Nellsar Limited

Abbotsleigh Dementia Nursing and Residential 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Abbotsleigh Dementia Nursing and Residential Care Home (which in this report will be referred to as Abbotsleigh) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Abbotsleigh accommodates up to 61 people across two units within the service, both of which have a dining room and lounge. There are facilities and lifts for people with restricted mobility. All bedrooms are for single occupancy with en-suite facilities. Abbotsleigh specialises in providing care to people living with dementia. At the time of the inspection there were 49 people living at Abbotsleigh across both units.

This inspection site visit took place on 16 and 17 November 2017 and was unannounced. The inspection was carried out by two inspectors 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.

There was not a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service the week before the inspection. An acting manager had been appointed and had begun working in the service.

Not all people received the support they required to eat and drink. Some people living with dementia did not have the level of assistance they had been assessed for or required to eat or finish their meals.

Peoples records were not always kept accurately and completely in relation to their health needs. This meant that staff may not always respond effectively to people's health needs.

People had not consistently been supported to be safe. There had been seven adult safeguarding issues reported to the local authority in 2017 and one of these had partially confirmed abuse. Risks to people were being managed through risk assessments, but we found some inconsistencies around how risks were managed.

The premises were well maintained and equipment had been checked regularly to ensure it was suitable and safe. The registered provider ensured that the risk of infection in the service was assessed and managed. People received their medicines when they needed them and medicines were being stored and managed safely.

Assessments of people's needs were not of a consistent nature. Some peoples' needs were tracked through their care plan effectively, and other people's diagnoses were not included in other parts of their care plans. We have made a recommendation about this in our report.

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. People had received assessments under the Mental Capacity Act 2005 and where appropriate had applications to restrict peoples liberty had been made. We noted that one application had not contained the correct information. We have made a recommendation about this in our report.

People were supported by staff who knew them well and people told us that they liked their staff team. People were treated with kindness and staff respected people's privacy and upheld their dignity. People were encouraged to maximise their independence.

Not all people were supported in a person centred way and people were not consistently supported to be involved with their care plans, or with decisions made around their care.

Complaints were used as a way of improving the service offered. However, not all actions had been recorded clearly. Ends of life care plans were in place for people who wanted them but they did not contain information on the emotional aspect of death or how to support relatives after a loved one has died. We have made recommendations about both of these points in our report.

The registered provider had not fulfilled their responsibility to comply with the CQC registration requirements. They had not notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Quality audits had not been effective in highlighting the shortfalls we found at this inspection.

Improvements had started to be made in the culture of the service since the last inspection. Staff had started to work more effectively as a team. This is the first time the service has been rated Requires Improvement.
We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Abbotsleigh was not consistently safe.

People had not always been safeguarded from abuse and harm. Risks to their safety and welfare were assessed to keep them safe but some risk assessments contained conflicting information.

There were enough suitable staff deployed to meet people's needs.

Staff were recruited to the service following safe procedures to ensure they were suitable.

The registered provider ensured that people were supported to manage their medicines safely.

People were protected against the risk of infection.

Is the service effective?

Requires Improvement

Abbotsleigh was not consistently effective.

Not all people were supported to eat and drink enough to meet their needs. Some people living with dementia did not have enough help at mealtimes.

People were at risk of not having their health needs met as records relating to people's health were not always accurate or complete.

People's care was based on an assessment of their needs but these assessments were not always an accurate reflection of people's needs.

Consent was sought before care was provided. Where people were unable to make their own decision staff followed the principles of the Mental Capacity Act to ensure their rights were upheld.

Staff had the knowledge and skills required to deliver effective care. They worked effectively with other areas of the organisation and with other professionals to ensure people's needs were met.

People benefitted from appropriate design and adaptions to the premises to meet their needs and promote their independence.

Is the service caring?

Requires Improvement

Abbotsleigh was not consistently caring.

People were not always treated in a way that upheld their dignity.

People were treated with kindness. Staff knew people well and supported them to make decisions about their care and support.

People's rights in relation to their privacy and dignity were upheld by staff and were promoted by staff.

Is the service responsive?

Requires Improvement

Abbotsleigh was not consistently responsive to people's needs.

Abbotsleigh was not consistently responsive to people's needs.

People were not always involved in the planning of, or decisions around, their care.

People knew how to raise concerns and complaints and could be confident they would be listened to.

People are provided with sensitive and effective care at the end of their life but care plans did not plan effectively for people's holistic needs.

Is the service well-led?

Requires Improvement

Abbotsleigh was not consistently well-led.

