Abbeyfield Society (The)

James House

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on the 11 and 12 October 2018.

At our last inspection in February 2016 we rated the service good in all the key questions and therefore good overall.

James House 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.

James House is part of the Abbeyfield Society. This is a charitable organisation that provides care and accommodation to older people living in England. James House provides accommodation and personal care for up to 12 older people or younger adults above the age of 55 years. At the time of our inspection 11 people were living at the home.

There was not a registered manager in post as the previous registered manager had left in August 2018. 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. There was a manager appointed in August 2018 who was in the process of registering with the CQC.

We found during our inspection that the bathroom was used to store equipment. This had meant it could only be used if items were removed first. The provider had plans to refurbish and modernise the facilities but this had not taken place at the time of our inspection. In addition, at least one window on the first floor did not have a window restrictor. This increased the risk of people falling from height.

Staff told us they felt well supported by the manager who had an open-door policy and was available to speak with. Staff had received training but some staff had not received all their refresher training. This concern had been identified by the manager who was in the process of addressing the short falls. We found despite some areas of training being overdue staff spoke clearly about key areas such as safeguarding and the Mental Capacity Act 2005 (MCA) and told us about the training they had received and how they implemented it in their work.

People told us staff were kind and caring and all said how much they liked their bedrooms and the home. We observed that staff were respectful and promoted people's self-respect by supporting them to remain as independent as possible.

People's care needs were assessed prior to them being offered a placement to ensure appropriate care could be provided. People had signed to give their consent to care as it was stated in their care plans. Care

plans were reviewed and updated on a regular basis and in response to changing circumstances.

Risks were identified through the assessment process and measures were taken to mitigate the risk of harm and guidance for staff was provided.

There were systems in place for the safe storage and administration of medicines.

People told us the food was, "very good" and "lovely." The cook tried to make sure people had the meals they wanted and usually produced homemade meals. The staff were aware of the need for people to remain hydrated and ensured people drank enough throughout the day. People's well -being was promoted and any sign of ill health was flagged with the appropriate health professional in a timely manner.

The manager had systems in place to recognise and report all safeguarding adult concerns. They responded well to complaints and addressed concerns. They were working in line with the MCA and Deprivation of Liberty Safeguards (DoLS) to uphold people's rights.

Audits and checks were carried out by the senior staff, manager and provider. There were good lines of communication in the home that included, daily shift handovers, informal information sharing and bimonthly staff meetings. The manager talked with people living in the home daily and held regular meetings to keep them informed of changes and listen to their views.

The manager told us they felt well supported by the provider and had the opportunity to network with other services.

We found one breach of the regulations in relation to the premises and equipment. 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

The service was safe. The manager and staff could recognise signs and symptoms of abuse and reported any concerns to the appropriate body.

The provider assessed the risks to people whilst they receive a service and put in place guidance for staff to mitigate those risks.

There were systems in place for the safe storage and administration of medicines.

The manager assessed staffing levels to ensure there were sufficient staff to meet people's care needs. They followed the provider's procedure to ensure the safe recruitment staff.

Staff had received infection control training and used personal protective equipment to avoid cross contamination.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The bathing facilities in the home were limited. The bathroom was used to store some equipment. There was at least one window on the first floor which did not have a window restrictor. This increased the risk of people falling from height.

Staff told us they felt well supported by the manager who had supported staff in a variety of ways including informal supervision and staff meetings.

The senior staff team assessed people prior to offering a service to ensure their care needs could be meet by the service.

People told us the meals were good and the staff ensured people ate well and remained hydrated.

Staff supported people to access the appropriate health care in a timely manner.

The manager worked in line with the MCA and ensure people's rights were upheld. They had applied for DoLS authorisations when people were assessed as no longer having the capacity to

make decisions about their care and treatment.

Is the service caring?

Good

The service was caring. People told us staff were caring and that their care and support was provided as they wanted it to be done.

Staff demonstrated they promoted people's privacy, dignity and self-respect.

People's care plans described how they should be supported to remain as independent as possible and how to support them to make choices about their everyday life.

Is the service responsive?

Good

The service was responsive. People had person centred care plans that informed staff about them and their preferences.

