Amesbury Abbey Limited

Amesbury Abbey Care Home

Inspection report

Church Street
Amesbury
Wiltshire
SP4 7EX

Tel: 01980622957
Website: www.amesburyabbey.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Amesbury Abbey Care Home provides accommodation which includes nursing and personal care for up to 45 older people, some of who are living with dementia. At the time of our visit 32 people were living at the service. The bedrooms were arranged over three floors . There was a communal drawing room for people to use. On the ground floor there was a communal dining room and conservatory and a central kitchen and laundry.

We carried out this inspection over two days on the 9 and 10 August 2016 in response to some concerns which had been raised relating to the quality of care and support people were receiving.

At the time of our inspection the manager had submitted their application to become the registered manager. This was currently going through CQC's registration process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care plans were regularly reviewed, but the quality of information within the plans was variable. Although some were comprehensive and detailed, others were not. Although some personal preferences were detailed, this was not consistently seen, and none of the plans we looked at contained any information in relation to people's lives prior to moving to Amesbury Abbey.

Whilst people had access to sufficient food and drink and were supported to maintain a balanced diet, the documentation associated with people's nutritional and hydration needs and monitoring was poor. People spoke positively about the food choices. People had access to specialist diets where required.

People and relatives spoke positively about the care and support they received. Staff showed concern for people's well-being in a caring and considerate way, and they responded to their needs quickly. Staff told us that people were encouraged to be as independent as possible.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to be involved with.

People said they felt safe living at Amesbury Abbey Care Home. There was enough staff on duty to meet people's care and support needs safely. Staff had a good understanding of what constituted abuse or poor working practices and understood their responsibility to report any concerns. People benefitted from staff that understood and were confident about using the whistleblowing procedure.

Safe recruitment practices were followed before staff were employed to work with people. Checks were undertaken to ensure staff were of good character and suitable for their role. People received care and support from staff who had access to training and supervision to develop the skills, knowledge and

understanding needed to carry out their roles. New staff were supported to complete an induction programme before working independently.

There were safe medicine administration systems in place and people received their medicines where required. There were processes in place to support people who were able to self-administer their medicines. People's care records showed relevant health and social care professionals were involved with people's care.

We checked whether the service was working within the principles of the Mental Capacity Act 2005. We found related assessments and decisions had been properly taken and the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS).

The manager investigated complaints and concerns. People, their relatives and staff were supported and encouraged to share their views on the running of the home. The provider had quality monitoring systems in place. Accidents and incidents were investigated and plans put in place to minimise the risks or reoccurrence.

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

Good

This service was safe.

People were protected from the risks of harm or potential abuse. Risks to the health, safety or well-being of people who used the service were assessed and plans put in place.

Staff had the knowledge and confidence to identify safeguarding concerns and what actions to take should they suspect abuse was taking place.

There were safe recruitment procedures to help ensure people received their care and support from suitable staff.

There were policies in place to support safe medicines management. People received their medicines when required.

Is the service effective?

Requires Improvement

This service was not always effective.

Whilst people had access to sufficient food and drink and were supported to maintain a balanced diet, the documentation associated with people's nutritional and hydration needs and monitoring was poor.

People were supported by staff who had access to training to develop the skills and knowledge they needed to meet people's needs.

People were supported to be able to make decisions and choices about the care they wished to receive.

Is the service caring?

Good

This service was caring.

People's privacy and dignity were respected. Staff provided care in a way that maintained people's dignity and upheld their rights.

People were actively encouraged to make choices about how they wished to live their lives. People and their relatives were

involved in making decisions relating to care and support.

People were treated with kindness and compassion in their day-to-day care. People and their relatives spoke highly of the staff and the care they received. □

Is the service responsive?

Requires Improvement

This service was not always responsive.

Care plans were regularly reviewed, but the quality of information within the plans was variable. Although some were comprehensive and detailed, others were not.

People had a range of activities they could be involved in.

People and/or their relatives said they were able to speak with staff or the manager if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken.□

Is the service well-led?

Good

This service was well-led.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home.

People benefitted from staff who understood and were confident about using the whistleblowing procedure.

