Abbeyfield Society (The)

Abbeyfield Winnersh

Inspection report

Woodward Close
Winnersh
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19 September 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 19 September 2017 and was unannounced. Abbeyfield Winnersh is a purpose built residential care home for older people who all have some degree of dementia. The home is arranged over two floors with en-suite bedrooms on both floors and communal areas comprising of dining areas, lounges, quiet rooms a cinema, library and a hair dressing salon. It can provide accommodation and personal care for up to sixty two people at any one time. On the day of the inspection forty four people were living in the service of which one was in hospital.

The service was registered on 3rd August 2016. This was the first comprehensive inspection since the home opened. At the time of the inspection there was no registered manager in post. The previous registered manager had left in April 2017 following concerns raised about the quality of the care provided. The current manager was temporary pending the recruitment of a registered manager. During the inspection we were informed that an appointment had been made and the new manager would take up the position once their notice period had been completed. 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.

The home had experienced difficulties with establishing an effective management presence from the point of registration and subsequent opening. It only became apparent that the registered manager had been struggling with their responsibilities when a number of safeguarding concerns had come to the attention of the local authority. The business manager who was the former line manager to the home took on the position of interim manager when the registered manager left in April 2017. A permanent manager was appointed in May but left within a few weeks. The interim manager has been a constant and stable presence in the home during this period of time. There was evidence of considerable improvement in all areas under their direction. Whilst the home is rated requirements improvement overall the inspection team had confidence that the developments and improvements seen would continue. The rating of requirements improvement in the well led domain is an acknowledgement of the work still to be undertaken and not a reflection of the interim manager's performance.

The provider completed thorough recruitment checks on potential members of staff. Maintenance and checks of the property and equipment were carried out promptly and within required timescales. Checks on fire alarms and emergency lighting had been completed in accordance with the provider's policy and manufacturer's instructions. There was a system to ensure people received their medicines safely and appropriately. The provider had plans in place to deal with emergencies that may arise.

People who use the service were able to give their views about the quality of the care provided. The majority of relatives, community professionals and commissioners told us they were happy with the service provided by Abbeyfield Winnersh and felt that people were safe using the service. The service had systems in place to manage risks to both people and staff. However, there was still work to be undertaken to eliminate

inconsistencies in recording. Staff were aware of how to keep people safe by reporting concerns promptly through procedures they understood. Information and guidance was available for them to use if they had any concerns.

People were treated with kindness, dignity and compassion. They were respected and had their privacy and dignity maintained by staff who understood these principles. People and staff interacted in a positive manner, choices were offered and explanations provided when staff supported people with daily living activities. There was a relaxed and friendly atmosphere and we saw people laughing and smiling with staff as they went about their daily routines. Visitors were welcomed at the service. There were no restrictions on visiting times and people were encouraged to maintain relationships important to them.

People's right to make decisions was protected. They were involved in decisions about their care as far as they were able. Staff understood their responsibilities in relation to gaining consent before providing support and care. Some relatives/representatives told us they had been asked for their views on the care provided whilst others felt that the lack of communication was an important issue. People's care and support needs were reviewed but this was not always consistently applied. The manager had ensured that up to date information was communicated promptly to staff through briefings and regular group supervision meetings.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. When people's freedom had been restricted for their own safety appropriate authorisations were in place under the Deprivation of Liberty Safeguards. There was a programme in place to ensure that all those people who lacked mental capacity and may require restrictions on their freedoms had applications in progress. People had a choice of food and drink which they enjoyed. When necessary their nutrition was monitored to help ensure their well-being. People now received appropriate health care support from health and social care professionals who were contacted promptly when necessary.

Staff felt supported and they praised the manager for the support she provided and said they were listened to if they raised concerns and action was taken without delay. There was a programme of training in place to ensure that staff acquired the skills necessary for their role. New staff received a comprehensive induction and training in core topics. We found an open culture in the service and staff were confident to approach the manager or any member of the management team for advice and guidance.

The manager had a clear vision to improve the service and they were held in high regard by the staff team who valued their leadership. The quality of the service was monitored by the manager however, the provider's comprehensive quality assurance process was not planned to be fully implemented until all identified improvements had been made and fully embedded. This included feedback surveys for all interested parties.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe in most respects.

Individual risks were assessed but monitoring and recording sometimes provided conflicting information.

Recruitment procedures were robust and protected people.

Testing of fire equipment was carried out in accordance with policy and essential maintenance of the property was completed promptly.

There were risk assessments for the building and equipment in place.

There were sufficient suitably skilled and experienced staff to meet people's needs. Medicines were managed safely.

Staff demonstrated a good knowledge of safeguarding procedures and reporting requirements. The provider had plans in place to manage emergencies.

Is the service effective?