The registered provider had not submitted all statutory notification to CQC.

Audits to monitor the quality of service delivered had not highlighted the shortfalls we found at this inspection.

The service was working effectively with other agencies.

The culture in the service was undergoing change led by a new management team.

Abbotsleigh Dementia Nursing and Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of injury and this inspection examined that general risk. CQC was aware of past injuries sustained at the location. This is why we explored particular aspects of current care and treatment during the inspection. We were aware that the incident had been brought to the attention of the Police and the Local Authority safeguarding adult's team. Subsequent to our inspection we were informed that the matter had been closed by the Police. On the day of the inspection we found that the registered provider had been taking action to keep people safe from the ongoing risk of harm and we made a recommendation about reviewing risk assessments and care plans to ensure the information is consistently recorded.

This inspection took place on 16 and 17 November and was unannounced. The inspection was carried out by two inspectors, a specialist nurse, an inspection manager and two experts 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.

We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and

improvements they plan to make. As part of our planning for this inspection we looked at records that were sent to us by the registered provider and the local authority to inform us of significant changes and events.

We looked at 11 people's care plans, risk assessments and associated records. We reviewed documentation that related to staff management and recruitment. We looked at records of the systems used to monitor the safety and quality of the service, menu records and the activities programme. We also sampled the services' policies and procedures.

We spoke with 13 people who lived in the service and four peoples' relatives to gather their feedback. We spoke with the operations manager, a director, the acting manager, two nurses, two activities co-ordinators, five care staff, and catering and domestic staff as part of our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Abbotsleigh. One person told us, "The staff make me feel safe." Another person said, "The nurses and staff are very good here." A third person commented, "I don't know why, but I just feel safe here." One relative told us, 100%, I believe my sister is safe here." Another relative commented, "Yes, he is safe. Since X arrived here he has actually improved." Despite these positive comments there were some areas of practice that were not consistently safe.

People had not consistently been protected against the risks of potential abuse. We had been made aware of seven safeguarding concerns in 2017; one of which had partially confirmed abuse due to poor moving and handling procedures. Staff members we spoke with told us they had undertaken adult safeguarding and moving and handling training. We examined the provider's training records which confirmed that staff had been trained and those whose training was due to expire had been booked for an update to their training. Staff members were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult social services safeguarding team should be made, in line with the provider's policy. There was a safeguarding folder in the service with documents such as the local authority safeguarding protocol and the provider's policy. We saw evidence of how a recent safeguarding incident was investigated by the registered provider in line with the multi-agency policy and were shown steps that the new management team had taken to ensure the safety of people.

Risks to individuals had been assessed; however, plans put in place to minimise these were not consistently effective. The risk assessments covered a variety of areas including pressure area care, nutrition, continence and falls, and provided further detail on the staff and equipment resources required to safely support the person. For example, we reviewed one person's moving and handling risk assessment and found this had been reviewed every month and included information about the use of a Zimmer frame. The falls risk assessment stated that the person was at high risk of falls and this has been reviewed following a recent increase in the number of falls. We observed in practice when the person stood up they were informed that a member of staff would collect their Zimmer frame. The person was then supported by one member of staff using their frame to walk as per the moving and handling assessment. Other moving and handling procedures we observed during our inspection were also in line with good practice guidelines. However, we also found some inconstancies around the management of risk. Another person had a falls risk assessment with the score of 11 which was rated as a medium risk. This risk had not been carried through to the care plan, which stated that the person was independent when mobilising. The care plan stated that staff were only required to prompt the person to use their frame, but the risk assessment was indicating a higher level of need. We raised this with the acting manager who asked staff to review the care plan. People's records were stored securely and were available to relevant nurses and care workers so that they could support people to stay safe.

We recommend the registered provider reviews care plans and risk assessments to ensure that information relating to risk is consistently recorded.

Environmental risks were being managed effectively through regular monitoring and checks conducted by

the management team. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The management team ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the risk and what actions were required of staff to reduce the risk. Fire protection equipment was regularly checked and serviced by the provider. Staff had been trained in fire safety and regular fire drills were carried out with the people's active participation. People had a personalised emergency evacuation plan that detailed their ability to respond to the alarm system, their awareness of procedures in case of emergencies, and any equipment they may need during an evacuation. Hoists and other equipment used had been serviced regularly and was well maintained. There were environmental risk assessments for health and safety of communal areas as well as individual bedrooms and these assessments checked the suitability of flooring and the safety of features such as hand rails and adaptable seats for bathrooms.

