Malhotra Care Homes Limited

Abbey Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 November 2017 and was unannounced. A second day of inspection took place on 28 November 2017 which was announced. This is the first rated inspection of Abbey Court with the provider Malhotra Care Homes Limited.

Abbey Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Abbey Court is registered to accommodate 45 people in one adapted building over two floors. At the time of the inspection there were 37 people accommodated at Abbey Court.

The current manager had been in post for eight months at the time of the inspection and had made an application to register with the Commission. Since the dates of the inspection site visits their application has progressed and they became the registered manager on 11 December 2017.

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.

We completed an initial walk around of the home with the deputy manager and carried out a further walk around with the registered manager to look at how safe the premises were. We found goods were stored in the under stairs areas on two fire escapes however this did not compromise the evacuation route. Clinical and general waste bins were open and the waste storage area was unsecured. Action was taken immediately to rectify these concerns and we have received assurances from the provider that all concerns have been resolved.

We also found during lunch time that a hot-lock trolley used for keeping food hot presented a trip hazard for people. This had been identified by the compliance manager and a permanent solution sought however the immediate risk had not been mitigated.

We found some concerns in relation to record keeping which had not been identified through the providers quality assurance systems. These related to some care records and two peoples medicine records.

We have made a recommendation about the maintenance and upkeep of records.

Safeguarding concerns, accidents and incidents and complaints had been logged. Lessons learnt in relation to safeguarding's and complaints were recorded and had been used to improve practice.

Medicines were managed safely and a pharmacy auditor confirmed they had no concerns with regards to medicines management at Abbey Court.

End of life care was provided sensitively and with compassion. The deputy manager was very aware of the need to ensure family members, as well as the person, were supported at this difficult time.

Staff were able to spend time with people chatting and supporting them in a relaxed and friendly manner. Caring relationships were observed and people and relatives were complimentary about the approach of the staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Care documentation included information about people's personal history, their likes and dislikes, past jobs and significant people and events. This information was used to get to know people, to plan activities and to develop support strategies. Care plans were detailed and specific to the person.

Risks were assessed and managed effectively. We found one person did not have a risk assessment in place for choking and the deputy manager was proactive in ensuring this was completed.

People were supported with their nutritional and hydration needs. Staff were offered praise during the handover in relation to the support they offered people to maintain a healthy fluid intake. Where specialised advice and guidance was needed there was active involvement from the external healthcare professionals.

People and their families where appropriate, had been involved in the planning of their care.

Safe recruitment practices were followed and there were enough staff to meet people's needs. Supervisions with staff had been held regularly and annual appraisals were scheduled to be completed.

Relatives felt staff were well trained and able to meet the needs of their family member. A training matrix was in place and where gaps had been identified a plan was in place to ensure staff attended the required training.

Some activities were being provided however they were not well advertised as notice boards were not yet available due to the ongoing refurbishment. The environment was being developed to meet the needs of people living with a dementia.

Staff, people and relatives were complimentary of the management team and felt significant improvements had been made since the registered manager and deputy had been in post. Quality assurance systems were in place which evidenced that areas for improvement had been identified and that action had been taken to address these areas.

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.

We found some concerns in relation to health and safety which were addressed immediately.

Safe recruitment practices were followed and there were enough staff to meet people's needs.

Safeguarding was understood. Lessons were learnt and action taken to mitigate the risk of a reoccurrence.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Some staff required some training however a plan was in place to ensure staff attended all the required, and some supplementary training. People and relatives told us they thought staff had the skills needed to support people safely and appropriately.

The principles of the Mental Capacity Act (2005) were followed and best interest decisions were appropriately made and documented.

People were supported to maintain a healthy diet and where specialised guidance was needed this was sought and followed.

Is the service caring?

Good

The service was caring.

People, and their relatives, told us they were well cared for and could not fault the care they received.

We observed warm and engaging relationships between staff and people. Staff supported people in a dignified and respectful manner.

People were encouraged and supported to make decisions and be involved in their care planning wherever possible.

Is the service responsive?

Good

The service was responsive.

Care documentation including information about people's life history and this information was used to develop an understanding of the person and to build relationships.

Care records were detailed and specific to the person.

End of life was managed in a sensitive and compassionate manner.

Activities were provided but we saw limited evidence of the advertisement and provision of activities.

Complaints were investigated.

Is the service well-led?

Good

The service was well-led.

