

Rapport Housing and Care Connors House

Inspection report

Craddock Road
Canterbury
Kent
CT1 1YP

Tel: 01227769774
Website: www.abbeyfieldkent.org

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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

This inspection took place on 2 and 3 November 2017 and was unannounced. The previous inspection was carried out in September 2016.

Abbeyfield Connors House provides accommodation for up to 47 people who need personal care and support. There were 41 people living at the service at the time of our inspection. The service provides care for older people and people living with dementia including some with other health and mobility needs. Some people had complex needs and were not able to communicate verbally with us. Connors House is a single storey residential care service located close to Canterbury city centre. The service is split into three units – Holly and Evergreen, which support people living with advanced dementia and higher needs and Cedar and Ash, which support older people and people living with dementia. The Maple unit is the newest part of the service and accommodates older people. In each unit there are communal areas such as lounges, dining areas and bathroom facilities, a conservatory and a well-equipped hair salon. There is an enclosed courtyard with safety rubberised flooring, patios with seating, a BBQ area, fishponds, floral and shrub raised planting as well as a separate vegetable garden.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection in September 2016 the rating for the service was Requires Improvement overall and in each of the five key areas. This was because although risks to people had been assessed, they were not always reflective of people's changing needs. Medicines were mostly well managed, however, some records were not accurate and people did not always receive their medicines when they should. There was not always enough staff on duty to meet people's needs and at times people did not receive the support they needed, for example, to maintain their personal hygiene. Staff were not trained in topics that would help them provide care and support specific to people's needs, such as, End of Life Care and Palliative Care as well as Parkinson's and Epilepsy awareness. Care plans did not always provide staff with the most up to date guidance, so they could support people in an individual way. Assessed risks to people's health, such as monitoring food and fluid intake, monitoring weight or pressure relieving equipment were not managed effectively and, at times, people did not receive personalised care that enhanced their dignity. People were not always offered choices, and sometimes staff made assumptions about what drinks people would choose. The audits and checks carried out each month by the registered manager or a nominated person had not always been effective in identifying the shortfalls highlighted during our last inspection.

At this inspection we found improvements had been made, however, there were some areas that still required further work around risk assessment, record keeping, auditing and statutory notifications. A statutory notification is information about important events which the provider is required to tell us about

by law.

Most risks to people had been properly assessed and actions were taken to minimise the likelihood of them happening. However, more action needed to be taken about people who experienced falls; including a more detailed audit processes to ensure risks were minimised. Other care plans were written in a person-centred way but had not always been updated to reflect people's needs when they had changed.

Medicines were generally managed safely but records of the administration of topical creams needed to be managed more robustly.

Not all complaints had been logged, however, they had all been investigated and responded to.

People were safeguarded from abuse and improper treatment and accidents and incidents were thoroughly documented. Referrals to the local safeguarding authority had been made appropriately.

There were enough skilled and competent staff on duty and people had their needs met promptly. Staff received appropriate induction and training to ensure they had the skills and knowledge to support people. Staff had opportunities to discuss their work performance, training and development. Recruitment processes ensured that only suitable staff were employed to work with people.

People were supported to eat and drink when needed and they enjoyed the variety of food provided. However, some improvement was required to better cater for diabetic and vegetarian needs.

Weights were monitored and dietary advice sought where people had lost weight. People's health care needs were met by the staff and through input from a variety of clinicians and professionals.

The service was mostly meeting the requirement of the Deprivation of Liberty safeguards (DoLS) and Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, the service had overlooked the renewal of a DoLS authorisation.

People's dignity was respected by staff and support was delivered by them with consideration and kindness. They encouraged people to be independent when they were able and people and families were involved with care decisions. End of life care plans had been improved.

There was a wide range of activity available to people; who enjoyed meaningful entertainment and individual sessions.

Policies and procedures were available to offer guidance to staff. People, relatives and staff were positive about the leadership at the service. Staff told us that they felt supported and could raise any issues or concerns with the registered manager.

We found two breaches of Regulation. 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 consistently safe.

Some risks to people had not been sufficiently minimised; such as falls and monitoring of water temperatures. Some records were incomplete and did not provide staff with sufficient guidance.