There were sufficient staff members deployed to meet people's needs. The service employed 10 care workers, two nurses, three activities co-ordinators, three domestic staff, a cook, kitchen assistant and kitchen porter. The staff were deployed on each shift with five care workers, one nurse, one activity coordinator, one dining room assistant and one cleaner on each of the two units. This left one domestic staff and one activities coordinator to be deployed where they were most needed through the day. Staffing rota's confirmed that these staffing levels were provided. The service used agency staff to meet any gaps in the staffing numbers. Where this was necessary regular agency staff had been employed so that they knew people's needs. We spoke with the operations manager about staffing and were told that a dependency tool had not been used to determine the staffing levels people need. There was one to one staffing in place for people when their needs determined it and we saw evidence of this. The rota was written by the acting manager and signed off by the operations manager to ensure that staff had the correct skills to work. For example, experienced care staff were employed on each shift on each unit.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. Robust recruitment procedures were followed to ensure that staff had the correct checks before commencing employment and ongoing audits in the form of periodic re-checking of staff DBS checks had been scheduled by the new management team.

People's medicines were managed and administered safely and people received their medicines as prescribed. The nurses ensured that people received their medicines as prescribed by accurately following the prescribing doctor's instructions. It is the responsibility of the nurses to order medication on behalf of people unable to do so themselves. We checked this area and there were no issues. Medicines were administered by staff trained to do so in a calm and unrushed manner, ensuring people received the support they required. Medicines were stored safely, securely, and at appropriate temperatures, including medicines which required refrigeration. There were suitable arrangements for the storage and recording of medicines which required additional safe storage. Only authorised staff members had access to medicines. Staff were aware of good practice guidelines, such as the National Institute for Health and Care Excellence (NICE) 'Managing medicines in care homes' guide, and were confident when describing how they implemented these in practice. Medicine Administration Records (MAR) were accurately and fully completed, showing when people received their medicines. Medicines prescribed to be given 'as required' (PRN) had guidance forms outlining medication usage and guidance. PRN medicines were being used appropriately and people with behaviours that may challenge were not being receiving excessive doses of

medicines. However, we found that the contraindications between medicines could be made clearer on these forms, as they were often left blank. Contraindications explain when certain medicines should not be used so staff would need to know this information. We raised this with the acting manager who ensured that this was put right by the end of our inspection visit.

People were protected against the risk of infection by staff who were trained in infection control and followed the provider's procedures. There were cleaning schedules in place to ensure that the home was kept clean. On our arrival on the first day we found some areas of the service that had a smell of urine, specifically two of the bedrooms, and two shower areas. Staff told us that some bedrooms did not have suitable flooring in them and were in the process of being changed to easy clean flooring of the person's choosing and we saw that this was happening. During the second day of the inspection we did not encounter any malodorous smells. There was an infection control audit that had identified flooring needed replacing and some of these actions had been completed. For example a steam cleaner had recently been purchased. There was an appropriate supply of personal protective equipment throughout the service and we saw that staff used this as needed. Suitable hand washing facilities were available and reminders about safe hand washing were displayed. There was alcohol gel in dispensers throughout the home and staff were observed regularly using this. There was a large and well organised laundry that enabled staff to keep clean and dirty linen separately to reduce infection risks. The service used the 'Safer Food Better Business'. Safer Food Better Business is a food safety pack produced by the Food Standards Agency to help small catering businesses comply with food hygiene regulations. Temperature checks had been carried out for the fridge and freezer and the temperature of food served to people. There were cleaning charts completed for the kitchen and dry stores area and these were clean.

Staff understood their responsibilities to raise concerns and report incidents. Accidents and incidents had been recorded and investigated by the management team. Where there had been shortfalls in staff reporting incidents the management team had taken action, including disciplinary action, re-training and supervision of staff members. We saw the action plan from one safeguarding incident where the management team had implemented a series of actions to be completed and for learning from this to be cascaded to the team via the daily meetings and scheduled staff meetings. Incidents and accidents were being logged by the service and the management team were investigating in a timely manner where an accident or incident had occurred and identifying any learning points. The management team were receiving NHS alerts via e-mail about safety issues relating to equipment or medicines. Any learning was shared with staff members at a daily meeting.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they felt the service was effective in meeting their needs. They told us staff had the necessary skills to provide the care they needed and that they supported them to access health services as needed. One person said, "The staff are experienced. I am very happy with the way I'm looked after. I like all the staff: they are very nice and I am very happy." One relative told us that staff knew the best way to support the residents, especially those with behaviours that may challenge, "Yes, certainly from what I have observed: staff gently talking to residents who we being difficult. They spoke to the residents in a very caring way and tried to distract them. I understand it can't always be easy but I believe the staff are doing their best." Another relative told us, "I am aware of the doctors and nurses' visits; my sister also sees the opticians when necessary." Despite these positive comments we found some areas of practice that were not consistently effective.