Requires Improvement

The service was not always as effective as it could be in relation to meeting people's needs as required.

People were supported by staff who were in the process of receiving relevant training and updates to enable them to meet their needs. Staff were now meeting regularly with each other for support and to discuss any concerns.

People's right to make decisions about their care was upheld by staff who understood their responsibilities in relation to gaining consent and mental capacity.

People were supported to be healthy and have enough to eat and drink in order to maintain a balanced diet.

Is the service caring?

Good

The service is caring.

We observed and we were told that people were treated with kindness and respect. People were encouraged and supported to maintain their independence as far as possible.

People's privacy and dignity were maintained and they were involved in their care. Regular staff knew people's individual needs and preferences well.

Is the service responsive?

Good

The service is responsive.

People's needs were assessed regularly. In most instances they and their relatives, where appropriate, were involved in planning their care.

People were offered choices and their decision was respected. People were supported in ways which took account of their wishes and preferences.

Information on how to make a complaint or raise a concern was readily available.

Is the service well-led?

Requires Improvement

The service is well-led whilst it was acknowledged that improvements still need to be made.

There was an open and inclusive culture in the service. People responded well to the manager and senior staff.

Staff and the majority of relatives told us they found the manager approachable and said she listened to them.

The quality of the service was being monitored and further monitoring by the provider was planned. Staff had opportunities to say how the service could be improved and raise concerns if necessary.

People had opportunities to maintain links with the community.

Abbeyfield Winnersh

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.

The inspection was carried out by three inspectors (one half day) on 14 September 2017 and one inspector on 19 September 2017. This was the first inspection of the service since it was registered on 3 August 2016. The visit was unannounced and was a comprehensive inspection.

We checked notifications we had received. Notifications are sent to the Care Quality Commission by the service to inform us of important events that relate to the service. We contacted the safeguarding and the quality and performance teams at the local authority and requested feedback from other professionals with knowledge of the service.

During the inspection we spoke with eighteen members of staff in private, including the interim manager, a visiting business manager who was providing regular weekly support to the home, the chef, house keeper, the administrator, five senior care staff and eight care staff. We were able to obtain feedback from people who used the service and spoke with four people in private. We spoke with four relatives at the home about the quality of the service that was provided for their family member and received email feedback from an additional fifteen relatives. We spoke with three professionals whilst they were visiting the home, received email feedback from one commissioner and reports from the local authority care governance quality team. We observed the lunch time activity of the service and saw people taking part in group and individual activities. We observed staff supporting people throughout the course of the inspection.

We reviewed the care plans and associated records for five people receiving a service. We examined a sample of other records relating to the management of the service including staff training, health and safety, complaints and various monitoring and audit tools. We looked at the recruitment procedures which were used to appoint staff within the home.

Requires Improvement

Is the service safe?

Our findings

There was evidence that changes in procedures and staff training had improved the overall safety within the home and for the people living there. However, there were remaining concerns from the local authority care governance team and some relatives that there were still areas requiring improvement to ensure the safety of everyone at all times. Out of the nineteen relatives we received information from, fifteen felt that their family member was safe in the home. The remainder thought that monitoring and communicating issues should be improved. Some examples of the positive comments included, "I did feel that Mum was safe and she was always treated with respect." And, "As to safety, I have had no concerns. I believe my mother is very safe there." And, "I think that Abbeyfield allow my mother the correct balance of freedom and safety, which allows her to retain some independence." For those relatives who were less confident about the safety of their family member earlier experiences of what was described as a "chaotic and neglectful" approach had left a lasting impression. For a small number of relatives errors and omissions were still occurring and until such time as this was better managed and ceased altogether they remained concerned about the welfare of their family member.

Risk assessments were completed and provided some guidance for staff on reducing the identified risks relating to the provision of care for people. However, some risk assessments were embedded within other documents. For example, we saw one care plan where anxiety and challenging behaviour was incorporated into the moving and handling risk assessment. However, in discussion with staff it was apparent that there was no issue with the expression of anxiety or challenging behaviour whilst assisting this person with moving and handling. This would suggest that there was confusion around the purpose of the document. The risk of generalised anxiety and challenging behaviour could have been more clearly reflected in a separate dedicated risk assessment and management plan. This lack of clarity had the potential to misdirect staff. This was particularly the case for those staff not familiar with the person's needs in relation to when and in what circumstances they should anticipate and manage their anxiety and/or challenging behaviour. In another example, we observed a person becoming agitated and accused a fellow resident of having an affair. She persisted in her accusation whilst staff seemed unaware of how to deflect the conversation. We checked the person's file and found that whilst it mentioned she may be challenging there was no risk assessment in place to safeguard others.