Medicines were generally managed safely, and people were safeguarded from abuse and improper treatment.

There were enough skilled and competent staff on duty.

There was a robust recruitment process in place.□□

Is the service effective?

Good ●

The service was always effective.

People's rights had been protected by proper use of the Mental Capacity Act (MCA) 2005, however, not all decisions were current.

Staff training and supervision was effective in equipping staff with the skills needed for their roles.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People received enough to eat and drink and were complimentary about the quality of food provided.

Is the service caring?

Good ●

The service was caring.

Staff acted sensitively to protect people's privacy and dignity.

Staff engaged well with people. Staff spoke with people in a caring, dignified and compassionate way.

People were supported to be independent where possible.□□□

Is the service responsive?

Good 

The service was responsive.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual and person centred.

There was a variety of activities, functions and outings on offer.

An accessible complaints procedure was in place. ☐ ☐

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

Regular audits and checks were undertaken to make sure the service was safe and effectively run. However, not all audits identified the shortfalls they were intended to.

Statutory notifications were not always made to the Commission when they were supposed to be.

People and staff were positive about the leadership at the service. Staff told us that they felt supported.

Feedback had been sought from people, relatives and staff and suggestions for improvement were acted on.

Staff were clear about their roles and responsibilities and felt supported. Policies and procedures were available. ☐ ☐

Connors House

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 November 2017 and was unannounced. The inspection was carried out by one inspector, an assistant inspector and an expert by experience with knowledge and understanding of caring for older people and people with dementia.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 18 people who lived at Abbeyfield Connors House, we observed some people's care, the lunchtime meal, some medicine administration and some activities. We spoke with nine people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with one senior carer, two care assistants, the kitchen and housekeeping staff as well as the deputy manager, registered manager and service administrator.

We 'pathway tracked' four of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for five other people. To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems, we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events, their interaction with each other and with staff.

During the inspection we reviewed other records. These included staff training and supervision records, staff

recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Is the service safe?

Our findings

People told us they felt safe living at Abbeyfield Connors House. Their comments included, "The staff all know that if I ever use my call bell it means business and they get to me post haste", "I know that I am safe here at all times of day or night, there is always a member of staff to help at any time of day or night", "I have all the equipment I need and can just ask for anything else I might need and they will always try to help without fail". Each person we spoke with commented positively about the staff, one visitor told us and we saw that call bells were left within people's reach so they could call for help if needed; and staff also regularly popped in on some people who preferred to spend time in their bedrooms.

At our last inspection care and treatment was not provided in a safe way for people because risk assessments, particularly in relation to continence and mobility, had not always been updated in response to changes in need or incidents that had occurred. Some fluid monitoring charts did not always accurately reflect what people had drunk, which made it difficult to know if they remained at risk of dehydration. Fluid output was also not always recorded for those who had catheters and, if this was not monitored, placed them at risk of fluid retention in the event of a catheter blockage.

At this inspection most of these areas had been satisfactorily addressed, but further work around the management of falls was needed to improve the way risks were managed. Although incidents and accidents were analysed and an audit monitored the times and places people fell, action taken had not successfully prevented further falls from happening. For example, some people had had further falls because preventative measures relied on them asking for help or remembering to use walking aids. In some cases, consideration of seat pressure mats, activated when a person gets off a chair, would have immediately alerted staff to people's movement. Staff could then have ensured walking aids and timely support was provided. Where assistive technology, such as floor pressure mats were used, room layout was not always arranged to ensure the mat would be activated. For example, although immediately following this incident the bedroom was rearranged, one person had experienced a fall getting off the bed on the opposite side to which a mat was placed. Other measures such as timely referrals to the occupational therapist, community mental health team or consideration of the use of bed rails or a soft mat on the floor next their bed may have helped reduce the number of falls or the impact of those that had occurred. This did not demonstrate an embedded culture of lessons learned and improvement made when incidents occurred.

The failure to appropriately mitigate risks is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, staff were aware of their responsibilities to record accidents, incidents and near misses and understood that they must be reported. Where some people could have behaviours which may be challenging toward others, incidents, causes and outcomes were logged and reviewed. This provided staff with information about potential signs and triggers and they had developed appropriate strategies to address these.