Not all people received the support they required to eat and drink sufficient amounts. We saw that two people, who had been assessed as requiring additional assistance to eat and drink, did not receive the support they required. Both people were living with dementia and had care plans in place that stipulated that they required a high level of encouragement and prompting from staff. However, we saw long periods of time where both people were sat looking at their food without assistance or prompting. One person, when prompted by staff, would eat independently for two or three mouthfuls and then lose focus and stop eating. During the 30 minutes the person was sat with their lunch, staff verbally encouraged the person to eat on three occasions in passing, and on each occasion the person ate two to three mouthfuls before losing focus. After 30 minutes the partially eaten lunch was removed and the person was left with a hot pudding for over 45 minutes. They did not receive assistance and had not eaten the pudding. After 45 minutes the person had dropped some of the now cold pudding on themselves when trying to eat it. Another person was given lunch but was only given four minutes before staff asked if they wanted sandwiches instead. Staff had not encouraged the person to eat but made an assumption that they wouldn't eat the lunch. After a further 10 minutes the lunch was removed untouched and a pudding was brought to the person. For both people staff were only interacting in passing and not sitting and taking time to encourage eating or to support them with prompts as per their care plans. We asked staff to ensure that these two people were supported with further food and raised this issue with the operations manager who said they would trial staff sitting with the two people to see if their intake increased. We checked the care plans for these people and saw that both had lost weight recently and one person had supplementary diet drinks.

The failure to ensure all people received adequate nutrition is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other people had their needs met around nutrition and hydration and had been assessed and provided with the care they required. The registered provider employed a nutritionist who worked with people that were at risk of malnutrition and had put in place specialist high energy drinks and foods to reduce the impact of their lack of appetite. Other people had food charts in place to monitor how much they had eaten.

People had access to a range of healthcare professionals, such as GP's, opticians, chiropodists and dentist

and were referred promptly when their needs changed. However, some people were at risk of not having their needs met. People's assessed care needs had not been accurately recorded. For example, one person had a current health needs care plan that stated nursing staff were to monitor blood sugar levels. However, there was no chart in their care plan to show this was happening. We raised this with the operations manager and were later shown notes handwritten by a nurse on a list of people visited by the GP and that the GP advised that there was no need to monitor the persons' blood sugar levels. However, the care plan had not been updated to reflect this change in need. When we spoke to a staff member about this person they were unaware that the person had a diagnosis of diabetes or that it was supposed to be controlled by diet. The same person had a care plan that stated staff were to encourage the person to drink one and a half to two litres per day. When we checked how this was monitored there was a fluid chart in place but it only recorded what had been offered and did not have the target amount. This meant staff may not know how much to offer the person to drink or when to raise concerns about their fluid intake. There were other inconsistencies in people's care plan. One person's health care plan noted a skin condition on one limb which could become itchy and blistered. However, the skin integrity care plan gave a different diagnosis of the skin issue on the same limb. When there had been an issue with this skin condition we were unable to tell from the records what treatment, if any, the person had received from their GP. This poor recording meant that staff may not always respond effectively to health care needs. Another person had been diagnosed with type 2 diabetes but this was not mentioned in their eating and drinking care plan. The same person had been diagnosed as blind but this was not in their care plans or risk assessments. Incomplete or inaccurate health records meant that staff may not know what treatment people had received or required in the future which would put people at risk.

The failure to maintain accurate and contemporaneous record for each person in regard to their health needs is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not all people had their needs assessed in order to achieve effective care outcomes. We found that assessments were of varied efficacy: some assessments were completed fully and comprehensively and others lacked some important details. For example, one person had a pre-admission assessment completed prior to moving to the service. The person had an enduring mental health issue but this was not explored in the assessment and there was only a mention that the person was known to the mental health team. Another person had a medical need relating to their diet that had not been recorded in their assessment. This meant that staff may not know important information about a person while supporting them.
The failure to carry out effective assessments of people's needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other assessments we reviewed had been completed comprehensively: people had full assessments made of their needs both prior to admission at the service, and after they had moved in. These assessments looked at areas such as maintaining a safe environment; eating and drinking; breathing; and personal care amongst other areas. Where people had a need, such as not being able to use a call bell, this was noted and action was identified.