We were told that risk assessments were graded and then set against a guide that provided an indication of the seriousness of the risk. For example, the risk of falls would take account of the past number of falls, their frequency and the potential for them occurring in the future. This would then indicate a potential management plan to reduce the risk. This supported an 'at a glance' evaluation of the level of risk which staff could quickly access. We were also made aware that a process of risk assessing mobility and use of aids for all affected individuals had commenced.

Care plans were being reviewed regularly and updated as required. However, those care plans seen were hand written with updates added to the bottom of each sub-section which could run to several pages. Staff were expected to read several pages within each section in order to find the most relevant and up to date information. This method of updating carries a potential risk of people not receiving the most appropriate

and up to date care. For one person who was receiving end of life care we noted that the care plan was not clear. We saw that sections had been amended on 13/09/2017 (one day previously) to state that the person was able to access communal areas and was able to dress herself with prompts. We checked with the senior carer on shift (who subsequently checked with care staff), whether this was an accurate reflection of the person. We were told this information was not accurate and did not reflect the person's needs as this person was unable to move and required full assistance. However, there was no indication this inaccuracy had adversely impacted on this person's wellbeing. Nevertheless, it was concerning given the person's stage in life.

We were told by the manager that all care plans were subject to review. They were to be transferred to a more appropriate format which would reduce the incidence of inaccurate recording and support swift access to relevant information. We were told this work was on hold until the latest local authority quality review had been completed and approval for the new care plan formats had been given by them. Overall we found that the detail and accuracy across the older style care plans was varied with the new style care plans providing more detailed and personalised guidance. In discussion with staff, it was apparent that in most instances they were familiar with the needs of people in their care. We noted that each person had a personal emergency evacuation plan in place.

Staff we spoke with were knowledgeable with regard to safeguarding people and their responsibilities to report any concerns. They described unexplained bruising and changes in people's behaviour as examples that would raise concern. One said, "It's important to follow policy and procedure, I know how to raise safeguarding with the local authority and I'm not afraid to do so." Staff also had an awareness of the whistleblowing procedures and how to use them. Staff were confident they would be taken seriously if they raised concerns with the management. We saw from the service's safeguarding records that any allegations they raised were taken seriously. Incidents were reported to the local authority safeguarding team and also notified to the Care Quality Commission (CQC) as required. The local authority safeguarding/quality team representatives told us that there had been occasions where the service had failed to alert them to safeguarding concerns. However, on closer examination it appeared that some of the incidents referred to did not meet the local authority's published safeguarding alert thresholds. We noted from the training record that 24 staff were booked onto safeguarding training in early October and of these eight were ancillary staff.

Risk assessments relating to the health and safety of the service and the premises were detailed. We saw that there were controls in place such as radiator covers and window restrictors. Regular checks were carried out to test the safety of such things as water temperature, legionella, gas appliances and electrical equipment. The fire detection system and the fire extinguishers had been tested in accordance with manufacturer's guidance and as recommended in health and safety policies. A fire risk assessment for the buildings was in place and had become due for review in July 2017. The maintenance person undertook to update this document as a matter of priority. Additional training for the maintenance person included legionella management and water temperature monitoring including when temperature management valves were installed. Walk through fire drills were conducted twice each year and involved staff acting as residents. These were arranged at different times of the day to ensure that all staff and people living in the home experienced evacuation procedures over a range of times and circumstances. The maintenance person undertook to record the attendance of staff involved in each drill.

Recruitment practices helped to ensure people were supported by staff who were of appropriate character. Disclosure and Barring Service (DBS) checks were completed to ensure that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. References from previous employers were requested to check on behaviour and past performance in other employment and

gaps in employment history were explained. In practice references often only included start and finish dates with little or no information as to past performance. Application forms were completed and notes from interviews were kept and were designed to form the basis for future supervision and training needs.

A dependency tool had been used to determine the staffing required. Staffing levels were sufficient to provide safe care. Call bells were answered promptly and we saw staff attended to people immediately if they required help. For example one person called a member of staff to say they were uncomfortable in the skirt they were wearing. They were immediately assisted to return to their room and change. It was evident they looked more relaxed following this. People were encouraged to use mobility aids as directed in their care plans. Staff ensured walking frames were placed in close proximity to people and reminded them to use them to move about. Staff walked alongside people to provide reassurance when people were unsteady or needed support.

Any gaps in the rota were covered by staff working additional hours or through the use of agency staff. The staffing levels were designed to ensure people's needs were met promptly in line with their support plans. We were made aware that there had been a high turnover of staff during the time the home had been open. Consequently there was a high use of agency staff overall where occasionally some days comprised of up to 40% agency staff. A core of agency staff had worked at the service for some time so were familiar with the people and procedures. A dedicated recruitment initiative had recently resulted in nine staff appointments. These individuals would be taking up permanent posts over the coming weeks. The recruitment campaign was intended to continue until a full complement of permanent staff was appointed.