Staff said they felt supported by the manager and could raise concerns. They felt appropriate action would be taken by the manager where required.□

Amesbury Abbey Care Home

Detailed findings

Background to this inspection

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

We carried out this inspection over two days on the 9 and 10 August 2016. The first day of the inspection was unannounced. One inspector, a specialist nurse advisor and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. This service had not been previously inspected since it had registered in April 2014.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had been requested to return the PIR in May 2015, which meant some of the information contained in this form was no longer up to date.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 16 people who use the service and three visiting relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included nine care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We

looked around the premises and observed care practices.

We spoke with the manager, the training manager, four registered nurses, four care staff, the activity co-ordinator and staff from the catering department. We received feedback from one visiting healthcare professional.

Good

Is the service safe?

Our findings

People living at Amesbury Abbey told us they felt safe living there. Comments included "It never occurs to me that I am not safe living here", "Yes, I do feel very safe here. All of the people around are very attentive. They will certainly help me", "Yes, I do feel safe here. I also feel safe with the staff, I know they would not hurt me. If I had any concerns, I'd go straight to (Staff member) downstairs. I do have confidence in them" and "There's always plenty of staff around to look after you so I do feel safe physically, emotionally and protected from the outside world".

A visiting relative told us "They are wonderful people here, they make both my relatives feel safe and I know that Dad's not concerned about the staff at all. I never do worry about his safety or his temperament here as the staff do know how to look after and cope with him".

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised. Clear policies and procedures were in place to inform staff of the processes they needed to follow should they suspect abuse had taken place. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this. Comments from staff included "If I saw any poor practice I would ask the staff member why they were doing what they were doing as it might not be intentional. Any concerns I had I would report to my line manager. If they didn't do anything I would go as far as reporting it to the directors. I have never seen anything that concerned me" and "Safeguarding is about looking after people's well-being. We have risk assessments in place to keep people safe. I report anything to the manager". Staff said they would report abuse if they were concerned and were confident the provider and manager would act on their concerns. Staff were aware of the option to take concerns to agencies outside of the service if they felt actions to deal with their concerns were not being taken. Records showed the manager had reported safeguarding concerns to the appropriate local authority and had worked with them to ensure action was taken to keep people safe.

Risks to people's safety had been assessed and actions taken to mitigate these risks. Care plans contained risk assessments for people for areas such as falls, mobility and skin integrity. Where risks had been identified, care plans contained guidance for staff on how to manage and minimise the risks. For example, moving and handling risk assessments were linked to plans on how to move the person safely; details of which hoist and sling to use were included. In one person's plan the risks associated with the person having a bath unsupervised were clearly identified and a risk management plan was in place, including the use of sensor mats and sensor alarms. When people had been assessed as being at high risk of choking referrals to the speech and language therapist had been made in a timely manner.

However, in some plans, although risks had been identified, the associated documentation was incomplete. For example, in one person's plan a risk of falling had been identified. Although required equipment was listed, there was no implementation date and the information had not been signed. In another person's plan there was evidence of telephone consent by the person's representative for the use of bed rails. However, this had taken place in April 2016 and staff had not gained written consent since then despite the relative visiting regularly.

When people had accidents, incidents or near misses these were recorded and monitored by the manager to look for developing trends or patterns. We spoke with the manager regarding their reporting protocol. They told us this had recently been reviewed and new paperwork had been implemented. They said when they had first joined the service in February 2016 the provider had several forms in place for the reporting of accidents, incidents and near misses. They said this caused confusion and it was difficult to monitor for patterns and address any actions taken. They had devised a new form and a list of which reportable events should be detailed on the form. This included such things as falls, complaints, medicine errors and people developing pressure ulcerations. A copy of this information was available in the staff room. As a result of some recent concerns they had now introduced a form for people who required 24 hour monitoring.

On the day of our inspection, one person using the service had been found on the floor by the night staff. We observed the process for reporting the incident and saw the monitoring form which had recently been implemented. However, the monitoring form did not specify the frequency with which staff should check on the person. This was discussed with the nurse on duty and the manager and we were informed that this addition to the form would be made.

Staff told us that when accidents or incidents occurred they had the opportunity to review and discuss what had happened to see if there were any changes required to people's care plans or lessons to be learned. One staff member gave an example of one person who had experienced a series of falls. They told us a low bed and crash mat had been purchased to reduce the risk of the person falling out of bed. We saw this equipment was in place during our inspection.