Relatives and staff told us the culture of the home was much improved since the registered manager had been in post.

Positive partnerships had been established with healthcare professionals. The home was part of the Vanguard Project which had developed relationships with dieticians.

Audits were completed on a regular basis and we could see that improvements were being made.

We have made a recommendation about record keeping.

Abbey Court

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 23 November 2017 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 28 November 2017 which was announced.

The inspection team was made up of two adult social care inspectors, a specialist advisor who was a nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority commissioning team, CCG and the safeguarding adult's team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with four people living at the service and seven relatives. We spoke with the registered manager, the deputy manager who was a nurse, the head of compliance, the interior designer and the estates manager. We also spoke with four care staff, the activities coordinator, a kitchen assistant, the handy man, a visiting GP and the pharmacy auditor.

We pathway tracked four people, including their care and medicine records. We reviewed six staff files including recruitment, supervision and training information. We shadowed the pharmacy audit and

reviewed records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

On day one of the inspection we completed a walk around of the premises with the deputy manager. We noted four nurse call bells were tied up in communal bathrooms. The registered manager said, "People can't use the nurse call bell so it hasn't been noted before." They went on to explain that none of the people living at Abbey Court were able to access the bathrooms without the support of staff. Risk assessments in relation to people being unable to use the nurse call system were completed.

We also identified that the under stair areas of fire exits were used as storage areas. We found items such as hoists, chairs, toilets, and pharmacy boxes were stored underneath the stairs. Whilst the items did not directly compromise the escape route inspectors did raise concerns. Items were removed immediately and assurances have been received from the provider that fire escape routes are not obstructed and that under stairs areas are not used as storage areas. We noted this was in place by the end of day one of our inspection.

We also noted the waste storage area was unlocked and accessible by people. The clinical waste bins were overflowing and also unlocked. These concerns were addressed by the handyman as soon as they were raised and long term action taken to minimise the risk of reoccurrence.
The registered manager explained, "It's being refurbished so I do at least a daily walk around and deal with concerns straight away due to the refurb." We asked if this was documented and was told it wasn't. The registered manager said, "I have daily catch ups with maintenance and nurses but it's not recorded unless it's major and made formal then it's recorded. People always know where they are at."

Health and safety checks were completed by the handy man. Water temperatures had been recorded on a separate sheet to the log book since June 2017. The handyman explained that this was because they were waiting for a new record book from Northumbrian Water. The electrical installation condition report had expired on 28 May 2017. We spoke with the estates manager about this who explained that due to the ongoing refurbishment the electrical installation condition report would be completed in January 2018 after the works had been completed. Certificates for minor electrical works were in place. An electrical safety risk assessment dated 30 April 2017 was shared with the commission. This detailed control measures to maintain electrical safety during the refurbishment. Confirmation has been received that an electrical installation condition report would be completed on 18 January 2018. A copy of this has been requested.

On day one of the inspection we observed lunch time on the second floor. A hot-lock serving trolley was used however the cable was stretched from inside the dining area to a socket on the main corridor. This presented a trip hazard. One person was observed to have approached the hot-lock trolley and had one leg either side of the cable. Inspectors intervened and alerted staff to the risk posed to the person. Care staff supported the person to safely negotiate the cable. We raised this with the compliance manager who said, "I've already raised that with the staff." They had arranged for the handyman to review the situation and a permanent solution had been sourced however the immediate risk had not been mitigated. Action had been taken to ensure its safe use by the end of the day.

Various environmental risk assessments were in place, such as legionella, the working environment, a fire risk assessment and control of substances hazardous to health (COSHH). Gas safety and lifting operations and lifting equipment regulations (LOLER) checks were also completed.

The kitchen extraction unit was serviced regularly and we saw evidence of this. The kitchen hygienic and tidy and Health and Safety information displayed. All kitchen staff were wearing hats and aprons. A kitchen assistant said, "They [management] fix anything we tell them about and we always clean as we go". We saw domestic staff cleaning the home on both floors on each day of the inspection.

People we spoke with told us they felt safe. One person said, "No one shouts at you." Another person said, "They are great with the hoist." A relative told us, "It's amazing here. I feel [family member] is safe here." They also said, "It's a major worry off my mind." Another relative said, "They do a cracking job, this is a home from home." The registered manager said, "We keep people safe by reviewing the safeguarding policy annually, team meetings, training and induction. We meet with staff and debrief and do lessons learnt."