There was a system in place to order, store and dispose of medicines safely. A change in the supplying pharmacy had recently taken place in order to facilitate more effective ordering and supply of medicines. Staff told us there had been considerable issues with the previous pharmacy not supplying medicines in a timely manner. Temperature within the storage areas was monitored effectively, and expiry dates for opened creams, eye drops etc. were noted. We reviewed a sample of Medicine Administration Record (MAR) charts and noted they were signed appropriately with the number of tablets remaining recorded under the signatures. However, on one MAR chart we noted a supplement had been prescribed but no administration/dosage instructions had been added to the MAR chart by the pharmacy. A handwritten 20mls had been added. On the reverse of the chart a member of staff had written the supplement had not been given as "no dosage instructions were available" and stated "GP to be contacted". There was no other record to suggest the GP had been consulted or that the appropriate dose had been confirmed by them. We asked why 20ml had been written in and where that instruction had come from. Staff were unable to answer this question at the time of the inspection. The senior on duty undertook to follow this up. We further noted that one staff member was initialling the MAR sheet using only one initial (M). This was the same as a code used on the MAR sheet which caused confusion as to whether in the example seen the code applied or it represented an initial to confirm the medicine had been administered. Staff were unable to clarify which was applicable.

Administration of medicines was carried out in a kind and compassionate way. Explanations of what people needed their medicine for were given and this was carried out in an unhurried manner allowing time for people to take their medicine as they wished. Some people had medicines prescribed 'when required' (PRN). We saw protocols were in place to guide staff as to what may indicate a person required these medicines and how they might demonstrate the need for the medicine. Allergies and sensitivities to medicines were noted on the photographic profile page held with the MAR chart. Guidance was available for staff who administered medicines to refer to and they told us they had received training from the pharmacist. Competency was also tested annually by the pharmacist to ensure skills were up to date.

We were told covert medicines would only be used as a last resort and if this was required a best interest meeting would be held with relevant professionals and representatives. We asked what action staff would take if people refused their medicines and we were consistently told it would depend on the type of medicine it was and their knowledge of the person. For example, if it was a person they knew well and would often refuse in the first instance but would usually then take them after a short interval they would wait for a short time and offer again. If they continued to refuse they would consider the type of medicine and the potential impact on a person's health and seek medical advice. We noted that monthly internal medicines audits had been introduced and there were plans to introduce monthly person focussed medicines reviews.

All accidents and incidents were recorded by staff before being reviewed and investigated, if necessary, by the manager. Accidents were collated into a spread sheet providing an overview of the circumstances, the person involved and the action taken. A similar document was planned to be introduced for all incidents to ensure that any trends or patterns where identified and addressed. The provider had a business continuity plan which included arrangements for alternative accommodation and procedures to follow in events such as fire, flooding, storms and loss of utilities.

There were infection control procedures in place. There was a dedicated housekeeper and an assistant housekeeper who had commenced employment on the day of the inspection. Overall the home was well ordered, clean and with no evidence of unpleasant odours. We saw and were told that since the interim manager had been in post there were always sufficient supplies of aprons and gloves and that staff wore them when required. We were told by a visiting nursing professional that there were rarely any paper towels available in people's bathrooms for them to use after they had carried out nursing procedures. We brought this to the attention of the manager who had addressed this issue by the time we returned on the second day. She also advised that she would ascertain the appropriateness of installing hand towel dispensers in private bath/shower room together with the wishes of new people as they moved in. We received a range of comments from relatives including, "The home is always immaculate", "It's very clean and always kept clean", "The public areas are about as close to spotless you can get in the circumstances", and "Cannot fault the cleanliness".

Requires Improvement

Is the service effective?

Our findings

Whilst many improvements had been made with the effective deployment and training of staff there were still occasions where errors or omissions occurred. The regular core staff knew people well and understood their needs and preferences. However, the high turnover of staff and reliance on agency staff had impacted on the consistency of care at times. Whilst this had stabilised to some degree many relatives commented on the number of new staff there were when they visited.

Staff told us they had received training. One said, "It has improved dramatically recently and I have had a number of sessions in the last few weeks. I know there are more planned." Staff all said they felt they had the skills to do their job role safely. We were sent the most up to date training matrix which indicated that all care staff had completed the care certificate. The care certificate is a set of standards that health and social care workers need to complete during their induction period and adhere to in their daily working life. All outstanding training for current staff was scheduled for completion before the end of October 2017. We noted that all core training with the exception of infection control was provided by a face to face classroom based method. We saw that all staff had completed an induction supported by an induction work book, however, the manager informed us that previous to her appointment induction had consisted of reading policies and procedures with little or no guidance on the role and expectations. As a result she had introduced a more thorough induction programme which included the allocation of a buddy to support and guide the new worker. In addition to the formal training programme, focused in house training had been conducted with senior carers and care staff in relation to responsibilities and standards of care, provided by a dementia care specialist. Emphasis was currently being placed on additional training for staff relating to best practice in dementia care. There were plans to develop dementia coaches and involve relatives in this training. We saw a programme of scheduled and regular dementia care training sessions which were full days and included all care staff.