However, other risk assessments were missing or incomplete and could not provide sufficient guidance for

new staff or staff who may not be familiar with a person. For example, one person required a softened diet to help reduce the risk of choking. Their nutrition care plan, in spite of having been reviewed a number of times, made no mention of the requirement for softened food. However, other information in the person's pen picture of needs clearly set out this requirement. Discussion found care and kitchen staff were aware of this requirement and, in practice, we saw the person received the correct food. Another person was at risk of skin breakdown through development of pressure sores. We saw appropriate monitoring was carried out, pressure relieving equipment was in use and skin care given, however, there was no risk assessment or care plan in place to provide guidance to staff. We found catheter risk assessments did not tell staff when catheter bags should be replaced and diabetic care plans did not ensure eye and foot care were actively monitored as part of this condition. People had diabetic passports, which contained foot and oral health assessments. After the inspection the provider told us they would add this information to people's diabetic care plans.' While discussion with staff and our observation found people received care appropriate to these needs, incomplete records and guidance introduced a risk that people may not receive consistently safe care.

Systems or processes had not been established and operated effectively to include a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following the inspection the registered manager contacted us to advise that risk assessments we highlighted had been reviewed and that a full review of all risk assessments had been planned.

At our last inspection medicines were not consistently managed safely because they were not always given as prescribed. At this inspection, improvement had been made and medicines were managed safely. People received their medicines when they needed them, staff had received appropriate training and competency supervision. There were clear protocols in place to make sure people received the right amount of medicines safely and on time. Staff were aware of people's conditions and the medicines they received. All medicines were stored securely in line with current guidance. Appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines by staff who had received training and who had been assessed as competent to do so. Clear records were kept of all medicine that had been administered. The records were up to date and had no gaps, showing all medicines administered had been signed for. Well established links with healthcare professionals ensured clear communication and guidance for staff of any changes to medicines, or the need for medicine reviews and when these were undertaken. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN). Regular medicine audits were carried out by the registered manager or key staff. This helped to ensure people received all of their medicines safely. Application of medicated creams were recorded separately and, although usually completed, there were some gaps where they were not. This was pointed out to the registered manager during the inspection who gave an undertaking to address these omissions in group supervisions and subsequent audits. This was an area identified as requiring improvement.

At our last inspection there were not always sufficient staff to meet people's needs. Some people told us that, at times, they had to wait a long time for assistance and others felt that there should be more staff at night; numbers of staff on duty had fallen short of those planned as needed . At this inspection there were sufficient staff to meet people's needs and a review of the staff rota for the previous three months found staff deployed matched the staff planned as required. Comments about the staffing included, "I don't ever get rushed, however busy they might be, they're very patient", "I never get rushed and I have never witnessed anyone else getting rushed either. We observed staffing levels were sufficient so staff could work at a calm pace to support people to get up and ready for the day. Personal care was completed when and in the way people wanted. Staff spent time with people throughout the inspection. People enjoyed this and told us

staffing levels were appropriate. Staff felt they were not rushed and there was enough time to give people the support they wanted. Some people told us they could have a shower or bath each day if they wanted to and were happy with this. The registered manager routinely reviewed people's needs against the deployment of staff and was confident that staffing was flexible enough to respond to changing needs. Agency staff were occasionally used, they received a familiarisation induction to the service and the tasks they were required to do.

Established checks took place to help ensure the safety of people, staff and visitors. The service was clean and free from odour, effective cleaning schedules set out appropriate levels and methods for cleaning of the premises and equipment. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. Records showed that portable electrical appliances and firefighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Records showed Health and Safety audits were completed monthly and that these were reviewed by management to see if any action was required. Fire risks had been thoroughly assessed and people had individual emergency evacuation plans. They gave details of the assistance each person would need in an urgent situation. Staff had regular fire safety training and could describe the way in which people would be helped. Testing and monitoring of water temperatures took place annually, however, this was not in line with the service's policy, which required sample checks to take place monthly with the expectation that all outlets would be tested over the course of a year. Discussion with the registered manager found maintenance staff had misunderstood the policy and gave an undertaking that sample checks would be made to meet the policy requirement. This was an area identified as requiring improvement.