People felt able to complain and complaints were acknowledged, investigated and addressed in a timely manner.

There was no one currently receiving end of life care but people's care plans contained their end of life wishes. Care staff and the manager had received end of life training to equip them to support people should this need arise.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The provider undertook audits and checks to ensure the quality of the service provided but identified concerns such as storage of equipment in the bathroom and a missing window restrictor had not been addressed at the time of our inspection.

The manager ensured people and staff felt able to voice their opinion and listened to their views and suggestions.

The manager worked in partnership with health care professionals and the commissioning body for the benefit of people living at the home.

James House

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 October 2018. The first day was unannounced and we agreed to return on the second day to complete our inspection.

Prior to this inspection, the provider had completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service. We reviewed notifications we had received. A notification is information about important events that the provider is required to send us by law.

One inspector carried out the inspection. During our inspection, we made a partial check of the environment. We looked at two people's care records. This included their care plans, risk assessments and daily notes. We observed two people receiving their medicine and looked at five people's medicine administration records. We reviewed three staff personnel files. This included their recruitment, training, and supervision records. During the inspection we spoke with six people who used the service, the manager, two senior care workers, a care worker and the cook.

Following our inspection, we spoke with a representative from the commissioning body.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. One person told us, "I am very content with my room and everything is very safe here. Oh yes, it is all very pleasant." Posters displayed reminded staff, relatives and people to, "Speak up" and report any concerns.

Care workers and the manager demonstrated they knew how to recognise and report safeguarding adult concerns. One senior care worker told us, "Abuse comes in different guises, for example physical abuse, you need to look out for bruising or flinching or acting strangely around someone. They might be withdrawn or lack appetite. I would speak with [manager] and to my colleagues, depending on the nature of the concern. You must act." A care worker told us, "Yes we have had safeguarding training, we look out for signs like a bruise or unusual behaviour like if they are withdrawn. We tell the senior staff or manager. The manager would report everything."

The manager had identified possible safeguarding adult concerns and had reported these to the local authority in an appropriate manner. They reviewed people's communication records, accidents and incidents and complaints to check to see if they were of a safeguarding adult nature. Whilst concerns were being identified and reported there was not a monitoring tool to track safeguarding referrals outcomes. We brought this to the manager's attention who agreed to implement this and sent us a template they are now using following our inspection.

The manager assessed the risks to people using a risk screening tool that identified the level of risk. Risk assessments included, physical and mental health, social isolation, medicines, personal care, nutrition, skin integrity, pressure sores, mobility, fire safety and finances. The risk assessments were reviewed monthly and in response to people's changing circumstances. When for example, a person had a fall the risk assessment had been reviewed and action had been identified to help mitigate the risk of falls. Measures in place included, supporting the person to move to the ground floor room closer to the care worker's office and use of an emergency call pendant to ensure the person could get help if they needed to immediately. When the manager identified a risk of poor nutrition or pressure ulcers they used a recognised assessment tool such as a Waterlow assessment to assess the level of risk to the person and identify measures for staff to implement to reduce that risk.

The provider had ensured a robust recruitment process. Prospective staff completed an application form and attended an interview to assess their suitability and aptitude for the role. The provider had completed checks to confirm staff identity and address. Criminal record checks were undertaken to check if staff were suitable to work in the care sector. These were repeated every three years to check their ongoing status. References were obtained from former employees to confirm their previous work history and if they were of good character.

The staffing levels during the day consisted of one care worker and one senior care worker, in addition to the manager. Other staff in the home included the cook and a cleaner. Staff told us there was enough staff generally but they could be stretched at times. One care staff described that they cared for two people who

required two staff for all their personal care support and one person who required frequent staff reassurance and monitoring as well as the other people. They said this meant at times it was difficult to manage people's conflicting support needs. However, they confirmed that the manager supported if they were very busy and this helped. Another staff member said, "Yes, there are enough staff with the ratio we have…we do have hot spots. Say when someone was palliative and required turning and oral care we could have benefitted from another staff...but apart from that it's ok." They confirmed that extra staff would be supplied if the situation warranted it, describing sometimes an extra staff member came for a few hours to cover the most demanding times.