Staff said they had not received one to one supervision sessions with their line manager. We noted a supervision structure had recently been drawn up to identify who would conduct supervision sessions. This document included dates for one to one supervisions for all staff going forward. However, staff did say they felt supported by the current manager. One said, "[Name] is extremely approachable and I never feel dismissed. She listens and I wish she could stay." In response to the lack of coordinated supervision the manager had introduced group supervisions as an interim measure to provide staff with the opportunity to discuss issues or concerns. These sessions had commenced in July 2017, included night staff and were also used to provide instruction and guidance for staff.

Overall communication within the service had been an area of concern and a major challenge historically. Whilst considerable progress was evident it was acknowledged that this was an area which still required improvement. A number of tools had been introduced to support better communication including a team briefing which was designed to communicate high level messages and instructions to staff. Handovers took place three times a day to provide information exchange between staff coming on and going off duty. Some staff did not always feel they got sufficient information about people at this time and one told us, "You pick things up as the shift goes on." This may present a risk of something being missed.

Communication with relatives was described as very poor by some, with some relatives still experiencing a lack of effective communication when they conveyed important information to staff or when they were not told about incidents involving their family member. Two recent examples involved hospital appointments where in one case a procedure was postponed because the person had been given breakfast despite instructions requiring 'nil by mouth'. The other example involved the failure to provide required medicine which was only communicated by phone to the relative as they were arriving at the hospital for the scheduled appointment. Other comments received from relatives included, "My main concern would be the lack of communication". "Communication with relatives is poor". "Communication has been really rather sloppy". "Communication is a huge, huge problem". "I think that there is room for improvement in the liaison about care planning". "A lack of communication, which was one of the main concerns that came out of the last relatives meeting, has not improved, the minutes from that meeting have not been sent". "I usually receive a phone call when my Dad has had a fall, but there have been occasions when I have not been notified, it seems a bit hit and miss". There were positive comments from some relatives indicating that improvements were being made, "At this point I believe the home is well managed and they are endeavouring (and succeeding) to improve communications". "When I have raised issues they have been dealt with quickly and professionally". "I have always been kept informed of incidents, of which there have been few." We raised the issue of communication with the manager who acknowledged that this was an area still requiring further improvement. She confirmed that there had been an issue with the accuracy of the minutes from the relatives meeting which had now been reviewed and circulated.

People's legal rights to make their own decisions were upheld and understood by staff who had an understanding of the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so, when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). Staff were able to say how the MCA related to their work. They told us they had received training and described how they supported people to make decisions and respected people's right to refuse. They described how they would return to people who refused personal care at a later stage and offer again. A senior member of staff described how they had held discussions with staff who found it difficult to accept they were providing good care if they had not been able to provide personal care to people. She told us this had helped them understand and know when to report their concerns. We saw a schedule of DoLS applications which had been made and those that had been authorised. Documentation for applications made under previous management could not be located or confirmed as received by the relative authority. In these instances further applications were in the process of being compiled and submitted.

Lunch time was a pleasant experience. Tables were laid very nicely and people appeared to enjoy the food. Show plates were prepared by the chef each day and taken to people to enable them to make a choice of what they wanted to eat. Staff sat next to people to assist and encourage them to eat. We saw when people were reluctant to eat staff sought advice from a senior member of staff. For example, one person did not eat all their main meal and said they were not hungry as they had eaten breakfast late. The senior staff knew the person's preferences well and suggested a pudding was kept for later. Other people were offered second helpings if they wanted extra. Throughout the day drinks and snacks were available and offered. Staff followed care plans with regard to providing adequate food for people. We saw one person who often lost interest in meals due to their concentration was offered extra snacks as indicated in their care plan. We received several compliments from relatives about the standard and variety of food provided at the home. The manager reported after the inspection visit that a new initiative to provide serving dishes on tables had

been well received with people able to choose the foods and the quantities they preferred. A food safety inspection was undertaken by the environmental health department in August 2016. We were told the advice provided at the time had been addressed shortly after the visit. A maximum five score rating was awarded as a result of the inspection.