Staff had the training and skills they needed to meet people's needs. One staff member commented, "The training has been brilliant. I mentioned to my manager that I wanted to do dementia training and she's going to sort that: she's looking in to it at the moment." Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. Staff had received essential training that included safeguarding, first aid, infection control, safe moving and handling, equality and diversity, person centred care, dignity and privacy and the Mental Capacity Act 2005. Competency checks were completed for training courses and staff had to answer questions to demonstrate that they had understood the training. Where there were gaps in training the management team had identified these and

booked additional courses for staff to attend. Nursing staff were supported by the management team to update their learning and their clinical practice was checked by the acting manager who is a registered nurse. Nursing staff had their medicine competency checked every year by a trained assessor. All staff including nursing and care staff received regular and effective supervision and appraisal.. New staff were required to undergo an induction that included the completion of the Care Certificate. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. We spoke to one newly recruited member of staff who told us, "I worked with the head of my department for a week and for the first few days I looked through files and care plans and after that shadowed directly."

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. Some people had received MCA assessments for decisions that they may lack capacity to make, and where capacity was assessed as lacking a best interest meeting had been held to make a decision on behalf of the person. For example, one person required prompting and assistance with their personal care and had been assessed as lacking capacity around this decision. There had been a full MCA assessment and a best interest meeting that involved other people and set out how staff should support the person to maintain good hygiene.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where required we noted that the registered provider had ensured people had an authorisation in place and other applications had been made. Each person had a DoLS checklist that looked at the admission to the service, what arrangements were in place and directed staff to look for the least restrictive option. However, we also noted that one person's DoLS application contained information for another person that appeared to have been copied and pasted to the application.

We recommend the registered provider reviews all DoLS applications to ensure they contain the correct information.

People's individual needs were being met by the design and adaptation of the premises. The service had painted corridors in one colour to help orient people to place. Door frames had also been painted to distinguish different rooms, so that toilets had door frames that had all been painted one colour. The lighting had recently been changed from strip lights to LED lighting so that the lighting of the building was more pleasing to the eye. The acting manager explained that they wanted to change the focus of some parts of the building, so the old activities store room was now a room for people to use, with a TV on order for that room where people who did not want large groups of people could be. The acting manager told us, "The front reception was not welcoming, so we're fully refurbishing that area and are putting up photos of staff members." The acting manager described their plans for changing the dining area to the lounge so that people could overlook the garden and provide two separate dining areas to enable people living with dementia to have choice over where they would like to eat. The acting manager told us, "We have added artwork and tactile images to the walls. We have actors and actresses area and a 'places of the world' area with photos of different cities. We've purchased football memorabilia to match the team's people support and will display that." We reviewed 'residents meeting' minutes and saw that plans to alter the environment were discussed with people and that people were able to voice their opinions about any proposed changes.

Requires Improvement

Is the service caring?

Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "They are all caring really. I think the night and day staff are all caring." Another person said, "The staff are caring and very kind to me; I always looked forward to seeing them." One relative told us, ""They [staff] seem perfectly pleasant to me." Another relative commented, "If I had to describe the staff's interaction with the residents I'd say 'very caring'." Despite these positive comments we found some aspects of care that required improvement.

People were not consistently supporting in a way that upheld their dignity. During one lunch service we observed two staff who were supporting two different people to eat their meal. The two staff were conducting a conversation between themselves and talking over the people they were supporting. This was not a positive dining experience for either person. We brought this to the attention of the acting manager who spoke to the staff members about the correct way to support people to eat. Some support we observed was not in line with person centred care principles. During the first morning of our inspection staff were observed to move a person in their wheelchair. Staff were attempting to move the person without their foot rests and were then heard trying to persuade the person to use foot rests. Staff were observed using loud voices; in response the person was shouting that they did not want to come out of their room. Several staff including the acting manager responded in a loud voice, calling the person by their name, which upset them, further. However, when we checked their care plan we found information on identifying and addressing change in behaviours and level of stress: one of the triggers listed was people raising their voices. This meant that the person was not being supported during a time of anxiety in the way they should be.