The manager told us that they assessed if the current staff team could meet the needs of the people living at the service. They explained since coming into post they had been assessing the effectiveness of the current staff team structure and had approached the provider to consider a review of the current structure to create another care worker role. They confirmed that if someone suddenly required extra support it would be provided in an emergency and they would approach the commissioning authorities for extra funding to fund the necessary staff.

The provider had systems in place for the safe administration of medicines. Medicines were stored securely and in the appropriate manner. We observed the medicines administration process for two people and found that the administration was in line with good practice. For example, one person requested a medicine that was not on their medicine administration record (MAR). The senior care worker would not give them the medicine in a manner that it was not prescribed and checked with the GP to clarify the instructions.

We reviewed five people's medicines records (MARs). We found that apart from one minor recording error these were completed appropriately. Only senior care staff who had received medicines training undertook medicines administration. Care workers had received training to apply and record on the MAR the administration of prescribed creams and ointments. We saw medicines audits had picked up not all care staff were consistently recording and this had been addressed with the staff team and individuals.

Some people were administered PRN (as and when necessary) medicines. There were clear guidelines in place for senior care staff, so they knew when to give the medicines and to support them to recognise any side effects. In addition, staff were asked to consider if the medicine had worked, for instance if pain relief had been achieved. Controlled drugs were kept securely, and two senior staff signed to say they had been administered. We checked the controlled drugs and counted the medicines and found the correct amount was recorded and signed for.

Senior staff handed over, checked and counted medicines at the end of each shift. There had been a few occasions when this had not been done. The manager was aware of this and had raised this with the senior staff as an action that must be carried out. The manager undertook random checks of the medicines during the week and there was a monthly audit. The provider checked medicines six monthly to ensure the provider's procedures were being followed.

The home was kept clean and well-maintained. There were hand washing facilities available and visual reminders for staff to wash their hands effectively in key areas such as the laundry room and wash rooms. Care staff had received infection control training. We observed they used personal protective equipment appropriately. People's care records assessed if there was a risk to them from infection and stated measures to be undertaken to minimise the risk of harm to them. The kitchen had received a five-star food hygiene rating from the local authority and the cook demonstrated that they stored food in an appropriately safe manner. For example, all opened foods were labelled with the date of opening to prevent the consumption of out of date food.

The manager was new to the manager's role and had only recently been appointed. They described how they were making changes in response to finding concerns. They had realised some information was not always quick to find so they had reorganised the office records to improve the filing systems in the home for both their and staff benefit. This had been shared with the senior staff, so they could find information quickly if necessary in their absence. They told us that they were open to learning from mistakes and near misses and believed in sharing their learning with the staff team. They were in contact with other services that belonged to the provider. They felt it was important that they shared their learning and that knowledge was shared between Abbeyfield Society services, so all could learn from the mistakes of others and avoid similar errors.

Requires Improvement

Is the service effective?

Our findings

There was limited storage and bathing facilities in the home. There was one communal bathroom and one communal shower room in the service.

The bathroom contained an easily accessible bath. However, there were items stored in the bathroom that included several commodes that were stored in the bathroom during the day as people did not want them in their rooms. In addition, there was a cleaning trolley and a vacuum cleaner. A staff member told us, "If someone wants a bath we take everything out and then put it back again afterwards. That's what we do." There was one en-suite shower for one person and one walk in communal shower room on the ground floor that everyone else shared.

We observed one person complaining to senior care staff that they had had to wait for their shower. They said they had wanted it earlier that morning. The staff member apologised, and the person was supported to take a shower at 10.30am. A staff member explained to us later in the day that another person had requested a shower that morning and as such there had been a delay. A second person told us, "They are short of showers, only one so there is a rota." We brought this to the attention of the manager. They told us that people were supported to have a shower when they wanted but people had often requested a specific time and day and they tried to meet their preferences. We saw people's care plans stated when people would like their shower or bath.

They explained the short comings of the current facilities had been recognised by the provider and that there were proposed plans to extend and refurbish the home to address this. However, the bathroom was not easily accessible because it was used for storing equipment and required staff to move items before it could be utilised by people."