Safe recruitment procedures were in place. Staff recruitment records reviewed showed all of the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. Staff were not allowed to start work until these checks had been completed. Staff confirmed there was a robust interview process in place and that they had been required to provide all the relevant documentation before they started working for the provider. This helped to ensure that staff employed by the service were suitable to work with the people they cared for.

All staff had received training about safeguarding adults. Staff confirmed this and knew who to contact if they needed to report abuse. Staff were confident any abuse or poor care practice would be quickly spotted and addressed immediately by any of the staff team. They were aware of different types of abuse including discrimination. Policies and procedures on safeguarding and equality, diversity and human rights were available in the office for staff to refer to if needed. Records showed incidents, warranting referral to the local authority safeguarding team, had been made. The registered manager investigated each incident and required staff to complete a written account of how an injury or incident had occurred. The registered manager had a well-established working relationship with the safeguarding team and provided examples of when they had contacted them for guidance. Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly.

Policies and procedures on all health and safety related topics were held in a file in the staff office and were easily accessible to all staff. Staff told us they knew where to find the policies.

Is the service effective?

Our findings

People told us staff looked after them well. One person told us, "I have always been given just the care that I need". Another person said, "The staff will always make an effort to explain what is going on for instance, if my equipment needs changing or cleaning in my room. They will never just do things over my head or ignore me".

At our last inspection although monitoring charts were in place for people whose food intake or weight needed to be monitored, they were not always completed accurately or with meaningful information. At this inspection improvement had been made. Where concerns were identified around how much people ate or drank, records were made. This enabled staff to track how much people ate and formed a starting point for dieticians to decide if fortified or food supplements were required. People were weighed regularly and in the event of weight loss, appropriate referrals made and support sought. Where fortified meals were recommended or supplementary drinks prescribed, records, staff and people confirmed they were given. Fluid charts were in place, records were up to date and staff were able to tell us of potential signs of dehydration and what to do. Hydration care plans gave staff guidance about how much people should aim to drink in a 24 hour period.

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 so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked whether the service was working within the principles of the MCA. Applications had been made for DoLS authorisations for people who needed them, three authorisations were granted since the last inspection with the remainder being processed. These authorisations were applied for when it was necessary to restrict people for their own safety. The service was responsible for making applications and the relevant supervisory body (local authority) considered each application, issuing authorisations as needed. This ensured any restrictions on people's liberty were warranted and the least restrictive as possible. However, a review of granted authorisations found one had expired in August 2017, the person still lived at the service and the restrictions in place were unchanged. The service should have ensured a new DoLS authorisation application was made before the previous one had expired but this had not happened. However, upon discovery a new application was immediately made to the local authority.

Otherwise records showed people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The management and staff had knowledge of and had completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good knowledge and understanding of the MCA. We observed staff offering people choices and they told us about people who needed more help to make their own decisions. For example, people were

able to make day to day choices about what they wanted to do, eat and wear. Staff asked people for their consent before placing an apron over their clothes, to protect them when eating. Staff knocked on bedroom doors and asked for consent before entering their room. If a person was unable to make a decision about medical treatment or any other big decisions then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

Most people were supported and encouraged to eat a healthy and nutritious diet. One person told us, "The food is really very good and I never leave a single bit it is so tasty". "We are certainly never short of drinks or something a little extra to eat if we want it" and "We do discuss in resident meetings about the food and sometimes we do find our suggestions on the menu". Picture cards with a bold print description were used to help some people choose what they wanted to eat. Other people were shown different plated up food so that they could smell and see what it looked like to help them make a choice. Where needed, plate guards were used to help people eat independently and staff prompted other people to eat with hand on hand support or verbally guiding people to what they were doing. Meal times were well organised, not rushed and people received the support and supervision they needed. Throughout the inspection regular drinks and snacks were offered by staff.