The failure to support people in a manner that upheld their dignity is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People benefitted from staff that knew them well and understood their personalities. The management team ensured people were treated kindly by giving staff training in courses such as dementia care and person centred care. Whilst there was some use of agency staff in the service this had decreased significantly in recent months and there were more staff employed in permanent posts. People knew the staff that supported them and staff were warm and friendly towards them. Staff were kind and compassionate in the interactions we observed. Staff used their specialist knowledge about dementia to recognise how the condition affected people's lives and sought ways for providing their care. Staff respected he people for whom they were caring including their personalities. The care plans listed the type of dementia a person had. One staff said, "My resident always forgets. I try to be patient and kind even when I have to say things over again I am kind. I always offer choice of food or clothes and try and include them in decisions." People who had difficulty with communication or coordination were supported and encouraged to be as independent as they could be. For example, one person's support plan for communication acknowledged their diagnosis of dementia and directed staff to use body language and facial expression when the person was having difficulty with speaking in full sentences.

Staff delivered care in a manner that was flexible and attentive to people's individual needs. We saw that

where people were seated in one lounge they were attended to by staff offering them a drink or a blanket, or discreetly adjusting their clothing to protect their dignity. One staff told us: 'I try my best to spend time with residents." Relationships were good between team members, and staff were complimentary about working at Abbotsleigh. People told us that they enjoyed talking to the their staff. One member of staff commented: 'I treat my residents as I would treat my grandmother. I always think about how I would want my family to be treated''

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. People had been supported to undertake their personal care to a good standard and people confirmed that staff were available to help them. One staff member told us, "We help people to maintain dignity by washing and giving personal care. We also offer choice of clothes." People's dignity was upheld during moving and handling procedures as staff members would shield people behind a screen as they were being hoisted so that other people could not see people being lifted. Staff had supported people to wear their glasses, dentures and hearing aids if they needed these. People were enabled to express themselves through their preferred dress. Staff were respectful in their interactions with people and we noted that they knocked on doors before entering rooms. People's records were kept securely to maintain confidentiality and staff did not discuss people's information in open areas of the service. Peoples relatives told us that they were made to feel welcome when they visited and they were confident that they could visit when they wished.

People were encouraged to be independent and to be involved in their care and support. People's care plans highlighted the importance of staff supporting people to maintain and achieve independence. One person's care plan stated that staff were to support the person's independence. The care plan went on to state how this was to be achieved. Another person's care plan had independence as a goal on their mobility care plan and encouraged staff to support the person to work towards this. Staff responded to people's requests for assistance in a way that promoted their independence. One person asked for extra sugar for their porridge. A staff member got the sugar for the person and allowed them to add the sugar themselves. The person then requested assistance eating. The staff member asked the person, "Can you manage to do it yourself?" The staff then held the bowl closer to the person so that they were able to feed themselves.

People had been supported to make some decisions about their care. Where people did not have the capacity to make decisions their relatives had been consulted about their care plans at regular care reviews. There was a resident of the day scheme and a 'residents meeting' forum where people could voice their opinion and make decisions about their care. Recent residents meetings had discussed food, activities and outings that people would like to go on. Staff were given the time and training to support people in a compassionate way. One staff member was observed speaking to a person's doll. We discussed this with the member of staff who told us, "That lady has a doll and all the staff know that it is real to her so we all are shown how to speak to her and speak to the doll and call it [name] as though it was a real baby."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they received a personalised service. One relative told us, "Yes definitely, the carers are quick to identify and respond X's needs even as they change." Another relative said, "I think the staff are good and really take time to understand each resident's needs." Despite these positive comments we found some areas of practice that were not consistently responsive.

Not everyone had been involved in their care plans or in reviewing their plans. We reviewed several care plans and found that where plans had been reviewed by the management team they had not been completed fully and with the person in line with person centred care principles. For example, one person had a care plan for their mental well-being which identified that they could become agitated and potentially aggressive both verbally and physically. There were known triggers such as, lots of noise and urinary tract infections (UTI). Staff were advised within the plan to direct the person to a quieter area or look for signs of UTI. The plan also noted that due to an underlying health condition the person had deteriorated and there were times when they could no longer understand simple tasks or hold a conversation. However, this was the only information in the plan: there was no reference to the persons' depression. Staff had been directed to 'learn' when the person was starting to worry and try 'calming techniques' but there was no guidance on how this was to be achieved. We reviewed this person's behaviour charts for two days in September and two days in October. They recorded the person was shouting and getting particularly upset with other residents. However, there had been no record on file of staff checking for signs of a UTI or how they had supported the person to manage their anxiety. The care plan had not described how staff would support the person. Another person who was living with dementia had a support plan that contained contradictory information about their likes and dislikes. This meant it would be difficult for staff to provide activities that the person used to enjoy. We discussed the principles of person-centred care planning, involving people and their relatives, with a member of the management team and were told that staffing issues had until recently affected the services' ability to review care plans.