A safeguarding file was in place and included a log of alerts. However we asked the registered manager to update it as the last entry was June 2017. Investigation reports were completed which included an outcome and recommendations to improve the quality of care. For example, nursing staff to check documentation daily.

Care staff were able to explain the safeguarding policy and what action they would take if they had a concern. One staff member said, "I've done a safeguarding course and we also have a protecting residents meeting. Staff discussed what they would do if they were unable to report the concern to management. One staff member said, "I would tell the Council and you [the Care Quality Commission]".

There had been one incident were a person had undone their lap belt and fallen from a chair. Action had been taken to minimise the risk of similar incidents happening again. Care staff explained a new care plan had been put in place which included ensuring there was always one member of staff with the person who was required to check the lap belt regularly. This was discussed with the deputy manager in relation to specialised lap belt guards which would also reduce the risk of reoccurrence.

The registered manager told us, "Lessons learnt are discussed in monthly managers meetings. They are shared with everyone in the meeting or emailed out." We asked the registered manager if we could review the minutes of the meetings and they said, "I don't keep them, I get them at the meeting but I don't keep them." The head of compliance emailed us redacted versions of the minutes following the inspection.

Any risks to people were assessed and measures put in place to minimise and manage the risk. We saw risk assessments had been completed in relation to moving and handling, mobility, falls, the use of bed rails, nutrition and hydration, continence, behaviour which may challenge others and skin integrity. Control measures included observations during the day and hourly observations overnight which were recorded. One person who had been assessed as being at risk of choking did not have a risk assessment in place. We raised this and received reassurances that it would be completed as an immediate priority.

Recognised tools were used to identify if people were at risk of skin damage and poor nutrition. The majority of assessments were reviewed monthly and reflected peoples current level of risk.

Accidents and incidents were logged using an accident book. A monthly analysis took place and we noted from May 2017 up to and including August 2017 it was noted that action was required about staff deployment. We spoke with the registered manager about the action that had been taken and why it had

been ongoing from May to August 2017. They said, "In May the night staff was increased so the document hasn't been updated."

The registered manager explained that they were currently supporting people whose behaviour was challenging to the service. One person was sleeping during the day and awake at night. The registered manager said they were making meals available for the person overnight in order to ensure their health and nutrition was maintained. They also explained they were looking into medicine administration at different times to fit with the person's day and night reversal.

Some incidents where people had displayed distressed and challenging behaviour towards staff was also recorded on accident forms in August and September 2017. We confirmed that the correct reporting system using behaviour forms was now in place.

The registered manager explained that staffing levels were calculated via the use of a dependency tool. The tool was completed monthly and provided a summary of the care needs of people at the home. This was used to ensure staff had the capacity and skills to be able to provide appropriate care. There were two nurses and nine or ten care staff available during the day, and one nurse and five care staff at night. This included one to one support for two people who had been assessed as needing one to one staffing between day time hours of 0800am to 2000pm. Rotas confirmed this level of staffing was maintained, with the occasional use of agency staff.

When asked if there were enough staff one person said, "Oh Aye. All of the time." One person said, "It would be better if there was more staff, especially when staff are on holiday or ring in sick and on a night time." A staff member said, "There's enough here to make sure everyone is looked after."

Our observations were that there were enough staff to meet people's needs. Staff were attentive to people and when people were spending time in their rooms, or were being cared for in bed staff and ancillary staff were seen to pop in and say hello to people and make sure their needs were being met.

Safe recruitment practices were followed and included an application form and interview followed by the receipt of satisfactory references and Disclosure and Barring Service checks (DBS). DBS checks are used to enable employers to identify people with a criminal record and make appropriate decisions to ensure only suitable people are employed to work with vulnerable adults and children. Where it had been identified on a DBS check that people had prior convictions risk assessments were completed to assess the appropriateness of employment.

Nurse PIN checks were completed every month to ensure nurse registrations were up to date and DBS checks were renewed every three years. If agency staff were used profiles were received from the agency, which included information on their training, DBS check and PIN if they were a nurse. This meant the registered manager could ensure staff had the appropriate training to meet people's needs.

We reviewed how medicines were managed. A relative said, "They get their medication on time," We observed staff explain to people what medicine they were taking and why. People were offered a drink with their medicines and given the support and time they needed to take their medicines. Staff also checked that all medicines had been taken.