Organisation within the kitchen ensured people received the correct meal choices and that they were prepared in a way that was safe for them to eat. For example, some meals were softened and others were fortified to suit individual needs. However, although people and their relatives felt nutrition needs were generally met, meal planning did not always take into account people's diabetic or vegetarian needs. For example, some desserts, cakes, jams and marmalades contained sugar, rather than sweetener which meant, because of the sugar content, diabetics were offered a smaller amount to eat. Had ingredients suitable for diabetics been used, people could have been treated individually but equally in terms of how much they wanted to eat. Following the inspection the provider gave us evidence to demonstrate how they meet the individual dietary needs of diabetics, this included the use of sweeteners rather than sugar to ensure people could have the portion size of their choice.

Similarly, people who ate meat were offered two main menu choices, whereas there was usually one main vegetarian choice. Again, people were not treated equally. We discussed these issues with the chef and registered manager who immediately undertook to review menu planning. In addition, there was a selection of alternative meal options available on a daily basis, both vegetarian and meat options.

Staff told us they had an induction when they started working at the service, this involved office time with a manager where they spent time reading people's care records, policies and procedures and getting to know the service. They also spent several shifts shadowing experienced colleagues to get to know people and their individual routines. New staff received a comprehensive programme of training before they started working with people. New staff were completing the Care Certificate; a set of standards that social care workers follow in their daily working lives. Staff were supported through their induction, monitored and assessed to check that they had the right skills and knowledge to be able to care for, support and meet people's needs effectively. Staff received support during formal one to one meetings with the registered manager; some meetings were planned in advance, while others were in response to situations arising. Staff discussed issues that had happened in the service and reflected on their practice. A schedule of supervision and appraisal ensured their frequency reflected the service's policy.

There was an ongoing schedule of training. Staff had completed a mixture of e learning and face to face training in a range of subjects which enabled them to perform their roles safely and to provide the right care and support to meet people's needs. Training in all mandatory subjects was up to date for most staff. Our observations found that staff were both competent and confident in delivering personalised care. Staff had

also undertaken extra training in subjects such as challenging behaviour, dementia awareness, diabetes, catheter and end of life care. Competency checks were completed after training sessions to check staff knowledge and understanding. All staff told us the training was a good standard.

People's needs were assessed using a holistic assessment tool, prior to them moving into the service. This supported the registered manager to consider if the service could meet people's needs and review if any additional staffing or training was required. Resulting care plans were developed in line with good practice, including guidance provided by the National Institute of Health and Care Excellence (NICE) and NHS guidance and the principles of person centred planning.

People's health was monitored to help maintain their well-being. Physiotherapists, speech and language therapists, occupational health practitioners, opticians, chiropodists and GPs all visited the service to assess people and contribute to their care and support on a regular basis. Records of the day to day care delivered ensured staff were able to quickly notice any changes to people's health and condition, this helped to ensure any healthcare needs or referrals were made in a timely way. One person told us, "We have the chiropodist regularly, every month or so I think and there is a hairdresser here too. I always have an eye test", another person commented, "The doctor is called immediately if we need them". People's weight and referrals to dieticians were well managed and there were examples of where people's weight loss had stabilised and improved. Where possible people and their relatives were involved in planning their care delivery and were aware of risks to be monitored and managed.

Abbeyfield Connors House provides accommodation and support for older people, many of them living with dementia. The registered manager had due regard to guidance of best practice for a dementia care setting. For example, there were handrails in corridors to aid mobility. Signage to toilets and lounge areas were easily visible and in written and pictorial forms; some doors were painted in contrasting colours to help people to more easily distinguish them. This helped to aid people's awareness of their surroundings. People's bedrooms were personalised with their own possessions, photographs and pictures. They were decorated as the person wished and were well maintained. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use; the height of some wash hand basins were adjustable to accommodate people of different stature and wheelchair users. One person told us, "I chose what furniture I wanted to bring from home and have even got my own curtains".

Is the service caring?

Our findings

People and their visitors were complimentary about the staff telling us, "The staff go out of their way to help my wife, they are so caring" and "The staff are incredibly caring, mum is always content and well cared for". One person commented, "They respect our feelings and our privacy at all times".