People's medicines were managed so they received them safely. Medicine administration records (MAR) were completed in full and we saw no gaps in the MAR charts we looked at. There was a checklist at the front of the medicines folders on all three floors, which showed that staff had previously checked for any gaps; however the checks had stopped during June 2016. One of the nurses we spoke with was unsure why this had happened. All topical medicine administration charts had been signed and completed in full.

Medicines were stored safely. Medicine trolleys were securely locked to walls when not in use. Within the trolleys some of the bottled medicines had not always been labelled when opened or when they expired, but this applied to only two bottles that we looked at. Items that required storing in a fridge were kept in a locked medicines fridge and the temperature of the fridge was monitored and recorded. When medicines were for destruction the items were logged and countersigned. However, the book had not been signed by the person collecting the medicines.

People received their medicines on time. We observed parts of three medicines rounds and during all three the nurses ensured people had drinks, asked them if they required any pain relief and stayed with them to ensure medicines had been taken. There were PRN (as required) and homely remedies protocols in place and when people received medicines on a PRN basis, staff had documented on the reverse of the MAR chart the reasons why. For example, 'Paracetamol 1 gram for headache'. When staff did not know people, procedures for confirming people's identity were followed. Although the majority of people had photographs at the front of their MAR chart, some of these were at least one year old and so might no longer be a true likeness of the person and others were not dated at all. There were also no personal preferences in relation to how people preferred to take their medicines.

People using the service were encouraged when able, to administer their own medicines in order to maintain and promote their independence. There was guidance in place within the provider's procedure on how people should be assessed as safe and competent to do so. We saw two assessment forms for two people who were being assessed. We observed one nurse asking the person which medicines they had

taken that morning, and the dose in order to confirm their understanding of what they had been prescribed. However, the assessment form referred to people having 'locked storage' within their rooms where they would keep their medicines locked away. Of the two people's records we looked at, neither had locked storage available. The provider's medicines policy stated that 'Service users who self-administer medicines must be provided with a personal lockable drawer or cupboard where medicines can be stored safely'. One person had a lockable cupboard installed during the second day of our inspection. There were no formal arrangements in place to monitor the medicines of people who were self-medicating, although these were in place for people who received their medicines from staff. One nurse said that checks of stock balances for people who self-medicated were carried out on an ad hoc basis, but that these were not documented. Because there was no formal process in place, staff were unable to monitor if people were taking their medicines as prescribed or if they were missing or stock piling medicines. The provider's policy stated 'Permission must be sought from service users to enable care staff to have access to monitor and review medicines' but this was not routinely happening.

Medicine errors were reported and investigated and we saw evidence of this. Audits of medicines were undertaken internally and the service had received a pharmacist advice visit on 15/03/2016. When areas for improvement had been identified, these had been actioned. For example, it had been noted during a medicines improvement audit in March 2016 that the provider's policy needed updating. This had been done. Other improvements that had been implemented included a medicines 'champion', and the introduction of self-medicating assessments.

The manager used a dependency tool to assess how many staffing hours were required each week based on people's needs. Rotas reflected the identified staffing hours. Staff told us there were sufficient staff to meet people's needs.

We saw safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. New staff were subject to a formal interview prior to being employed by the service. People using the service were able to be involved in the interview process and selected their own questions to ask candidates.

Requires Improvement

Is the service effective?

Our findings

Whilst people had access to sufficient food and drink and were supported to maintain a balanced diet, the documentation associated with people's nutritional and hydration needs and monitoring was poor. For example, in one person's care plan staff were informed to offer pureed choices from the menu, but in the meal preferences section it was documented that they liked bread, butter and marmalade. When asked, staff said the person was on a normal diet, although pureed food had been trialled prior to a referral for a speech and language assessment. Another person was nil by mouth due to their condition, but there was a generic nutrition care plan in place which mentioned "toast" and "sandwiches". Because of the conflicting information there was a risk that people could be given the wrong food.

When people were having their fluid intake monitored, the recording of this was poor and did not indicate that people had received enough to drink. For example, one person had a documented fluid intake on 05/08/2016 of 350 mls. In another person's plan they had been assessed as a "high risk of dehydration" and had recently had a urinary tract infection. Their charts showed that on 06/08/2016 they had received 270 mls and on 07/08/2016, they had received 260mls. There was no reference made to the poor fluid intake within the daily notes.