Systems were in place to ensure medicines had been ordered, received, stored, administered and disposed of appropriately. Protocols were in place for the administration of 'when required' medicines. Protocols were detailed; however, for two people they did not record the interval of time that was required between

doses. We raised this with the deputy manager who said they would seek clarification from the prescribing doctor. We have received confirmation that advice was sought from the link GP for Abbey Court.

Medicines which required cool storage were stored within a fridge. Daily temperature checks were completed and were within the required range. The treatment room temperature was recorded and was within recommended limits which meant medicines were stored appropriately.

Some prescription medicines are controlled under the Misuse of Drugs because they are liable to misuse. These are known as controlled drugs. These were stored and administered appropriately and staff knew the required procedures for managing controlled drugs. It was noted there were no doom kits available for the destruction of controlled drugs however the pharmacy were going to provide them.

During the inspection the pharmacy were completing an audit. The auditor told us, "I'm happy and have no concerns."

Medicine administration records (MARs) were used appropriately to show people had taken their medicines. The reverse of the MAR was used to record the time and reason for 'as and when required' medicines. Topical medicine administration records (TMARs) were used to record the application of prescribed creams. If a medicine was administered as a patch a system was in place for recording the site of application. This is important as because the application site needs to be rotated to prevent skin damage.

Good

Is the service effective?

Our findings

We looked at how people's needs and choices were assessed and how care, treatment and support was delivered. People's needs and preferences were included within care documentation which meant people's choices were documented.

People and relatives told us they thought the staff were well trained to meet their needs or their family member's needs. One relative said, "Everyone is well trained." They added, "There are lots of good staff in now. When we changed hands things took a dip and a lot of good staff left but there's nowhere near as many agency staff in now. Good staff have been taken on." Another relative said "I wouldn't change any of them," and "The atmosphere here is great." A third relative said, "They are well trained and willing to learn as well as."

A staff member said, "I am supported and we have the best management and staff so we have happy residents". Another staff member said they received regular supervision. They said, "I am supported at work and personally."

A supervision matrix was in place which evidenced supervisions were held six times a year. Discussions were held about the standard of work, health and safety issues, training and actions for the next supervision. Annual appraisals had not yet been completed as they were not yet due.

We discussed training with the registered manager who said, "We do safeguarding training, dignity training, equality and diversity." A training matrix was in place which evidenced the need for additional training in areas such as safeguarding, dignity, nutrition, dementia care, end of life care, challenging behaviour, mental capacity and deprivation of liberty safeguards and care planning. We discussed this with the registered manager and the head of compliance. They shared with us a training plan which included most of the areas where staff required training other than mental capacity and deprivation of liberty safeguards. Confirmation was received verbally that this training was being rolled out by the head of compliance; we were able to confirm this by looking at the minutes of management meetings.

Nurse competencies were not detailed on the training matrix but we received confirmation from the registered manager that nurses had been trained in the administration of medicines and the use of Percutaneous Endoscopic Gastrostomy tubes (PEGs). PEGs are specialist feeding tubes used by some people who are unable to eat orally. A new training matrix had been developed which included nurse competencies. This was in the process of being updated and implemented. Training had also been confirmed for nursing staff to attend pressure care, catheter care and syringe driver training.

New staff who had no experience of working in health and social care were completing the care certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

During the handover the nurse held a small meeting with the newer care staff to see how they were and how

thigs were going in relation to the support people needed. They discussed how the day would work in relation to allocating staff roles, whilst also ensuring staff knew what was required of them. Meal times were also discussed in relation to how best to support people.

One relative said, "[Family member] is well fed and well looked after and happy so I'm happy. Everyone is happy." There was a set menu but if people had a specific request for a meal, such as an omelette this was accommodated. There were enough staff available to support people if they needed one to one support with their meal and people were offered a variety of hot and cold drinks during meal times. People were offered the time they needed and wanted to enjoy their meal and no one was rushed. We observed staff showed people the meal choices which meant they could see and smell the food when making their choices. This was particularly supportive for those people living with a dementia related condition.

Where people received support with food and nutrition, monitoring was in place to minimise the risk of malnutrition and dehydration. All food and fluid charts were fully completed and analysed which evidenced effective monitoring. Action was taken as required if people's intake was low. For example, it had been recommended for one person to receive their meals at night as this was when they were most active. Things such as additional sources of protein and milkshakes between meals had also been recommended in order to maintain people's weight and minimise the risk of weight loss.