The failure to consistently provide person centred care plans or support to people in a person centred way is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's preferences and choices for their end of life care were kept under review and acted upon. The staff were skilled and they spoke about providing person-centred care for people at the end of their lives that was tailored to the needs and sensitivities of the people and families. One staff said, "We make sure people are comfortable and free from pain. There are hospice nurses who come in if people want to end their life here." People who wanted to plan ahead had an end of life care plan in place. End of life care plans took into account the practical aspect of death. For example, one we reviewed highlighted that the person had a DNA/CPR in place, and that palliative wishes had not been expressed by the person or their next of kin. There were plans for this to be visited if the person became terminally ill. However, end of life care plans did not cover several important aspects such as the emotional aspect of death e.g. how to support people's families after a person has passed; how to care for the body in a culturally sensitive and dignified way after death, and how people will have access to support, equipment and medicines in their final days.

The failure to provide end of life care plans that reflect a holistic profile of people's needs is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was an activities plan in place and there had recently been an increase in the amount of activities staff: there was now one activities staff per unit plus another 'floater' to go where needed every weekday. One person told us, "I usually join in with the activities and prefer the music ones. We really do have some fun sometimes." We observed different activities during the course of our inspection. A church group played music and sang hymns for people and staff handed out instruments for people to play along with the music. Some people had hand over hand support to shake the percussion instruments and other people clapped their hands to the music and staff were aware of peoples' favourite hymns. We spoke to an activities co-ordinator who explained that the way people were informed about activities had recently been changed and there was a monthly plan from morning to evening each day. The plan contained activities such as walks, gardening and crafts. Some people were at risk of social isolation and this was managed by staff from the activities team visiting these people. We spoke with one activities co-ordinator who told us, "We visit people at least twice a day for activities. I tend to read the paper to them which they enjoy. Some people call us if they want a chat but we manage to see to everybody every day." We saw from people's daily notes that these visits were happening.

Complaints were used by the management team to drive improvements in the service through lessons being implemented but complaints had not always been recorded correctly. There was a complaints policy in place but the previous manager had not kept a log of complaints to record each issue and the provider's response to each complaint. We spoke to a member of staff who had raised a complaint with the management team. The complaint had been resolved satisfactorily but there was no record of the action that was taken, only the verbal account of the member of staff that raised the complaint. We raised this with the acting manager who told us, "The policy has a complaints log attached to it but we are only just putting the complaints file together." We saw one complaint that had recently been made where a relative was unhappy about the weight loss of their loved one. This complaint had been recorded and investigated and the complainant had been satisfied with the response. People told us that they were able to make a complaint if he had to. One person commented, "I don't have anything to complain about but I'm sure they would take my complaint seriously if I did."

We recommend that the registered provider reviews all complaints and ensures they are responded to and recorded in line with the company policy.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that the service was well led. One person told us, "Yes, I think the home is well run. I don't have anything to complain about." Another person commented, "Yes I do know the manager and she is very nice." One relative told us, "I don't know about the day to day running of the service but the staff seem to be happy and I am very happy with the care my sister is receiving." Despite these positive comments there were some aspects of care at Abbotsleigh that required improvement.

The registered provider had not fulfilled their responsibility to comply with the CQC registration requirements. They had not notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Several safeguarding incidents that had been reported to the local authority safeguarding adult's team in the past 12 months had not been notified to CQC. CQC had been notified of some of these incidents but only as incidents that had caused injury, and not as suspected abuse. The registered provider has a statutory duty to notify CQC of any safeguarding alerts and this had not happened. We were shown evidence that all safeguarding alerts made since the new management team had been in post had been notified correctly.

The registered provider had not ensured that the Care Quality Commission had been notified of incidents without delay. This is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was no registered manager in post at the time of our inspection. The last manager had left the service in October 2017 and their registration was cancelled in November 2017. There was an acting manager appointed who was in the process of registering with CQC to become the registered manager for the service. The registered provider had an operations manager in place to work with the previous manager and to oversee the service whilst the acting manager was settling in to the post. The operations manager would work at the service until the acting manager was confident in their role.