Another person had a documented intake of 100mls on 06/08/2016. The daily notes made no reference to the poor intake and nothing was documented in the handover book. The person's care plan stated 'Should be offered a cup of tea regularly throughout the day and a continual supply of fresh water'. Another person's plan informed staff to 'ensure at least 2000 mls per day'. When we asked staff to show us the fluid chart in relation to this person they told us they were not having their fluid intake monitored.

Although the fluid and food monitoring charts had a section for a staff member to sign them daily as checked, it was unclear how or if concerns in relation to people's intake were escalated or acted upon.

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives spoke positively about the food and told us there was sufficient to eat and drink. Comments included "The food is nice and we get a good choice. If there is something I don't like I can ask for an alternative", "They do come round with drinks and biscuits and you can phone them for more if you want any extra. The menu choice is fine", and "The food is very good and there is always plenty of it. I get to have my breakfast in bed which is very nice". One person told us "The chef does come around to find out if you're happy and what you might want for the future".

The service identified risks to people with complex needs in relation to eating and drinking. Where required external support and advice was sought, for example, a nutritionist and speech and language therapist. One visiting health professional said "They are very responsive here, and will always ask the GP to refer people if they have any concerns about swallowing for example" and "The care staff really listen, and I've seen them sit with people prompting them to eat or assisting when required".

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering department; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu they were able to request alternatives. The second chef told us "We plan the menu weekly to include the food people like".

The kitchen was clean and tidy and had appropriate colour coded equipment and utensils to ensure that food was prepared in line with food safety guidance. The kitchen had been awarded a Food and Hygiene five star rating by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

Staff told us they had the training and skills needed to meet people's needs. Comments included "We get a lot of training. It's varied, sometimes it's in a classroom or on the computer. I feel we get the right training for our job" and "Training is good here. Part of my role is to ensure we have the right mix of skilled staff on each floor during my shift".

There was a training manager in post who explained their role was to monitor people's training needs and ensure staff received refresher training as required. They told us that each year they sat down with staff and completed a personal development plan for the coming year. Training needs would be identified and this would assist them with planning the training requirements of the service for the coming year. New staff had access to a comprehensive induction period before commencing work independently. This period included completing the care certificate and shadowing more experienced members of staff.

The nursing staff we spoke with demonstrated they had the necessary skills and experience to undertake their roles. Staff said they had all recently been allocated 'lead' roles for different aspects of the service. For example, one said they had completed a tissue viability course and were now going to be the lead for tissue viability for the service. Another was the lead for medicines and another was the lead for promoting continence.

All of the nurses said they had access to opportunities for continuing professional development. They said recent study days included venepuncture (use of needles) and catheterisation. When staff had specific training requirements in relation to a person's care, this was provided. For example, prior to a person moving to the service who was receiving Percutaneous Endoscopic Gastrostomy (PEG) feeding, the nurses attended training on this. Percutaneous endoscopic gastrostomy is used when people are unable to swallow or to eat enough. Nurses also said they undertook annual medicine administration competency assessments to ensure they were still competent to carry out this role. All said they felt well supported in relation to achieving their revalidation requirements with the Nursing Midwifery Council. One nurse said "We're encouraged to attend extra courses and the company pay for all training and give us paid time off to attend. I get to discuss my personal training plan at my supervision sessions". There was a training matrix in place, and staff said they were sent reminders to complete on-line mandatory e-learning training when required.

Comments from people using the service included "The staff do it correctly as far as I'm concerned and I reckon they're well trained" and "The staff are well trained to provide the level of care that we need. I do feel satisfied that the care I'm getting is what I actually want".

All staff said they felt supported by the manager and they had received regular supervision sessions and annual appraisals. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home.

These meetings would also be an opportunity to discuss any difficulties or concerns staff had. Nursing staff said they attended regular nurse meetings and we saw the minutes of the latest meetings in April and July 2016. We also saw the minutes of general staff meetings, senior care staff meetings, domestic staff meetings and home manager meetings.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals, such as a chiropodist, physiotherapist or tissue viability nurse. Referrals were made in a timely manner. Care plans confirmed people had access to health care professionals. Visits from health care professionals and any outcomes of these visits were recorded. Comments from people included "If I needed medical help the staff would call for the doctor for me. The doctor has seen me for my feet as they're very swollen at the moment. I do have medication for it and the staff sort that out for me. The staff would arrange for an optician or dentist for me if I needed one" and "The doctor comes every Monday I believe and the staff would call the doctor in another time if I needed one I'm sure. I've already seen the podiatrist, that wasn't long ago".