If specialised support with regards to food and fluid was needed, speech and language therapy (SALT) had been involved. The registered manager explained that it had been recognised that one person with highly specialised needs displayed some impulsivity with regards to food and fluid which placed them at risk. Consultation had happened with the person, their family and their doctor with regards to comfort eating. It had been agreed through best interest decisions that comfort eating would be an appropriate strategy to follow as this meant the person could enjoy small tasters of food and sips of fluid which would reduce their impulsivity whilst allowing them some comfort.

The registered manager explained that where people required a pureed diet, food moulds were used. This meant food was presented in an attractive way and looked like the actual meal people were being served. This encouraged people to eat and helped people achieve a healthy diet.

We observed a handover in which detailed information was shared in relation to each person and how their health was at the time. If a referral or discussion with other healthcare professionals was needed this was noted to be addressed. Staff were praised by the deputy manager for their support in encouraging people with food and fluids and staff spoke about people in a caring manner. The nurse was able to share their knowledge about making decisions in people's best interest when they lacked capacity and was very clear when care plans needed to be written or evaluated.

Documents were in place which accompanied people if they were transferred to another setting such as the hospital. This meant the hospital staff received vital information about the person to support consistency of care and treatment.

A relative said, "There are regular dentists, chiropodist and optician visits." A visiting GP said, "Ward rounds are organised, staff have ideas and contribute to the functioning of the round. I couldn't ask for more, we have a good hour and a half each Wednesday, we meet relatives and it works well."

Care records showed details of appointments with, and visits by, various health and social care professions. For example, GP's, psychiatrists, social workers, dieticians, speech and language therapists (SALT) and tissue viability nurses (TVN). Care plans reflected the advice and guidance provided to ensure people's current

needs were appropriately met.

The registered manager explained that Abbey Court was undergoing refurbishment. The majority of the building had been refitted with new furniture and equipment and had been redecorated. We noted the environment was not specific to the needs of people living with a dementia. We spoke with the interior designer and estates manager about this. The interior designer said, "We are in the process of finalising the art work for communal areas, looking at reminiscence, people's interests and hobbies. We are also looking at memory boxes for bedrooms to support people to recognise their rooms." The estates manager explained that the specific lighting had been chosen to support people as the lights in bathrooms and toilets were motion activated. Specialist baths and raised toilets had been installed. Lounges and dining areas now included tea making points and additional nurse call points had been added. The outdoor space was also being updated with sensory gardens and fixed seating for people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

For some people DoLS applications were not necessary. For others applications had been submitted to the supervisory body for authorisation. We noted for one person their DoLS authorisation had expired. The deputy manager addressed this during the inspection and confirmed to us that a further application had been made that day.

Mental capacity assessments had been completed to ascertain whether or not people had the capacity to make particular decisions. For example, the use of bed rails, smoking and comfort food when there was a risk of choking. If it was identified that people lacked the capacity to make the decision, best interest decisions were made on their behalf. The decision making process included the person, any significant people in their lives, staff from the home, and any medical or health care professionals if appropriate. This meant people's rights to make particular decisions had been upheld and their freedom to make decisions maximised as unnecessary restrictions had not been placed upon them.

There were some decisions which had been made by a previous manager that were not decision specific, and had not been made with the involvement of appropriate people. These decisions had not been reviewed, nor had it been identified that they were not in line with the mental capacity act 2005 code of practice. We raised this with the registered manager and the head of compliance who stated, "They need to be taken out and updated. We will do it now."

Good

Is the service caring?

Our findings

People who lived at the home said they were well cared for and comments included, "Nothing seems too much trouble for them," and "They wash me but try to keep me independent, they are kind and chat to me. If there are any problems I speak up for myself but there are no problems!" People also told us staff were very kind. One relative said, "I think the standard of care here is excellent." They explained how "wonderful" the staff were to their family member and themselves. Another relative said, "The staff are kind but [family member] only trusts her family." Another told us, "I can't fault the staff. [Family member] can't do anything for herself and she is washed regularly, they are very kind, patient and gentle." We were also told by a person, "It's amazing." One staff member said, "It's a pleasure to come to work knowing you are making someone's life better. Even in a small way."