In addition, we found that at least one window where there was not a window restrictor which meant it could be fully opened which therefore increased the risk of a person falling from a height. The Health and Safety Executive in its guidance, 'Falls from windows or balconies in health and social care' states that "Where vulnerable people have access to windows large enough to allow them to fall out and be harmed, those windows should be restrained sufficiently to prevent such falls." We brought this to the registered manager's attention they said this would be addressed in the refurbishment of the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A care staff member told us they had not received a supervision session for many months. They said, "Last time it was done was in February or March." Staff files we reviewed recorded that two staff had not received supervision sessions since April 2018. The third staff member who had commenced working in the home in May 2018 had not received a supervision session and did not have a supervision agreement.

The Abbeyfield supervision policy did not give a definitive time scale for supervisions to take place. The

policy stated, "The format and frequency of supervision should be discussed, agreed, and reviewed at the supervisee's annual appraisal meeting. There should be a written supervision agreement between supervisor and supervisee about the purpose of supervision."

The manager described they had supported staff in a number of ways. They were reassigning supervisors and supervisees. They confirmed following the inspection they had undertaken several supervisions. They stressed it was an area already identified for action. To ensure staff were supported, the manager had held bimonthly staff meetings. They had an open-door policy and if staff had an issue they could raise it and they would speak one to one with them. They also spoke with each staff member when they were on shift. Staff told us they felt they could speak up if they had a concern and confirmed that the manager was approachable and supportive. One care worker said, "[Manager] has just started, they are approachable we can talk with them anytime…at the staff meetings we talk about everyday things."

Staff told us they received an induction and training. A care worker told us, "We have an induction we had to complete, and training is helpful of course." Induction was thorough and new staff received an induction pack they worked through and they shadowed different shifts to get to know each person's routine. The workbook was comprehensive and covered training that included, the care worker's role, workplace familiarisation, fire awareness, communication, safeguarding adults, health and safety, moving and handling and infection control.

Further ongoing training was also provided. One senior care worker told us, "Training is sufficient. There was one training session last month that could have been better, I was able to feedback about this, but by and large training is fine." Staff had access to online training so they could keep their learning up to date and they received face to face training as well. Further training offered support to staff to understand the specific needs of the people in the home. This included, first aid, end of life care, oral health, positive behaviour support and some in-depth dementia training.

The provider kept a training 'matrix,' a tool to monitor and ensure all staff receive training refreshers in a timely manner. However, at the time of the inspection the manager had been unable to access the matrix. Following the inspection, the manager sent us the matrix but it was not up to date as the provider was in the process of updating their old matrix monitoring system to a new one. However, the manager had risk assessed and found that some staff were overdue for some areas of training and had highlighted this as a high level of concern and had put in measures to implement the necessary training as soon as possible.

The home was described by both people and staff as, "homely." For example, one, a senior care worker told us, it's so homely here and this generation find that quite comforting." It was a converted house and a lift had been installed to make both floors accessible. The stairs were equipped with hand rails should people wish to use them. The garden was wheel chair accessible using a ramp. There was a communal lounge area, with appropriate comfortable seating and a nicely presented dining room with laid out tables to invite people to eat their meals there. There was a seating area next to the care workers office where people could sit and chat with the care workers as they went about their work. People's rooms were very personalised. They had been encouraged to bring familiar items from their home including small pieces of furniture and paintings, photos and memorabilia. People spoken with all said they liked their rooms and felt comfortable living in the home .

Prior to a person's admission to the home a member of the senior management team carried out an assessment to ensure the service could meet the person's care needs. The manager described that they would try always to meet the person in their own home as they felt they got a clearer picture of them in their own environment. However, they explained that this was not always possible, so they would then try and

meet them in hospital and capture how they wanted their care provided and tell the person what they could expect from the home in terms of a service. In the pre-admission assessment the manager had identified what was 'very' important to the person as this was often crucial in supporting the person to settle in. Most people living at the service had arranged their care themselves or with their relative's support but where a commissioning body had made a referral the professionals assessment was considered.

People spoke positively about their meal time experience. One person told us, "It's always nice now, [cook] always tries to make it as you want it, it's very good now." Some people eating in the dining room agreed the food was, "Lovely." Other people spoken with who were eating in their rooms said, "Can't grumble. I think the food is pretty good," and "Food is excellent!"