At our last inspection people were not always offered choices, at times, staff made assumptions about what drinks people would choose. In addition, some people looked unkempt with greasy hair and long/unclean toenails and some people were wearing clothes that were crumpled and stained. At this inspection we found improvement had been made. People's hair was brushed; they were helped with nail care, jewellery or make-up. People who wanted to shave were assisted with shaving, while other people chose to have a beard. People we spoke with were happy with their appearance, nails and cleanliness. People had clean and trimmed nails and were generally well-presented.

Staff were friendly and accommodating of people's requests and support needs. Staff spoke with people with courtesy and kindness and it was clear that relationships of trust had been built. For example; one person needed a lot of reassurance at different points during the inspection. Staff responded to this with compassion and patience on every occasion and made time to stop and comfort them and distract them from their anxieties with a cup of tea and a chat. Another person did not want any of their lunch. Staff arranged for several different meal options to be brought and offered to the person. Staff spoke to this person with care and consideration and tried to gently persuade them to try something to eat. People told us, "There is always someone to have a chat with, if it's not another resident it will be a member of staff, they will always make time for me or for anyone they are brilliant" and "There is always someone to chat to at any time you feel a bit lonely, whether it is someone else living here or a member of staff". Lounges were arranged and furnished thoughtfully, many with settees to allow people to sit together if they chose.

There was a clear person centred culture at the service and a commitment to supporting people to express their views, feelings and maintain their independence. Staff knew about people's background, their preferences, likes and dislikes and supported people in a way that they preferred. One visitor told us, "They are caring, kind, patient and knowledgeable and always manage to make (my relative) happy". Information was available to people and visitors about community organisations and advocacy services, which could independent support and advice.

People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us how staff contacted them if they had any concerns about their family members.

People received discreet assistance, which allowed them to stay independent with some tasks. For example, some people had plate guards on their meals which prevented food being pushed off the plate as they ate.

This enabled them to eat independently. Other people told us about the support they received with personal care and how staff only did what they wanted them to rather than trying to take over. One person told us, "The staff are unfalteringly kind, friendly and above all very patient".

Staff were attentive. They observed and listened to what people were saying and communicating. Staff picked up on communication cues such as use of arms and hands to communicate yes or no and facial expressions and body posture which may indicate discomfort. Staff knew people well and were easily able to hold a conversation with them. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner. Staff ensured to involve people in conversations.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task and ensuring people's privacy by use of screens or private areas. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their needs. People were moving freely around the home, moving between their own private space and communal areas at ease. Staff knocked on people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discreet support with their personal care.

People's care plans told us how their religious needs would be met if they indicated they wished to practice. One person told us, "My parents were both strict church goers so it is important to me to keep my faith going, we have a regular service here and the other day I was even taken to the cathedral for a service". People's information was kept securely and well organised. Staff were aware of the need for confidentiality and meetings were held in private.

Abbeyfield Connors House was proud to be a 'pet-friendly' home; people had been able to move in with their pets. One person moved in with their dog and another with their cat. The registered manager explained this was following an initial assessment and with risk assessments and agreements put into place. People were made aware before they move into the service that there are pets. The home also had a house cat, a bird and fish ponds. One person told us, "I particularly like to watch all the goldfish, they are so mesmerising". We saw the pleasure and comfort given to another person because they were able to sit with their dog.

Is the service responsive?

Our findings

People were supported to have their needs met effectively by a staff team who knew them. People told us "The staff do things to help me just the way I like it and just the way I have instructed them", "I like a wash before I go to bed not in the morning like most. So, someone will always make sure that's done for me" and "They went out of their way to find out all about me and to get to know me". A visitor told us, "The management all helped when we moved mum in here two years ago and we haven't looked back. I can't fault it in any way; mum's care is fantastic in every respect".

At our last inspection not all health care needs had been assessed, there were no care plans developed for people who required care and support with a catheter. At this inspection catheter health care plans were in place providing staff with most of the information needed. We have commented on this earlier in the report. Our observations during this inspection showed staff knew people's needs well and they were able to respond to people's needs quickly and ably.