We observed positive interactions between staff, people and their visitors. People seemed relaxed and comfortable with staff and the staff chatted and seemed to really enjoy helping everyone. Care staff supported people to make decisions, such as choosing what they wanted to eat and drink. They then offered the appropriate support to enable people to enjoy their meal, snack or drink. One care worker said, "Would you like another one of your favourite ones [biscuits]." The person smiled and hugged the staff member's arm as they were given the additional biscuit.

People were treated with dignity and personal care was provided in a discrete and respectful manner. Care staff spent time with people, taking an interest in what they were doing and engaging them in activities. One person was looking at magazines with a care worker whilst they spoke about the pictures. Another staff member asked a person if they would like to decorate the Christmas tree for the home. The person was very happy at this and clapped their hands and smiled.

We observed one person who tried to get out of their seat whilst the three staff members were serving people tea and coffee. A member of staff helped the person back to their chair and placed a small table in front of them upon which they placed their drink and biscuits. By placing the table in front of the person, rather than to the side it restricted their movement so they couldn't stand up. We raised this with the registered manager and the deputy manager who explained the member of staff was new in post and they would have a discussion during the staff member's supervision.

During meal times staff chatted with people while they waited for their food to be served. People were encouraged and prompted with their meals, with staff comments including, "Have a little taste," "You're doing really well, have a drink to refresh your mouth." We observed staff supporting people to ensure they were close enough to the table to eat their meal comfortably and when one person needed some support the staff member asked, "Would you like me to help you get started." The deputy manager told us, "The designer had been to the service and we are waiting for the dining room to be refurbished."

People were supported and encouraged to express their views on a day to day basis during meal times and personal care. People and their family members, had, where possible been involved in developing care plans and documenting people's life history and preferences. Reviews were held on a regular basis, with the

involvement of people and their families. Care plan documentation was signed by the person, if they were able to do so, or by relatives if they had been involved. No one currently needed the support of an advocate, but the registered manager was in the process of discussing this with regards to one person.

Good

Is the service responsive?

Our findings

People and relatives we spoke with were happy that the staff knew what care they needed. One relative said, "In an ideal world all care would be one to one but the staff are excellent. They hold his hand and he goes to sleep, he needs human contact, they are marvellous." One staff member said, "[Person] can get upset and because she can't communicate to us she screams and points to where she wants to go. I hold her hand and push her (in her bespoke chair) to where she likes to go. I know she likes to watch in the kitchen, so I take her to watch through the hatch and she smiles".

Pre-admission assessments were completed so people's needs had been assessed before they moved into the home. This meant staff could meet people's needs and the home had any necessary equipment to ensure the people's safety and comfort.

Following the initial assessment care plans were developed for people's needs such as physical well-being, diet, mobility and personal hygiene. There was specific information about how people's needs should be met and the frequency of specific interventions was recorded.

Care plans in relation to wound care were specific and the treatment plans were clear, detailed and documented a description of the wound, the healing progress was recorded together with action to take should there be any deterioration. Care plans evidenced support from the tissue Viability nurse in assessing skin conditions and providing specialist support in relation to care and pressure relieving equipment to minimise risk.

Communication care plans were in place and were specific to the person. There was detailed information on how to engage with the person and how to involve them with decision making and interaction. For one person, it was recorded that their speech could be difficult to understand at times. It stated that they did not like to repeat themselves more than twice and could present with some behaviour which staff found challenging. There were no strategies to follow should the person have repeated themselves twice with staff still not understanding their communication. We raised this with the deputy manager and registered manager who said they would think about the action to take. Our observations were that staff who knew the person well were able to understand their communication and responded appropriately.

When it had been identified that people could present with behaviour that may challenge others care plans were completed. They identified triggers for the behaviour, alongside information on why the person may be distressed. For example, pain, feeling unwell or being over stimulated. Staff were directed to offer support by offering the person time, using verbal and nonverbal cues to support communication and express that they were listening and understanding.

The majority of care plans were reviewed and updated on a monthly basis to ensure they were up to date. Daily communication notes were kept for each person which contained a summary of the support delivered and any changes to the person's preferences or needs. This ensured information was up to date in related to how people wanted, and needed, to be supported.

Care documentation included information on what was important to the person, such as their family, previous pets and places of significance. There was also information on how best to support people. This was specific to the person and included detail on specific times or events the person found distressing and how to reassure them if they were upset or anxious, for example by going for a walk or sitting holding their hand and talking or listening to specific music. There was also information on the person's preferences and their previous jobs and how this influenced them now.