People had access to health care professionals. However, there were letters in one person's file from the GP requesting appointments to discuss test results and another to attend a dementia review. We could find no evidence of these appointments being made or the results of any consultations. Furthermore, an appointment for an incontinence assessment was seen but records did not indicate if this had been completed. We asked the manager to follow these up. We spoke with two visiting health care professionals one of whom reported huge improvements to the management of health care and well-being of residents. The other felt there was still areas requiring improvement particularly relating to staffs knowledge of people's individual needs. She thought this most likely related to junior and temporary care staff which was why she always consulted with the senior's on shift who were generally more knowledgeable about people's health care needs. They told us that the strengthening of senior operational staff was a welcome development but would take time to bed in.

The home was purpose built and arranged over two floors. The design of the premises was extremely relevant to people living with dementia. Each bedroom door was designed as a traditional front door with a window to the left that contained memory items. Every door had a doorbell. Each area was designed in a circular fashion which was given an individual street name. Street lights were added to the walls of each area to add to the street theme. All bedrooms had an en-suite facilities fitted and were personalised by the occupants with furniture and personal effects, if they chose. There was a range of assisted bathing options available. Facilities included a hairdressing salon, a cinema room, a shop, an independent kitchen, library and a spa bath with music and lights for sensory stimulation. Many of the relatives favoured the flexibility of the layout which enabled their family members to move around freely including the outside areas. A very small number of relatives had concerns about how staff would be alerted should their family member fall or need assistance in the garden areas.

Good

Is the service caring?

Our findings

On the day of the inspection we saw that people looked relaxed and calm. We observed many positive interactions between people and staff. The approach of staff was kind and compassionate. For example, staff always greeted people as they met them and people sought the company of staff showing they were relaxed and comfortable with them. We received some positive feedback from relatives who told us, "The carers were astonishingly patient with her with regard to getting up, personal care and getting dressed". "Staff are very pleasant, cheerful and courteous." "I cannot fault the care". "I have no complaints about any of the staff that I have met nor the care they give to my father". "The staff are, without exception (in my experience), warm and caring towards the residents. They show genuine affection for my mother." "They show loving, gentle kindness and affection for my mother. This is true, even of the agency staff." Other relatives felt that there was room for improvement with comments such as, "High staff turnover, and preponderance of agency staff, mean that staff do not get to know the residents individually." "I think the level of care given varies widely between some very committed staff, and some not so engaged." "Most staff do not wear badges so – bearing in mind they are dealing with dementia sufferers – it is virtually impossible for residents to know names and the same goes for relatives."

Staff knew people well and were able to describe people's interests and how their behaviour could indicate a particular need. For example, one staff member said, "I know things like if [name] twitches a finger they want a cup of tea." Staff treated people with respect, they spoke quietly and gently and provided reassurance if people looked lost or confused. One person became upset and began crying during an activity. A member of staff moved to their side and touched their arm in a reassuring manner asking what was upsetting them. The person did not know so the staff member began to talk about the next activity which distracted the person who was soon smiling again. We were told by staff, that when they assisted people with personal care they maintained their dignity, and respected their choice. For example, they asked before helping, covered the person, drew curtains and closed doors.

Relatives were asked to discuss and complete a document called preferred priorities of care with their family member. This outlined a person's wishes regarding the care they wanted to receive at the end of life. This document was not present in all care plans reviewed but it was noted that relatives had been given the document to complete. Relatives commented on the caring attitude of staff one said, "They are very caring." Another told us, "Staff are lovely and most will go the extra mile." A visiting professional also told us of the caring attitude of staff and said, "Staff are very helpful. People always look happy and well cared for."

People were supported to maintain their independence as far as possible. Staff encouraged people to make choices and take part in activities such as music, singing and religious ceremonies. One relative commented, "I think that Abbeyfield allow my mother the correct balance of freedom and safety, which allows her to retain some independence."

Staff told us they were kept informed and up to date with any changes in people's support requirements. This was achieved through handover meetings and informal discussion with other team members. A few staff said this was an area which was still in progress and improving. Feedback from staff about the service

and care provided was overall very positive. People were as involved in the care planning and review process as they were able to be. One relative told us, "We have found (Name) care has been very well managed and we have been kept well informed about care and there have been no incidents to cause concern." However, a small number of relatives reported that communication with the service could be very difficult with important changes within the home or related to their family member not passed on. One relative told us, "If we don't ask, we don't know and, quite often, when we do ask we are not given straight answers."

People were provided with a range of information when they moved into the home which explained some of the procedures and what they could expect with regard to their care. It had become apparent that historically relatives had not been advised to label all of their family members clothing prior to their admission. As a result large quantities of clothing had accumulated and the owner could not be identified. The house keeper had arranged for a manikin to be placed by the front door which was 'dressed' with unclaimed clothing. This had resulted in some articles being identified by relatives and returned to their owner. In addition, photographs of lost clothing were now taken in an effort to assist relatives in identification of property. There had been issues with the laundering of some clothing which had been reported as damaged. This was generally described as much improved. Night care staff were now deployed on a rolling basis to undertake laundry tasks and additional laundry assistants had been employed.