A system was in place to receive, record and investigate written and verbal complaints and track the complaint resolution process. The complaints procedure was available to people and written in a format that people could understand. People told us, "None of us would have the slightest hesitation in approaching staff or management, if we had even the slightest concern we would say and we would get assistance" and "If I ever have any concerns I wouldn't hesitate in raising it with the staff or the manager they are brilliant". One visitor commented, "I had a couple of concerns initially when my wife arrived but they were sorted out immediately and we haven't looked back.

The service had received very few complaints and all but one had been recorded, however, all complaints including the unrecorded complaint had been investigated and responded to. We spoke with the registered manager about the unrecorded complaint. The registered manager updated the complaints log immediately, this is an area however identified as requiring improvement.

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. The assessment included consideration of the current resident group and how the potential new person would adapt to living in the service, with the people already there. Admission assessments and resulting care plans captured an inclusive approach to care and included the support people required for their physical, emotional and social well-being. These included all aspects of care, and formed the basis for care planning after they moved to the service.

Staff demonstrated a clear understanding of the people they supported. Staff told us that they followed the care plans and guidance, and asked colleagues if they needed help. Within people's plans were life histories, guidance on communication and personal risk assessments. In addition there was guidance describing how the staff should support the person with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. Care plans contained information about people's wishes and preferences and guidance on people's likes and dislikes around food, drinks and activities. Health plans detailed people's health care needs and involvement of any health care

professionals. Each person had a healthcare passport, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were regularly reviewed and mostly reflected the care and support given to people during the inspection.

People had review meetings to discuss their care and support. They invited care managers, family and staff. Where able, people were encouraged to be involved in the content of their care plan and where possible family or friends were asked to assist. Where people had been involved, and were able to, they had signed their care plan. Staff had developed positive relationships with people and their friends and families. Staff kept relatives up to date with any changes in people's health. People and relatives felt the care and support delivered to people received at the service was responsive and suited to their individual needs.

People's end of life wishes had been discussed and were recorded in their care plans together with any Do Not Attempt Resuscitation (DNAR) decisions. This promoted good practice to ensure people were supported in accordance with their wishes. When people received end of life care, the service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medicines. People often experience new or worsening symptoms outside of normal GP practice hours. The provision of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods, by anticipating symptom and pain control needs and enabling immediate availability of key medicines within the service.

The service had employed a full time activities coordinator, but they had recently left and this position was being covered by the deputy manager until a new person took up the post. People told us they were supported to take part in a variety of activities including music therapy, physiotherapy, quizzes, bingo, singers and entertainers. Planned social events took place such as garden parties; the service had recently held a summer party, Halloween party and planned a fireworks party. One person told us, "There is always something going on here during the day. What I like best is the bingo and that's today. We have music playing and a man who plays the guitar too. Always something to join in with". Another person commented, "There are quite a number of outings organised and we residents sometimes come up with a good idea for a trip, we went to the memorial in town the other day and had a coffee out too". People also told us "We all helped to make fairy cakes the other day and they were not only jolly good fun to make but they were delicious too. I miss being in my kitchen so it was nice to get the chance to cook something". Some people also volunteered to help out with activities, everybody we spoke with was very positive about them, describing them as 'engaging, enthusiastic and committed'.

Is the service well-led?

Our findings

People told us, "You can go to her (the registered manager) anytime, she's really good and very approachable" and "I have never seen the manager or any member of staff cross, they're all happy to talk with us". A visitor commented, "The staff and manager are all approachable without fail. If I, or my daughter, have the slightest concern about anything it is always sorted out to our satisfaction with no delay". People and visitors felt the service was well led.

The service had a registered manager in place who was supported by a deputy manager, an administrator, senior carers and a team of care workers along with ancillary staff. Staff told us they felt the registered manager led the service well; they felt that they had provided structure and guidance to make sure they could support and care for people in a way that met their needs. Staff said they could go to the registered manager at any time and they would be listened to.

