness, which varied from day to day. Another plan identified a person had a history of dry skin and "tissue paper" skin on their hands. Staff were required to

apply topical creams and monitor the person's skin on a daily basis. There was an instruction that any changes needed to be reported to the nurse on duty.

People told us they were happy with the care and support they received. One person told us "I am content here and well cared for". A relative told us "X [family member is thriving here and she likes the home very much". Staff told us the care provided was of a "very good standard". They said they always offered people the choice of a wash, bath or shower. One member of staff told us the majority of people had a shower at least three times a week. They said they listened to what people wanted and adhered to their wishes. A health care professional told us staff provided "excellent care" in a very person centred way.

The registered manager told us social activities were arranged according to people's needs and preferences. There was a dedicated member of staff, responsible for the organisation of social events but they were not on duty during the inspection. Staff told us activities such as historical talks and coffee mornings were arranged rather than the "usual" activities, arranged in care homes. There was no organised activity on the first day of the inspection. On the second day, a coffee morning took place in the drawing room. People enjoyed a glass of sherry whilst talking to each other. One person told "They have good activities here".

People and their relatives were aware of how to raise a concern if they were not happy with the service. One person said "If I have any concerns, I talk to the manager". People told us they found management responsive to their need. One person told us they did not have any complaints but said "The lifts are a problem, as they do breakdown and that is a problem for many of us". The registered manager confirmed there had been difficulties with the lifts but external contractors had addressed the problems, as quickly as possible. They said the lifts were now in good working order. People were asked, within the yearly satisfaction surveys, whether they were aware of the complaint's procedure. The documentation was reissued if needed.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. They started employment at the home in February 2016. During this time, improvements had been made to the service. This included recruitment, care planning and the stability of the staff team. Staff confirmed there was a period of instability as before the registered manager, there had been a series of different managers. Staff said this had now improved.

There were a range of systems to monitor the quality of the service. However, shortfalls found during this inspection had not been identified and properly addressed. This particularly applied to the management of risk associated with choking and the radiators within the home. The lack of consideration given to these risks was of particular concern. This was because there had been two related, significant incidents, which had led to an investigation by the coroner.

Records showed audits were in place to monitor areas such as care planning, medicine management, staff training and recruitment. Other audits targeted the kitchen, the control of substances hazardous to health and the environment. The information was detailed and clearly identified areas, which required further attention. Organised plans were in place to address the shortfalls and any actions taken, were clearly shown.

Some audits were undertaken by external professionals. This included an audit of medicine management, which had been completed by the supplying pharmacist. Records showed the majority of action points had been completed and further work was planned. The registered manager told us they worked closely with the pharmacist to improve the service. As part of the auditing process, meal time observation checks had been undertaken. These particularly considered people's experiences of the dining experience. Whilst it was positive these audits took place, much of the information was difficult to read due to the registered manager's handwriting.

There were monthly management reports which gave an overview of the service. Records showed the directors had reviewed the reports and had requested more information, if required. The registered manager told us they had a high level of contact with the directors. The service, potential challenges and areas which worked well were regularly discussed. The registered manager told us any additional resources required, were either agreed or if larger, were costed and put forward for the following year's budget. The training manager confirmed they completed a training needs analysis every year. The requirements identified were then taken into account within the budget setting process.

Some of the carpets within the corridors were discoloured through wear and tear. In one area, grey tape had been used to secure an area in a doorway. Whilst this minimised a trip hazard, the tape did not look good. Within another area, there was a stained area to the ceiling. A senior manager told us these shortfalls had been recognised and were in the process of being addressed. They said consideration was being given to a suitable carpet, which was homely but durable and reflected the ambiance of the home. They said this was proving difficult to find. Staff told us there were plans to refurbish areas such as the drawing room. They said this included new furniture, which would be more responsive to people's needs. The registered manager

told us consultation with people regarding the refurbishment was currently being undertaken.

There were a range of assessments, which related to the environment and specific tasks undertaken. These included the risks associated with items such as the rug in the front hall, particular steps and the use of wheelchairs outside. The fire risk assessment had recently been reviewed and was up to date. However, a policy stated staff were required to take part in two fire drills annually. Records showed 25 staff had not attended any drill so far, this year.

People and their relatives commented positively about the environment and the grounds. One person told us "It's beautiful place". A relative said "It's like living in a stately home and the grounds are absolutely fabulous". Another relative said "Who wouldn't want to live here. It's an amazing place". There were two comments regarding suggested improvements to the environment. One involved having a dedicated outdoor space near to the main building to store and charge electric scooters. The other was to have space, where activity items such as art painting or games could be left out. This would enable continuation of the activity, rather than getting items out again when needed. There were fresh flower arrangements within the communal areas of the home. The registered manager told us flowers were delivered weekly and staff were employed to arrange them.

There were a range of systems to ensure staff had the information they required. This included meetings, which were related to role and key topics such as diet and nutrition and clinical focus. All staff had a detailed handover at the start of their shift. A half hour, cross-over of shifts enabled this to be unrushed. Staff were given a handover sheet. This identified each person, the key points of their care, potential risks and any action required as a result. The document was informative and used as another way to ensure staff had up to date information they needed about people. The registered manager told us they had updated a number of the home's policies and procedures. To ensure staff were aware of this information, a different policy was discussed with staff each week. The order was determined in response to priority.

People were positive regarding the management of the home. One person said "The management are responsive particularly in the last year". Another person said "I would give the management 8/10 and improving". Other comments were "The management are approachable and I talk to them as needed" and "This is a well-run care home". One person commented there had been some changes in management and staff, which had led to an improvement in the running of the home.

Staff were also very complimentary about the registered manager. One member of staff told us "The manager is friendly and very supportive. They are always in handover and 'pipe up' when needed". Another member of staff told us "The manager is good at listening. They are firm but friendly and have a laugh although all staff know their boundaries". One member of staff told us the registered manager and the directors were very aware of people's needs. Other comments were "He [the registered manager] is always around and knows what's going on", "The office door is always open" and "[The registered manager] often goes into residents for a chat. Everyone knows him".

There was a clear, person centred ethos that was adopted throughout the team. Staff explained this as providing "high quality person centred care", "a family type feeling and environment" and enabling people to "feel it's their home". One member of staff told us "The ethos is very person centred. It's all about what the person wants. We work together as a team and our work is based on respect. It's the back bone of the service". The member of staff continued to say "Staff in all departments work together for the same aim". Another member of staff told us "The ethos of the service is good care and empowering people to live as independently as possible".

People were given satisfaction surveys on an annual basis so they could give feedback about the service they received. The surveys asked people about aspects such as the quality of the food, cleanliness, the quality of care and value for money. The registered manager told us any concerns raised were discussed with the person further, in order to agree a "way forward".

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 Risks to people's safely were not being appropriately identified and addressed.