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care was sought in line with legislation and guidance. Mental capacity assessments had been completed and where people had been assessed as not having capacity, best interest decision meetings had taken place. Where needed they had made applications for DoLS authorisations. Applications had been submitted by the manager to the local authority.

Staff understood the requirements of the Mental Capacity Act and sought consent prior to providing care. For example, we overheard staff asking one person "Will it be ok if we just check this for you?" and "Would you like me to walk along with you?" However, it was not always clear how people were supported to make decisions when they were unable to communicate clearly. For example, one person was unable to communicate verbally due to their medical condition. In the care plan staff had documented "Able to express self using non-verbal means including facial expressions", but there was no further detail or information on what these facial expressions were. In other plans, where it had been assessed that people were unable to consent to their care, best interest decisions had been made with input from people's representatives, the GP and staff.

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received from staff. One person using the service said "It's lovely here. I've come for a rest and it feels good to be welcomed. The staff are lovely". Other comments from people included "Overall there is a nice community spirit with staff being both friendly and helpful", "Staff are fantastic, hardworking, helpful and understanding" and "The staff are very helpful. They are all polite and nice". One person told us "This whole place is what it is because of the staff. They go out of their way to help me. Staff are remarkably good". People's relatives and friends were able to visit unrestricted.

Staff said they enjoyed their jobs. One staff member said "I like it here because its family orientated" and "The staff here are very good at caring for people, it's homely here". They said "It's the little things that count. For example, when a new resident moves in, they have fresh flowers and a welcome card in their room".

There was a pleasant and friendly atmosphere throughout the home. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included items such as ornaments, photographs and their own furniture. People told us they could spend time in their room if they did not want to join other people in the communal areas. One person told us "I do like the room, yes, it's very nice. All that's here belongs to the home at the moment. I might bring my own stuff in at a later date. It's all very clean here, quite spotless really". Another person said "I do love my room and the views, they're spectacular. You find it easy, very easy to get around this place. It is rather nice".

People were treated with kindness and compassion. We observed staff taking the time to explain to people what was happening. For example, one person was waiting for their shower. We heard staff explain they were currently helping someone else and would be along shortly to help them have their shower. They checked the person was alright with this and reassured them they would be along "Soon". One person told us "The staff here are wonderfully caring, extremely kind, and very considerate. I do like chatting to them when we get the opportunity".

During our conversations with staff they demonstrated they cared a great deal for the people they supported. Staff told us they felt that people received high standard of care and support. Comments included "Everyone works together here to provide a high standard of care to people. We encourage people to be independent and choose what they want to do" and "Care is very personalised. It feels like it is people's home".

Staff treated people with respect, calling them by their preferred name and title. Staff were aware of the importance in respecting people's rights to privacy and dignity. Staff knocked on doors prior to entering people's rooms and introduced themselves when they were meeting people for the first time. All personal care took place behind closed doors and there was a discreet sign placed on people's doors to indicate when personal care was taking place in order to prevent anybody walking in. One member of staff told us "People can choose if they want a male or female carer. I always talk through with people what I am doing and check they are okay". Comments from people included "When they want to come in they knock and

they wait for me to invite them in. They say why they're there and usually I agree with it and they sort it all out", "They're very polite as they knock and they wait for me to respond. They say what they want to do and providing I'm happy, we do it. They always give you a big good morning with a huge smile" and "They will knock and enter then explain what they want to do and request permission to go ahead".

Care plans contained information on how staff should respect people's dignity. For example, care plans were written in sections titled 'What I am able to do' and 'What I need help with' and were written in the first person. In one person's plan it was documented 'I prefer not to wear make-up' and 'I prefer to wear trousers'. Where people had a preference care plans included information on whether the person wished to be supported by a male or female staff member. One person told us "I think the staff are very good indeed, which is great. They're very friendly, they're friends. I certainly do feel very comfortable with them and they're very approachable. Frankly the gender of the staff washing me doesn't tend to worry me. They do respect my privacy and they also look after my dignity. Frankly at my age, why worry?".