Social profiles were used to detail people's life histories and things that were important to them. This meant staff who had not supported the person before could familiarise themselves with them.

The activities co-ordinator explained that they tried to get people out as much as possible. They said, "People need fresh air, we are currently waiting for a driver for our mini bus." They added, "We have mainly been doing activities through trial and error to see what works and what doesn't. We make biscuits and crispy cakes, bounce balloons. We wash and dress dolls and I bring a dog in for them to stroke." They added, "To be honest a lot of our activities are on a one to one basis." They also said, "I even wash hair and style it to help out." We were also told about involvement from the Church, visiting entertainers once a month and 'Rookie Sports'. This is a community organisation which visited and engaged people with games of golf. There were also plans to arrange gentle exercise sessions.

During the inspection we noted there were no advertised activities so people could not see what was available or planned for that day. The registered manager and head of compliance explained that they were waiting for notice boards to be put up. They felt that once this was completed and activities could be displayed it would generate more enthusiasm and interest. The registered manager also said they had raised activities with the activities co-ordinators. We saw this was recorded within meeting minutes.

A complaints file was in place and complaints had been investigated to the satisfaction of complainants. One person said, "If there are any problems I speak up for myself but there are no problems!" A relative said, "I don't have any problems." Another said, "I don't have any problems to discuss, because if I did I would see [registered manager or deputy manager] and it would be sorted immediately." One relative said, "Occasionally you might get wrong clothes from the laundry but that's a niggle not a problem and with name tags on it's easily sorted." One complaint was ongoing as it involved an agency worker and the registered manager was going to follow up on the action taken by the agency. For other complaints, lessons learnt were recorded such as, reflective practices with regards to speaking with relatives at the time of bereavement. It was also noted that palliative care training was being put in place. We asked to see evidence of the reflective practices and the registered manager said, "I don't think they have been documented." They later said they thought it had been recorded in the minutes of the nurse meetings.

Compliments were recorded and included thank you cards and a letter. Relatives and visitors had made comments such as, 'Staff gave care and dignity he deserved,' and 'Thank you for the help and guidance during bereavement' and 'Thank you for the care and dignity you gave.'

One relative spoke with us about the care provided by staff after their loved one had passed away. They said, "Their after care service is beyond reproach, six of them even came to the funeral!"
We were also told, "They were so helpful in the last few weeks of my [loved one's] life. To be honest they were a Godsend and now they are so helpful to me trying to help me through my grief and if that isn't work above and beyond the call of duty I don't know what is!"

The registered manager said, "We provide family support for end of life care, it's emotional support, it's about the whole person and the family, my doors always open, it's inclusive. We talk to family, keep them

informed of what's happening, asking do they want to stay, and we provide food." They added, "We have information available, the end of life policy on bereavement. We also work with NHS documentation. We are training the nurses."

We observed a handover during which time the nurse leading the handover explained the expectations when staff where caring for someone nearing the end of their life. This was completed with respect and compassion for the person and their family, whilst also informing care staff of their role and responsibility. The nurse was also very conscious of their need to be available to support the person, their family and the staff.

End of life care plans were completed, where appropriate, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Good

Is the service well-led?

Our findings

The manager had been in post since March 2017 and had applied to the Commission to be the registered manager. Since the inspection site visits their application progressed and they became the registered manager on 11 December 2017. They were aware of their responsibilities and accountabilities. They described their role as being to support and develop the team, address practice, be supportive and identify training issues. They said, "I see myself as a nurturing manager, I enjoy it and am good at it." They explained there was some involvement from staff, people and their relatives in relation to the décor and the environment. They were planning to send quality assurance surveys outs for feedback in the near future.

We discussed health and safety with the registered manager and the compliance manager. The registered manager told us that daily walk arounds were completed, but not recorded. This meant there was no log of their findings and therefore no audit trail in relation to any concerns and action taken to address them.

The head of compliance advised that ten percent of care plans were audited on a rolling monthly basis. We found audits had been completed and improvements made to those records that had been audited. However, we found one person who had been assessed as at risk of choking who did not have a choking risk assessment and we also found some care plans had been missed in relation to a monthly evaluation.

Medicines were administered safely however there were some recording concerns. The interval of time required between the administration of 'as required' medicine for two people was not recorded.

Analysis of accidents and incidents had been effective in identifying the need for a review of staff deployment. Positive action had been taken and staffing levels overnight had been increased. However the action taken had not been recorded and the concerns remained on the analysis from May 2017 to August 2017.