People's care plans stated when they had specific dietary needs or support to eat. We saw that people who required support to eat their meal or had specific requests were catered for as their care plan had stated. For example, one person who had a small appetite was visibly reassured by the cook who said, "I have given you a very small portion." The person said, "Oh thank you." Another person with a sight impairment received support to eat independently by use of a plate guard to prevent food spilling and being told where each item of food was on their plate. Staff support was provided in a sensitive manner and the cook and supporting staff watched to ensure people were managing well, intervening promptly when they saw their help was needed.

The cook remained present during the meal time and served food to people in the dining room or if they preferred in their bedroom. People chose their food from a menu that contained a choice and could change their mind if they wished. The cook told us that they tried to make everything 'home made' using fresh ingredients wherever possible. This included desserts and cakes. The cook described they met with each new person and talked with them about their preferences and dislikes. We saw they tried very hard to produce meals that people would enjoy and had learnt to cook dishes to meet people's cultural preferences.

There was a large display in the communal area next to the carers office for both staff and people living at the home that promoted the need for good hydration. Pictures and easily read text encouraged all to drink enough during the hot weather. The main text read, "Water is essential for life." The symptoms of dehydration were listed for staff reference. Care staff had been encouraged to write on the display to state how they would encourage people to drink more fluids. Ideas included offering more water with medicines and offering a variety of drinks. We observed staff offering people drinks with meals and serving drinks throughout the day. One care staff explained they served drinks at regular times but anyone could ask for a drink at any time and it would be provided.

People were supported by staff to access the appropriate health care. Care staff were observed contacting people's GP for advice several times during our inspection. On one occasion they had observed symptoms that had caused them concern and following the GP advice had prepared the person for an admission to hospital. They had reassured the person and had explained why it was important to go and have a second professional opinion. People's records demonstrated that health concerns were raised quickly with the appropriate professionals. We saw on occasions the manager had advocated on people's behalf to ensure they received all the health support they were entitled to. The staff had developed hospital passports to ensure people's important support and health information went with them when they were admitted to hospital.

Care plans contained information to promote their physical and mental well-being. There was detailed information in each plan about people's oral care. This included if they had dentures and what daily support

they required. People were supported with eye and hearing clinics. There was a day advertised in October when both staff and people were going to focus on eye care called "Eye inspire," this was looking at everyone's eye care including the work of charities that support eye care in other countries. Staff recorded information to monitor people's well-being in their daily notes. Entries reviewed contained information about people's mood, if they had slept well and if they had eaten well. When people had specific health support needs, for example, about changes in their cognitive state this was recorded so that the care staff could present the detailed information to the health professional when the person visited the clinic.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People had been involved in planning their own care and they had consented to this. Records of their consent were in place. They had also consented to professionals accessing their records if necessary and for their photo to be used in their record. Some people had appointed a relative to be their lasting power of attorney (LPA). That is the relative had the legal right to make decisions on a person's behalf when they no longer have the capacity to do so. The provider had confirmed that relatives did have relevant LPA's in place where they made decisions for people. When the provider had reason to believe a person may no longer have capacity to consent to their care and treatment they had applied to the relevant local authority for a DoLS authorisation. The manager was tracking the DoLS authorisations and requesting reviews appropriately to ensure these were being appropriately monitored.

Good

Is the service caring?

Our findings

People spoke positively about the care they received. Their comments included, "They are very good here. We have a laugh. It makes such a difference" and "They look after us, we are all quite happy." Another person told us, "It is care as you want it, they never make you feel awkward. I like some carers more than others, but that is natural and they are all ok," and another said, "They are kindness itself and very patient."

We found the care staff we spoke with were emphatic towards the people they cared for and understood how it might be for a person to move into the home. One senior care worker told us how they promoted people's independence to maintain their self-respect. "They have had their own lives, worked, lived through the war, raised their own family and had their own family house. They are independent and proud so we are not trying to deskill people, we support them in a person-centred way, encourage those who can to remain independent for as long as possible."