Historically there had been major issues with lost or stolen property. Some of this property had been of high monetary or sentimental value causing great distress to people and relatives in particular. No inventories of people's property had been taken in the past as an integral part of the admission process. The manager confirmed that this would be implemented when admissions recommenced. Some losses had been reported as safeguarding incidents or to the police as possible crimes. The manager had worked hard with relatives to explain the difficulties presented by the nature of the service where some people may forget where they had put things whilst others may have a propensity to gather up and collect things not belonging to them. It was proposed that the dilemma of meeting individual's need for familiar items with the risk of the loss/misplacement of these items would be addressed with all parties as a part of and during the course of admission processes.

All confidential information was kept securely in the office or care stations and available only to those with authorised access.

Good

Is the service responsive?

Our findings

The service was designed to offer people person centred care and was committed to improving this approach. Staff were trained and guided to provide person centred care and people's care plans were being improved to reflect this. We were told by the manager that regular reviews of care plans which entailed constructive feedback for staff had resulted in improvements in the standard and quality of recording. Care plans were person centred, particularly the new style care plan which provided detail of the person's wishes and preferred routines. The pre-admission assessment had been reviewed and provided good detail on which to establish the care plan. Further detail was added as the person settled into the service and staff became familiar with their needs and wishes. Care plans were reviewed monthly however, not all information was consistent. For example, in one person's file a continence assessment indicated they were incontinent of urine while the care plan said they were fully continent. There was risk that staff may not know the appropriate support required by this person regarding their continence. When we raised this it was apparent that staff knew the correct information and we were told the discrepancy was due to the change in care plan paper work. Staff agreed to ensure it was corrected.

Activities were well planned and attended. We saw many activities taking place and people engaging in these at their leisure. This included music bingo, word games, and a sing along. We saw an outside agency attend the service, to update books kept in one of the rooms. This demonstrated that people were offered a variety of reading materials. The shop was also designed as an activity and focal point for people. They were encouraged to visit, when they had run out of items – for example, toothpaste, reading materials (magazines), or treats such as sweets.

Activity staff were enthusiastic and provided a variety of meaningful activities for people throughout the day. People engaged and appeared to enjoy balloon tennis very much and we observed smiles and the competitive nature of some people coming to the fore. A member of the activity team told us another favourite activity was a crossword completed as a team activity. They explained how when they first began doing this people took over thirty minutes to complete just a few clues but since this had been a regular activity it was now completed in just a few minutes which they felt indicated it was helping to stimulate people's minds.

A resident PAT dog visited the home regularly and there was consideration given to particular skills and talents people had. For example, one person took photographs which had been enlarged and mounted for display. We saw there was also a display of cameras in one lounge to stimulate this person's interest. Rummage boxes and sensory equipment were put to good use and we saw staff spent one to one time with people talking about the content of these boxes. Other people were engaged in routine tasks such as setting tables, peeling vegetables and wiping cutlery. Staff explained these were things they had enjoyed doing in their lives previously and wished to continue to do. One person had held a very responsible job and liked to have 'projects' to help them feel useful. Staff typed projects for them to complete such as checking door handles which they told us made the person feel useful and valued.

We were told by two relatives that the cinema had previously been used to 'entertain' people allowing staff

to undertake other tasks. One relative told us, "Putting the residents in the cinema and leaving them unattended cannot be described as caring". We raised this with the manager who was aware that this practice had been used prior to her appointment in the home. She was adamant she had stopped this routine immediately she took over responsibility for managing the service. In discussion, staff confirmed that this was the case.

Relatives told us they knew how to complain if necessary. One had raised complaints in the past but did not feel they had been fully addressed. Another felt communication was not as good as it could be and did not always feel they were kept up to date with their family member's wellbeing. Some relatives told us they appreciated the meetings held to discuss the care provided and the opportunity to offer their opinions. However they were unsure if actions had been taken as a result of these meetings. Staff were aware that some people were unable to make a formal complaint without assistance and were able to describe how people would let them know if they were not happy. There were eight complaints and six concerns recorded since the service opened. Some of the concerns were of a very minor nature. Prior to the current manager's appointment it was not always easy to see what action had been taken or whether the outcome had been communicated to the person raising the issue. However, records demonstrated that this had improved under the management of the current manager. Five compliments had been recorded during this time which all related to the care that people had been provided with.

Requires Improvement

Is the service well-led?