At our last inspection, care plan and medicines audits had failed to identify that some details were not accurate or up to date. Medicine audits had failed to identify shortfalls in some areas of recording and administration. Checks had failed to identify that there was not sufficient staff to meet people's needs. At this inspection audits and checks continued to be carried out each month by the registered manager, provider and staff with key responsibilities. While there was positive improvement in many areas of the service, not all checks completed had been fully effective in identifying shortfalls or bringing about the changes needed. In particular in relation to care plan and risk assessment reviews. This was because some care plan and risk assessment reviews had failed to take into account key events such as continued falls or address why this was happening. Audits of these reviews had failed to identify that details were incomplete, not always accurate or up to date. In addition they did not consider the impact on individuals in terms of reducing risk and ensuring all had been done provide support for people. Medication audits failed to include records for the application of creams and other audits failed to identify discrepancies in complaints records and notification about a decision that should have been made to CQC. These audits had not been used to their expected potential as tools to assess the quality and safety of the service provided and did not bring about needed improvement.

The failure to effectively audit the service is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events and DoLS authorisation decisions. However, when reviewing DoLS decisions held by the service against notifications received, a statutory notification had not been made on one occasion. Although the notification has subsequently been forwarded to CQC, it was not made without delay, therefore the service had not informed CQC of the decision in a timely way. This is an area that requires improvement.

However, other checks and audits had been effective. The registered manager and provider had developed

an action plan for the service to maintain focus on areas previously identified as requiring improvement; and at this inspection improvement was seen. For example in relation to medication, infection control, dignity and respect. This demonstrated that the service had taken appropriate action to rectify and monitor identified shortfalls.

The registered manager made sure that staff were kept informed about people's care needs and about any other issues. Staff handovers, communication books and team meetings were used to update staff. There were a range of recently updated policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. The registered manager demonstrated a good knowledge of people's needs. During the inspection we observed that people, staff and visitors engaged well with the registered manager, who was open and approachable.

There was a positive and open culture between people, staff and management. Through our observations it was clear that there was a good team work ethic and that staff felt committed to providing a good quality of life to people. All staff we spoke to told us they were clear about their roles and who they were accountable to. They felt they all worked well as a team, all staff told us they felt proud of the work they did and of the service. Throughout the inspection, the registered manager and staff were open to different ideas when we discussed matters. Their responses showed they were keen to develop and improve the service, so they could meet people's needs safely and effectively.

Feedback about the service was sought in the form of quality assurance surveys sent to relatives, staff, and health care professionals. Responses from previous surveys had been collated and any areas of concern addressed, for example in relation to increased activities for people. Residents meetings and feedback questionnaires gave people the opportunity to raise any issues or concerns. Any concerns raised were taken seriously and acted on to make sure people were happy with the quality of service they received. Relatives were also invited to these meetings. They provided people and their relatives with an opportunity to discuss and comment on the day to day running of the service. People talked about what they would like on menus and what activities they would like to happen and upcoming events that they were looking forward to. People told us, "Yes, there are frequent resident's meetings, at least once a month and you know it's quite fun to take part in them and feel that we are listened to", "Well I do make the odd suggestion in the meetings and usually something will come of it. For example, I asked for mint sauce to be served with lamb and then we had it the next time, I was chuffed" and "It makes us feel involved coming to the meetings and discussing how it runs here. We are constantly involved in decision making if we want or able to be". Another person told us, "We do have regular resident's meetings and they are very productive as far as I am concerned. It means we get to know what the plans for here are and we can put our views and concerns across too and know that we will be listened to"

The provider's philosophy of care was ensuring that they listen to the opinions and feedback of residents and their families, and go above and beyond the minimum standards. One of the staff we spoke with summed up the philosophy by telling us, "Everything we do is for the people who live here. It is important to listen and make any change needed to provide quality support for them". This reflected a clear vision that promoted a person-centred culture and demonstrated it was embedded into everyday practice. Regular meetings were held with the provider, which were attended by the registered managers of their services. Case studies of incidents were used to share experiences, collect ideas for resolutions, provide support and develop best practice. The service had developed effective professional relationships with the local authority, local surgeries, pharmacies, Canterbury College and Christchurch University.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where

a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure care and treatment was provided in a safe way for service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.</p> <p>Regulation 12 (1)(2) (a) (b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems or processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the services provided or include a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>Regulation 17(1)(2)(a)(c)</p>