Abbey Court Nursing and Residential Homes Limited

Abbey Court Nursing and Residential Home

Inspection report

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Tel: 01332364539

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 January 2018, and the visit was unannounced.

Abbey Court Nursing and Residential Home provides residential and nursing care for older people. Abbey Court is registered to provide care for up to 40 people. At the time of our inspection there were 36 people living at the home. Abbey Court Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the last inspection of the service on 7 and 13 July 2016 we found staff were not ensuring people's consent and there was an absence quality monitoring. These were breaches of Regulation 11 and 17 of the Health and Social Care Act 2008.

Following the last inspection, we asked the provider to complete an action plan to show how they would meet the regulations. We did not receive an action plan from the provider which should have outlined the action they were going to take. At this inspection we found that the provider had made improvements in both areas where there was a breach.

At the last inspection of the service we found there was a lack of oversight by the provider to check quality monitoring had been carried out effectively. At this inspection, we found that the provider had commenced a wide range of quality monitoring checks. We will return to ensure these are embedded and protect people in the home.

On this inspection we found that there was a breach in ensuring people's safety by making sure chemicals were stored properly and doors were locked to prevent access to dangerous areas.

There was a registered manager was in post. 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 provider carried out quality monitoring checks in the home supported by the registered manager and home's staff. The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours if an emergency arose, or an equipment repair was necessary. Staff had access to the maintenance diary to manage any emergency repairs. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service and their relatives.

We found that applications had been made to the local authority to legally deprive people of their liberty. The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. They were

also aware of best interests meetings to ensure peoples treatment was in line with the MCA and Deprivation of Liberty Safeguards. People were asked for their consent before staff provided care for their written consent to care following their admission to the home.

Following their recruitment staff received on-going training for their particular job role. Staff were able to explain how they kept people safe from abuse, and were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse. Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home, and most were employed from a similar culture to the service user group.

People were provided with a choice of meals that met their dietary and cultural needs. The catering staff were aware of people's dietary needs, and sought people's opinions about the menu choices to meet their individual needs and preferences. Staff regularly provided a range of activities that are tailored to people's interests. Staff have access to information about people's interest, likes and dislikes and through this have developed a good understanding of people's care needs. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

Relatives we spoke with were complimentary about the provider, registered manager and staff, and the care offered to their relations. People were involved in the review of their care plan, and when appropriate their relative's views were included. Staff had access to people's care plans and received regular updates about people's care needs. Care plans are updated to include changes to peoples care and treatment. People were offered and attended routine health checks, with health professionals both in the home and externally.

We observed staff interacted positively with people throughout the inspection, people were offered choices and their decisions were respected.

We received positive feedback from the staff at the local authority with regard to the improved care and services offered to people at Abbey Court Nursing and Residential Home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The safety of people was put at risk by a poorly secured chemicals and environment. Protection from infection control issues was not well documented.

Care plans included risk assessments and informed staff of areas where people required care to ensure their safety. Staff understood their responsibility to report any observed or suspected abuse. Staff were recruited and employed in numbers to protect people. Medicines were ordered administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff now understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care before it was offered.

Staff had completed essential training to meet people's needs safely and to a suitable standard. People received appropriate food choices that provided a well-balanced diet and met their nutritional and cultural needs.

Is the service caring?

Good

The service was caring.

Staff were caring and kind, treated people as individuals and recognised their privacy and dignity at all times. Staff understood the importance of caring for people in a dignified way, and people and their relatives were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs. People

and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People and their relatives were confident to raise concerns or make a formal complaint if necessary. People were supported to have a dignified and pain free death.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Though the provider uses quality audits to check people were being provided with good care, not all of these identified shortfalls in safety .

There was a registered manager in post. People using the service and their relatives had regular opportunities to share their views and influence the development of the service.

Abbey Court Nursing and Residential Home

Detailed findings

Background to this inspection

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

The comprehensive inspection was prompted to follow up the enforcement action which resulted from the last inspection in July 2017.

Inspection site visit activity started on 9 January 2018 and ended on the same day. It included direct observations of the staff group and how they offered care to people, speaking with the people and their relatives, the management staff and a visiting health professional. We visited the office location on 9 January 2018 to speak with the provider, registered manager and office staff; and to review care records and policies and procedures.

This unannounced inspection was carried out by one inspector, a specialist adviser and expert by experience. The specialist advisor we used had a professional qualification and expertise in care and nursing. 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 visit we looked at the information we held about Abbey Court including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection of the home.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool

(SOFI) and other observations to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with ten people who live at the home and four visiting relatives to gain their experiences of Abbey Court. We were assisted on the inspection by the provider, registered manager, deputy manager and lead nurse. The registered manager is known locally as the Matron. We asked them to supply us with information that showed how they managed the service, some of which we received following the inspection visit. We also spoke with a senior carer, three care staff, the cook, handyperson and domestic assistant.

We looked at five people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily records and risk assessments. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Requires Improvement

Is the service safe?

Our findings

The safety of people in the home was not assured.

We found the premises were not being adequately maintained to ensure the safety of people using the service. On a tour of the home many of the doors that were required to be locked, were not. These areas presented a danger to people who may enter accidentally, for example the lift machinery room and boiler room. We also saw where there were threshold strips between different areas in the home that had screws that protruded from the floor; which presented a trip hazard to people. We mentioned this to the registered manager who had the area made safe before we completed the inspection.