Staff were aware of the importance of enabling people to make choices about how they lived their lives and supporting people to be involved in their own care. In the section titled 'What I am able to do' information detailed how staff should support people to remain independent. For example, supporting people to choose what clothes they wished to wear, activities they wanted to take part in and their meal preference. One member of staff told us about one person who had recently been unwell. They said this person wasn't able to weight bear during this time and needed to use the hoist. They told us "As soon as they were having a good day we encouraged them to get back on their feet and use their Zimmer frame. It's important to people that they remain independent".

One person told us that when they first came to Amesbury Abbey they were unable to walk and were using a wheelchair. They said they were now able to walk with a stick and had the use of a mobility scooter which they used to get around the grounds. They said "I can go out and about when I want. I just let them know when I am leaving. I'm pleased I'm using my stick now".

Staff had received training in equality and diversity and were able to explain how they promoted this within the home. Comments included "It's about treating people as individuals. It's important you know people's backgrounds and what their preferences are" and "Diversity, it's about supporting people to what they need or want to do. Everyone is different". One person told us "We are all different and staff treat as such. They treat you as a person".

We looked at the care plan for one person who was approaching the end of their life. Their wishes in relation to this were clearly detailed and the staff member who had written the plan had spent a lot of time speaking with the person in order to ensure the information was correct. They said "I think we provide excellent end of life care. We have an extra member of staff on duty when someone is dying so that there is someone to sit with them, hold their hand, and ensure they are not alone".

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. For example, one person was assessed as being a high risk of their skin breaking down. The care plan informed staff the person should have an airflow mattress in situ and two hourly position changes whilst in bed. There was nothing documented in relation to the required setting on the mattress and when we checked, it was set incorrectly. Staff who were caring for the person did not know what the correct setting should be. In addition, the person was having their position changes monitored. The chart for this person indicated that on 01/08/2016 the person had been sat in an armchair from 11.30 to 19.40. There was no pressure relieving mattress on the chair. On 07/08/2016, the chart indicated the person had been sat in the chair from 10.00 until 17.30. Although the person's skin was intact on arrival in July 2016, they subsequently had some minor skin breakdown, possibly caused by pressure. We discussed this with one of the nurses and a pressure relieving cushion was provided for the chair.

Care plans were regularly reviewed, but the quality of information within the plans was variable. Although some were comprehensive and detailed, others were not. For example, one person's care plan noted they could become anxious and agitated but did not contain any guidance for staff on how best to support the person during these times. We were made aware of one person who may at times refuse personal care due to staff being unfamiliar. One staff member explained how best to support the person if this should happen. However, we could not find this information in the person's care plan.

In another person's personal care section, the care plan stated 'requires full assistance in order to meet personal needs', but the plan did not specify what these needs were. The plan said 'ensure he is well groomed and presentable', but gave no detail of what well-groomed and presentable meant to the person. In their communication plan it said that following a stroke the person was unable to communicate verbally, but was 'able to express himself using non-verbal means, including facial expressions'. There was no detail of what the facial expressions were or what they might mean. The care plan also said 'he becomes frustrated at times and will express this by crying or lashing out', again there was no detail of what staff should do to support the person during these times.

One person had a catheter in situ. Their plan said 'ensure catheter is changed regularly' but did not clarify how frequently it should be changed. Their nutritional plan also stated 'encourage fluids using windows of opportunity'. There was no explanation of what constituted a window of opportunity. This meant there was a risk people would not receive consistent care in the absence of guidance.

Where able, people signed to indicate they agreed with their plan of care. The plans focussed on promoting independence where possible. Although some personal preferences were detailed, this was not consistently seen, and none of the plans we looked at contained any information in relation to people's lives prior to moving to Amesbury Abbey.

We were informed by the manager that the care plans were all being reviewed by the nurses in conjunction with the senior care staff and this was a work in progress.

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When asked about people's input into their care plans, comments from people included "My care plan may have been sorted with me but I'm not actually sure. I do get to talk to the staff to sort things out so the plan's updated in that way" and "The care plan, I didn't do it at all. I do know it's updated as they go along. If I wanted to talk about something I know they would listen".