The culture of the service was undergoing change and the new management team were working towards a positive ethos that was person-centred, open, inclusive and empowering. The management team had a good understanding of the challenges facing the service and spoke to us about the need to empower the staff team and give them the confidence to make decisions and do their job. In the months prior to this inspection there had been a number of concerns raised with the local authority about the practice of some staff members and the culture in the service. These had been investigated and had led to this inspection. Prior to this inspection some staff had left the employment of the service. Other staff who had been living at Abbotsleigh were at risk of blurring boundaries between staff and people and had been moved out so that only residents of the service lived at Abbotsleigh. During this inspection we spent time with the acting manager, and discussed the culture change that was being enacted. They told us that the culture of the service they found was not positive enough and there was no laughter in the service. They were keen to support staff as well as relatives and people. We could see that a culture change was underway and staff old us that there had been positive changes. There had been a 'ten at ten' meeting initiated where staff and the management met every day for ten minutes and ten in the morning to share any problems or good practice.

The acing manager described how staff had made requests and these had been provided.

Quality audits had not been consistently effective in highlighting all shortfalls in the service. During this inspection we had identified several areas of care and practice that required improvement which had not been highlighted during the preceding months. Since the new management team had been in post there had been an improvement in both quality monitoring and the service people received, although some issues were still awaiting action. For example, we were given a list of care plans that had been updated. We reviewed several of these care plans and saw that most had been worked on and were of a higher quality than other plans that had not been reviewed and updated by the new management team. However, we did find two that had been updated that still contained inconsistent information, with some important information missing and they failed to identify that people were not getting the support they needed with meals and that record keeping was poor.

The registered provider had not ensured that quality monitoring was effective in highlighting and rectifying shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

The acting manager was a visible presence in the service. The staff we spoke with told us that they felt well supported and were clear about their roles and duties. The acting manager was observed to have a good rapport with people and staff and a good working relationship with people, and had a hands-on approach and knew people individually. One staff told us, "The managers are pulling people up by their socks and giving them a 'shake up' and trying new things: its' a really positive change." Another staff member told us, "The managers are really approachable and you can go to them with idea. For example, I suggested using the minibus to take people for outings and business support arranged it all and the manager risk assessed the bus and ensured the maintenance man comes with us for extra support."

People were being engaged in the running of the service and involved in their own care. The service had a resident of the day scheme and invited families to the service to review care plans. The acting manager had sent out letters to families the week prior to our inspection to ensure that the service knew how to manage people's toiletries and their preferences so that people never ran out of their preferred products. Where people were able to the new management team were involving them in reviews of their care. All residents had been formally invited to a meeting to meet the new acting manager and there had been a staff meeting scheduled to follow so that any issues that may arise could be discussed. There were residents meetings where issues such as diets and menus, activities and outings were discussed. A programme of outings was being devised and the activities team were involving families so that they could receive feedback about where people liked to go and also so they were aware of where their loved ones were going.

The new management team were learning from past mistakes and learning was being used to improve the staff team. We discussed with the acting manager and operations manager how learning from incidents was being utilised to drive improvement and were shown an accident and incident monitoring form had been completed by the management team. All incidents were checked by the acting managed and audited: this additional form tracked incidents and accidents for each month and case tracked a minimum of two incidents to check action taken and to examine whether any learning points could be identified and shared with the staff team. One case tracking had identified that poor recording of action had meant that it was unclear whether the family had been informed of the incident or whether the GP had looked specifically at the minor injury. This was followed up with the nurses and the importance of recording was re-stated. The operations manager informed told us, "The training budget is open ended. In January we are providing diabetes and epilepsy training for the nursing and senior staff and we are always looking for ways to make improvements."

The registered provider worked with other agencies to ensure the service was effective. This included the local authority commissioners and the safeguarding team. Feedback from other health professionals confirmed that the service worked positively and proactively to adopt suggestions made through investigations and contract monitoring visits. The new management team had contacted the local authority safeguarding adults team when a complaint had been received. The acting manager told us, "We are going to share the work that our nutritionist does with the local dietician when they come in and we will work in partnership to make sure people who do not eat much are well nourished."

The registered provider was aware of their responsibility to comply with the CQC registration requirements. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The acting manager confirmed that incidents that had met the threshold for Duty of Candour had been shared appropriately with people's relatives.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to ensure that the Care Quality Commission had been notified of incidents without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to carry out effective assessments of people's needs. The registered provider had failed to consistently provide person centred care plans or support to people in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to support people in a manner that upheld their dignity. The registered provider had failed to provide end of life care plans that reflect a holistic profile of people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that all people had received adequate nutrition. The registered provider had failed to maintain accurate and contemporaneous record for each

person in regard to their health needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that quality monitoring was effective in highlighting shortfalls in the service.