The manger told us that if someone requires support with personal care but finds it hard to accept this after being independent all their lives, they will ask a staff member who has a good relationship with them, to work with them. One care worker described to us how they gained a person's trust so that they would allow them to support them with personal care. They explained, "At first they were hard to convince but now they enjoy. They enjoy their routine. I don't rush with people because they are people too." They talked about how they reassured one person who had a sight impairment, "I always let [person] know I am there. I hold their hand, so they know I am there for them."

We observed staff promoted people's dignity by ensuring they wore a comfortable dressing gown and slippers when supporting them from their bedroom to use the shower room. They were discreet and closed bedroom doors when supporting people with personal care and knocked and waited to be invited in before entering people's bedrooms.

When discussing people's care, staff and the manager closed the office door to keep their information confidential. We saw in staff meetings minutes that care staff had been reminded they must keep people's information in a confidential manner and there should be no discussing peoples business with others inside or outside the home.

Care staff told us how they promoted people's dignity and give them choice. They said, "We talk with people in a non-patronising manner and offer choice. They are adults, we adapt if there is a level of poor comprehension, but we still offer choice and support them to participate in the process. They could choose an outfit, voice their opinion. People can all vocalise which is great as we can act on that." And, "At breakfast I ask, what do you want? and do you want a shower or a bath? Or show me which clothes you want? One person she likes to choose her clothes we take her out and show her."

People's care plans contained information about how they communicated their wishes and contained information, so staff could understand what support they required. Comments in people's plans included, "Encourage [person's] independence," and "Be patient."

Good

Is the service responsive?

Our findings

People had person centred plans that included information about their background and their family. In one set of records there were lots of photos and personal information. This gave staff a good sense of the person and their former achievements. This was important as it helped staff to get to know the person and gave them topics for conversation. The care plans included people's diversity support information for example, their religion and what support they required to practice.

The manager told us the people living at the service currently were predominantly from one cultural background and religion. They supported their cultural and religious celebrations. However, they would welcome people from diverse backgrounds and would celebrate their festivals too and respect any observances that were required. They told us they, "Would expect staff to respect all people's diversity and if they were disrespectful it would be a disciplinary matter." Staff attended equal opportunity training as part of their induction. Following our inspection, the manager sent the provider's diversity policy statements and associated policies that were shared with staff to promote the provider's expectations that people's diversity support needs must be met by staff.

A senior care worker told us, "We would encourage any creed, we are totally unbiased in any shape or form. If they would like a certain diet or if they wanted support to go to their place of worship, we would arrange that. We would embrace their festivals. I would do some research as you need to educate yourself. I wouldn't want to do something disrespectful." They continued to talk about how they would support people from the lesbian, gay, bisexual and transgender plus community. "We wouldn't treat anyone differently if they had a different sexuality. If they wanted to go to Gay pride or similar we would support them. It would be their choice."

Care plans were reviewed regularly and in response to changing circumstances. Staff described spending time with people reading through the proposed changes with them to support them to understand. Care plans reviewed were signed by the person. We saw that changes to the care plan were shared with the staff group in shift handovers and team meetings.

People's care plans stated how they liked to be supported and if there was something important to the person for staff information. In one instance, a person's care plan recorded that they were proud of their personal appearance and liked to smell nice. Staff were instructed to always suggest to them to use their perfume. A senior care worker told us, "People have their own routines and we have to respect this." This was reflected in people's care plan.

People were mostly positive about the activities. One person said not much had taken place the week before, but the week of the inspection was better with a singer performing. There was a weekly programme of activities that people were encouraged to join in. This included, entertainment, games and quizzes. In addition, there was listed activities in October, these included, exercise sessions and games, a religious celebration, musical entertainment, Halloween crafts, an outing to Rickmansworth Aerodrome for tea, a sing-along of favourite songs and Halloween cake decorating. There was an activity co-ordinator and staff

joined in with ideas and support. There was a pleasant atmosphere in the home. This was because staff chatted and interacted well with people throughout the day. Music was played on occasion in the communal lounge and there was TV that some people liked to watch for example as they ate their supper. People were encouraged to undertake everyday living activities such as borrowing books from the bookcase and reading or planting flowers for the summer months. There was a 'post box' provided where people placed any mail to be posted, if they wanted to keep in touch with their relatives and friends.