People were supported to follow their interests and take part in social activities. There was an activities coordinator in post who was responsible for organising activities for people throughout the week. There was a timetable of weekly activities, which included yoga, quizzes and arts and crafts. The coordinator also organised outside speakers and entertainers to attend periodically throughout the year. The coordinator told us they regularly spoke with people about what activities they wished to take part in. People had a copy of the timetable in their rooms and were able to choose the activities they wished to join in with. People told us it was their choice to attend activities. Comments included, "I go to the activities, yes but it's becoming less common now as I'm not quite as mobile, I'm not quite so interested. We did have an exhibition of our handicrafts recently, which was very good. There's a very good girl who organised it all and I think it was very well attended. There is a church service once a week and the priest comes along to give us Holy Communion. I find that quite comforting" and "I have been to the activities, I like to do the yoga and I went to the Garden Party recently. Anything I'm interested in I will take part in".

There was a procedure in place, which outlined how the provider would respond to complaints. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. All had been resolved to people's satisfaction. The people we spoke with said they did not have any complaints about the care being provided. Comments included "I've never made a complaint but if I needed to I would go to (manager). I know him and I know that he would be very good at talking it out. I've not been to a residents meeting yet, I might go next time", "I've never moaned but do know what to do if I wanted to. I'd go downstairs and tell someone in the office or go maybe to the nursing sister, especially if it was a nursing style complaint" and "I've never needed to complain about anything but do know how to. I did go to the last residents meeting but nobody really had much to say, so I don't know if I'd go again".

Good

Is the service well-led?

Our findings

There was a manager in post who was responsible for the day to day running of the service. They were supported by two clinical nursing leads. The manager had submitted their application to CQC to become the registered manager for the service.

People and their relatives spoke positively about the management of the service. Comments included " My views are listened to, yes. I believe it's well managed by (Manager) and he does tend to be leading the staff in the right direction it would appear" and "It is well managed I believe, yes, and I do know the manager. I don't know what he's like with his staff but I imagine he does treat them well as things are improving. He is very approachable and certainly would listen".

One visiting relative told us "(Manager) is managing this place well. I'm very impressed with him really. There is a good interaction between him and the staff. He's always available to the staff and he's very friendly with them but not too much so, and with us, he's got a good personality. I think he has good management skills. The place is very good and yes I would recommend it to somebody else without a doubt. He and his staff have really looked after my Mum here".

People and their relatives' views about the service were sought. The manager ran meetings with relatives and representatives of people using the service. We saw the latest minutes of these from April 2016. In this meeting the manager discussed his 'Intention to hold formal care reviews to ensure support planning was person centred'. They also discussed complaints, compliments and suggestions, which actively encouraged people and their relatives to speak out.

The manager demonstrated positive management and leadership. There was an "Open door" policy with staff saying they felt supported within their roles. Comments from staff included "(Manager) is approachable. He is a really bubbly manager. I can discuss any concerns or ideas I have with him" and "(Manager) is the best manager I've had. He is good at covering for staff absences". Staff had clear values about the way care and support should be provided and the service people should receive. Comments from staff included "This is a family run business and it feels like home to people" and "It's important to know about people's preferences and how they want their care to be". Staff were aware of the organisations' visions and values which they told us included promoting people's independence, encouraging choice and respecting those choices.

Staff were supported to question the practice of other staff members. Staff had access to the company's whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

The provider had effective systems in place to monitor the quality of service being delivered and the running of the home. The manager carried out audits throughout the year to assure themselves of the quality and

safety of the service people received. The manager completed a monthly report for the directors, which was linked to CQC's five domains. The report included information relating to the Key Lines Of Enquiries (KLOEs) linked to each domain. For example, the manager reported on complaints, supervisions and appraisals undertaken, risk management, care planning and reporting processes. Whenever necessary, action plans were put in place to address the improvements needed.

Staff members' training was monitored by the training manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. The training manager regularly discussed the training needs of staff with the manager to support the planning of training throughout the year. Staff told us they received the correct training to assist them to carry out their roles.

The service had appropriate arrangements in place for managing emergencies, which included fire procedures. We discussed with the manager the need to bring fire information for people using the service up to date. They agreed to address this immediately. There was a contingency plan, which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. The management operated an on-call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Whilst people had access to sufficient food and drink and were supported to maintain a balanced diet, the documentation associated with people's nutritional and hydration needs and monitoring was poor. People did not always receive care that was responsive to their needs. Care plans were regularly reviewed, but the quality of information within the plans was variable. Although some were comprehensive and detailed, others were not.