Action plans were completed at the time of the audit. However they were not always fully completed in terms of recording who was responsible for the action, the timeframe for completion and when it had been completed. On reviewing documentation we did see that the actions had been completed. We noted there was no signature on the audit of the person completing the actions.

Whilst there was no evidence that the gaps in recording we identified had resulted in a direct impact on people. There was the potential for impact, for example, in relation to the risk of choking, care plans not being updated in light of changing need and the possibility of administering medicines too frequently for two people.

We recommend the provider reviews the systems for ensuring records are up to date and accurate.

A range of audits had been completed on a monthly basis including catering and nutrition audits, pressure sore audits, medicine audits and care plan audits. A scoring system was used to evidence compliance and areas requiring improvement and we could see that scores had increased over the months they had been

completed. This was reflective of the improvements being made.

The head of compliance had produced action plans which were shared with us. An action plan from March 2017 indicated improvements were needed in areas such as medicine management, the completion of audits and training. Actions had been documented when completed and we saw most areas had been met and were continuing to be monitored. A more recent action plan dated 26 October 2017 reflected the areas where further improvements were ongoing and all actions had a responsible person identified and a timeframe for completion.

All of the relatives had positive things to say. One relative said, "Yes it's well led." One relative said, "The whole place has been decorated and totally revamped. If I was boss I wouldn't change anything, last year I would have changed everything!" Another said, "Oh I think so, they are so much better organised now than before the take-over, there is a marked improvement." Care staff said that there had been a positive effect on the culture and care provided since the registered manager and deputy manager had started working at the home. One care worker said, "I am supported and we have the best management and staff so we have happy residents." Another described their experience when first working at the home and the changes that the new management team had put in place. They said, "I am supported at work and personally."

We spoke with the registered manager about the quality of the service and how this was improving and being maintained. They explained that a full refurbishment of Abbey Court was taking place. This included the interior and exterior of the building, all bedrooms and ensuites as well as communal areas. They told us one of the key challenges was in improving the quality and sustainability of Abbey Court. They explained the culture when they first joined the home as being unhealthy. They explained there were lots of issues with the standard of care, staff approach, training, support, supervision and recruitment which had now been resolved. It was explained how they had maintained a regular presence during the early months of change, including weekends, bank holidays and overnight. This supported change as they were able to lead by example, ensure safety and good working practices whilst also getting to know people, their relatives and the staff.

The registered manager said, "The vast majority of the staff team are new, there are some longstanding staff who have moved with us and want to work to our standards but others didn't." They added, "We are on the way up, there's a good atmosphere. It's a work in progress but I like coming to work and am proud to say it's my home."

When we asked about the governance framework they told us there was no set framework, but they did audits, meetings, and provider audits completed by the head of compliance. A quality assurance policy was in place which included information on the frequency of various audits and meetings.

We saw various meetings were held, including staff meetings, nurse meetings and activity meetings. Discussions included updating knowledge and information in relation to pressure care management as well as sharing information in relation to recruitment, improvements, safeguarding, reflective practice and training. Meetings with activity coordinators included conversations about planning future events.

Relatives and residents meetings were organised however no one had attended the October meeting. The previous meeting had included information on the refurbishment, use of agency staff and ongoing recruitment activity and a presentation on the pureed food moulds that were available should people need a pureed diet.

Management meetings had been held and discussions included the induction of agency staff, training and

recruitment. Reminders about new procedures and sharing of information from the management board had been shared.

The registered manager said, "We have a really good senior management meeting, there's time to discuss things, from CQC, quality assurance meetings, safeguarding's, near misses. There's good peer support. New policies are sent out and shared with staff to read." A nurse told us, "The nurse assistant practitioner is a godsend, really useful to have and better than any bank nurse as they know everyone well." They added, "We are supported really well, [registered manager] has an open door policy, we have the best two heads of care, they are supportive, at our level and have empathy, they offer help and support."

We asked the registered manager about partnership working. They said, "We are part of the Vanguard project which has been really beneficial, we've had nutrition training and are part of the pilot to put forward a business case for a dietician in Newcastle." There was a clear focus within handover meetings in ensuring people had received appropriate nutrition and hydration. The registered manager also told us they were a member of the Alzheimer's Society and often shared their fact sheets with family members in order to support their understanding when a loved one was living with a dementia.