Our findings

It was evident that the home had been through a very turbulent time in respect of the management arrangements. The original manager had been struggling with the opening, staffing and managing of the service alongside a flow of new admissions. This situation had not become apparent until a number safeguarding issues had been brought to the attention of the local authority. When the interim manager took over the responsibility of running the home it quickly became clear that staff had been left to provide the service at operational level with little or no support or direction. Both staff and many relatives described the home as chaotic, lacking in clear procedures and focus. It was difficult to retain staff and a reliance on agency staff was required to manage the shortfalls. A permanent manager was recruited in May 2017 but left after a short period of time.

The current manager whilst temporary has worked hard to stabilise the home, to support and direct staff whilst ensuring that people's needs were addressed as a priority. In recognition of this huge task the provider made available experienced clinical and managerial personnel to support and drive the improvements required. The manager has been working to a detailed action plan required by the local authority safeguarding and governance framework together with an internal plan of detailed aims and objectives. This has been managed alongside the daily operational requirements of the service.

Positive feedback was received about the manager who staff described as "approachable" and "supportive". Staff described "good team working" and one said, "[Manager] has brought the team together." Another told us, "I really enjoy working here, it's a good home to work in. When you have a good team it's nice to come to work." A senior member of staff told us the ethos was about providing affection for people, they said, "I want to make a difference; I don't do my job for money." They went on to say they felt the provider and manager support this ethos and lead the team to "be on the same page". Overall, staff raised a mixture of responses to the management of the home since opening. It was stated that it had been varied depending on who was in the managerial position. Some relatives recognised the contribution of the current manager and commented on the improvements that they had seen. Others were more cautious depending on their experiences. Many negative experiences were historic but whilst issues still occasionally arose some relatives would take more convincing of the sustainability of improvements.

As time had progressed the service was now described as being managed more openly. A much more clearly defined management structure was now in place. This included the manager, supported by a business manager from another area and a dementia care specialist. Two heads of care had been appointed recently and the plan going forward was that between the two of them weekends would always be covered. There was a complement of senior care assistants and care assistants who were deployed to cover the various units within the home. The management team aimed to work alongside staff, and offered training to support newly developed roles. Recruitment was progressing and formed part of the internal objectives to eliminate the use of agency staff. In addition, there was a range of ancillary staff covering domestic and laundry duties, kitchen, maintenance and administrative staff.

Staff were aware of their responsibilities and understood how they related to the wider team. Staff informed

us the manager and senior staff were always available to provide guidance and advice when required. Throughout the course of the inspection the manager was observed being approached by staff and people in a relaxed manner and they were responded to positively and with respect. Staff confirmed there was a good team spirit that encouraged staff to work well together for the benefit of people using the service. The manager told us that the quality of care provided was regarded as crucial to ensure that people's well-being was maintained and that their quality of life, choices and preferences were central to the ethos of the service.

Meetings and/or communication with relatives was an area which required further work. Some relatives reported that communication was good whilst some others told us that this was an area that concerned them. This has been included elsewhere in the report and is known to the manager. The manager told us that this was an action which would be developed and brought to the attention of the new manager who had recently been appointed.

The manager and senior staff conducted a range of audits including infection control, medicines and weekly care plan related reviews. The scope of quality monitoring required by the provider was largely on hold until such time as the home had completely stabilised. Monitoring of significant events such as accidents and incidents was the responsibility of the manager. It was acknowledged that whilst accidents were reviewed work still needed to be undertaken with regard to incidents which either impacted or had the potential to impact on people living in the service. We were made aware that a range of additional audits were in the process of implementation. These included slings, equipment, daily MAR charts, falls and cleaning. It was proposed that electronic trackers were to be used for medicines, safeguarding incidents, complaints, residents log sheets and accidents to ensure they were appropriately and accurately completed within required timescales. All new systems for monitoring and quality purposes were targeted for full implementation by December 2017.

The service worked with health and social care professionals to achieve the best care for the people they supported. They had links with the specialist district nursing health team, local authority commissioners and GP's. We spoke with one visiting senior health professional who told us that staff overall were now very good at contacting district nursing when needed and staff were now following instructions. They went on to comment, "There is a happy atmosphere now and the team seems to be working well together."

There were systems in place to obtain feedback from people, staff and stakeholders regarding their views about the service. These had not been fully utilised due to the difficulties experienced within the service since first opening. The manager told us that the surveys designed for people's feedback were not dementia friendly and were included in the action plan for review.

People's needs were reflected in their records but as reported elsewhere there were some inconsistencies found within and across documentation designed to accurately reflect people's needs and to provide guidance for staff. We had confidence that the new care plans provided much more accurate information which provided clearer directions for staff. The process of transferring records to the new care plan formats was at an early stage at the time of the inspection. We were told of plans to prioritise this work which was scheduled to be completed in the coming weeks. Records relating to other aspects of the running of the home such as meal plans, health and safety and maintenance records were detailed, accurate and up-to-date.