The manager confirmed that at the time of our inspection no one was receiving end of life care. However, staff and the manager had received end of life training and had cared for people who had previously been living in the home. People had their end of life wishes recorded in their care plan. This included their preferred place of care at the end of their life, religious observations to take into consideration, what type of funeral service they wanted and, in some plans, where they wished this to take place.

People told us they felt able to raise concerns and they felt that they would be addressed. During our inspection we heard people raising concerns when something had not occurred as they would like and they clearly felt comfortable doing so. The provider had ensured information was displayed that informed people how to make a formal complaint and what to expect from the complaints process. The manager told us if people complained verbally, then if the complaints could be addressed immediately they would do so. Or if the person preferred they would support them to write a complaint. We saw complaints had been logged, acknowledged, investigated and addressed by the manager. Compliments were also recorded so staff could benefit from the positive feedback from satisfied people and their relatives.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to audit and check the quality of the service provided. However, we found some shortfalls in that the bathing facilities at the home were not always being utilised in an appropriate manner. The single bathroom was used as a storage area. The use of this facility to store equipment meant that staff had to remove a number of items before people could use the bathroom. We also identified that a first storey bedroom did not have window restrictors in place. Although, this had been recognised as an area that required attention, the concern had not been addressed at the time of our inspection.

Audits and checks took place. There was day to day checks that included medicines, handing over information and checking records were completed. Weekly checks included, fire alarm bells, a visual check of firefighting equipment, bed rails, running of taps in void areas to manage the risk of Legionella and hoist and slings checks. Monthly audits were undertaken and included a monthly maintenance checks, medicines, bed rails and mattress inspection, kitchen and people's care documents. There were six monthly and yearly checks that included an infection control audit, an environmental risk assessment and a fire risk assessment. Firefighting equipment was serviced on a yearly basis and staff had attended fire training and first aid training to assist in the event of an emergency.

Risks to people from the premises were graded as high, medium or low and actions to minimise the risks were stated. We saw that most actions had been undertaken or were in the process of being addressed. Where there may be a risk identified to a specific person and individual risk assessment was undertaken for that person. There was a fire emergency and contingency plan should a major incident occur. Yearly checks such as electrical appliance testing and gas checks and five yearly electrical installation had taken place. We noted that the water hygiene report was overdue. We brought this to the manager's attention and they sent us evidence after the inspection that they had made the provider aware of this oversight.

The manager had worked at the home as the team leader for many years and had been successful in their application in August 2018 to become the manager. They were familiar with the running of the home and knew the residents and their support needs well. The manager told us that the provider had been supportive during their change of roles. They said, "Yes in the transition period they have supported a lot." They had support from their area manager who visited the home on a regular basis.

Care staff told us they liked working in the home. Their comments included, "I really, really like it here, it is a lovely home and lovely ethos," and "It is really like my next family." All staff spoke positively about the manager. Care staff told us, "[Manager], is very, very good and enthusiastic. They have good leadership skills…more than capable, very thorough and has some excellent qualities," and "[manager] has just started. They are approachable and we can talk to them anytime." Bimonthly staff meetings had taken place and staff told us they could raise any issues at the meeting and they would be addressed.

We saw that senior care staff were given responsibility about daily, weekly and monthly checks and audits. They acted in a confident manner and benefitted from being involved in the day to day running of the home.

People told us they found the manager approachable and spoke warmly about the home and the service they received. There were regular resident's meetings. Topics included, welcoming new people, the fire procedure and confidentiality. We observed people went into the office to speak to the manager and felt able to contribute their views about how they wanted their care provided.

Abbeyfield Society are a national charity organisation that have 149 sheltered houses and 22 care homes across England. The home benefited from being part of their vision of providing housing and care homes to people and championing the needs of older people in care. They recently decided for James House to take younger adults aged 55 years and above. This was because they felt there are some people in that age bracket to whom they could offer a service.

The home was inspected by the local authority prior to the service. The manager told us they welcomed their input and found the process supportive. The manager liaised with other services and attended an Abbeyfield Society conference in August 2018. They explained this gave them the opportunity to network, learn about other services and hear about changes affecting the sector.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider did not always ensure that the premises were suitable for the purpose for which they were being used. Reg15(1)(c)