The glass windows in the first and second floor corridors' did not appear to be protected to ensure they would not break accidentally if fallen against. The provider had not risk assessed these areas. This placed people at risk from falling against the glass and injuring themselves.

In a bathroom we found a container of bleach, and in a corridor the trolley used by the domestic assistant was also left unobserved, again there were chemicals on the trolley. These presented a risk to people in the home, where these substances could be consumed by a confused person. This does not demonstrate a home that provides a totally safe and secure environment.

Although the provider carried out regular infection control audits, these did not include the suitability or cleanliness of the sluice, bathrooms or the laundry. The provider did not have suitable systems in place to identify, monitor or assess the cleanliness of the home to help the prevention of infection. This did not ensure that people were cared for safely.

We saw from records and staff confirmed that staff attended regular fire drills. However we found there was no readily available record of the staff who attended these events. That meant the registered manager could not ascertain quickly that all the staff had up to date instruction and training on the procedures involved in ensuring people's safety in the event of a fire.

These identified areas constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

People told us they felt the home was well kept. One person said, "The home and my bedroom are cleaned to my standards." A relative said, "The home is well maintained and clean. [Named] room is always kept lovely."

The registered manager had put an action plan in place to addresses the known areas of non-compliance within infection control which included regular monthly disinfection of shower heads and flushing of water outlets that were not used regularly.

People and their relatives told us they felt safe in the home. One person said, "I feel safer here [than my

previous accommodation], they're very careful. They won't let me do things on my own. They're super careful." A second person said, "Yes of course I do [feel safe] I would speak to any of the carers if I had any concerns."

A relative said, "Yes [named is] safe here, I used to work in care so I know what that means. She is excellently looked after. A second relative said, "They know how to move her by using the hoist. I know as I used to have to do this at home and it can be stressful."

Staff we spoke with understood their responsibilities to keep people safe. Staff confirmed they had received training in safeguarding vulnerable adults and were enabled to recognise when people may be at risk of harm. Staff were able to explain what they would do if they suspected or witnessed abuse of any person who used the service. They told us they would share their concerns with the registered manager, deputy or the staff member in charge. A staff member said, "If I suspected any abuse I would report it on to the manager." This demonstrated that the provider had taken steps to ensure people were safeguarded from harm.

Staff were aware of the support people required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. People's care records included risk assessments, which covered the activities related to their health, safety, care and welfare. Care plans and associated risk assessments are regularly updated and identified the risks to people's health and wellbeing. The care plans provided clear guidance for staff in respect of minimising risk.

We observed people were relaxed when staff offered assistance and support to people, and saw that staff moved and handled people safely using the equipment designated in their care plan.

We found that staff were employed in sufficient numbers to care for people safely. One relative said, "If we had any concerns we'd talk to matron [registered manager]."

We observed staff responded to people's requests for assistance promptly. We spoke with the registered manager who explained the staffing numbers were adjusted in line with people's dependencies, to ensure there was enough staff to provide a safe environment for people.

Staff confirmed the number of staff on duty each day. The registered manager was currently being assisted by the deputy manager as well as two nurses on duty each day and one at night. There was also a senior carer and six care staff in a morning, a senior carer and five care staff in an afternoon and evening, and a senior carer and two care staff at night. In addition there were catering and domestic staff and a handy person. We confirmed the staff numbers were typical with the current staffing rota, and most were from a similar cultural group to the people who lived in the home.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for four staff, and found that the relevant background checks had been completed before staff commenced work at the service. Staff we spoke with confirmed that they did not commence employment until they had the required pre-employments checks in place. This included a disclosure and barring check (DBS) and references. A DBS disclosure can help employers make safer employment decisions. Nursing staff provided evidence of their registration with the Nursing and Midwifery Council (NMC) and the provider had systems in place to ensure their registration was maintained.

We found that medicines were mostly administered with people's safety in mind. One person told us, "I haven't ever run out [of medicine] I always get pain relief when I need." A second person said, "Yes I get my medication on time."

Medicines were stored securely and at a temperature to ensure they remained active. Staff kept records of the room and fridge temperatures, and were knowledgeable about what to do if they were above or below the recommended storage temperatures. However the food supplements prescribed by the GP were not labelled. We could not be assured that everyone who was prescribed these supplements actually received them. We spoke to the registered manager who said they were looking at changing the current pharmacy and would ensure in the future all the supplement bottles would be individually distinguishable.

We looked at the medication administration records (MARs) for six people. All the MARs were signed appropriately, and information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely. However we noticed there was an excessive stock of one type of medicine which we mentioned to the registered manager. They said, and we confirmed by the medicine order, that they had stopped ordering that type of medicine to ensure they used up all the stock prior to ordering more. We checked and all the excess stock was in date, and so safe to administer to people.

We observed how staff administered medicines to people. People were being offered pain relief which was prescribed on an 'as required' basis. Staff followed the provider's medicines policy; they stayed with people to ensure their medicines were taken, which demonstrated that staff understood the safety around administering medicines.

People who were prescribed 'as required' or PRN medicines had instructions along with the MARs which detailed under what circumstances they should be administered and the maximum dose the person should have in any 24 hour period. For example, if people experienced pain they could ask for Paracetamol. Staff understood the signs and symptoms that some people may display when they may require PRN to be administered.

We spoke with the nurse who supported people to take their medicines and had recently had updated training in this area. They also confirmed they were subject to regular competency assessments which helped to ensure their practice reflected the training they had received. We viewed the training matrix which confirmed nurses had undertaken regular medicines management updates.

The registered manager used information from incidents and complaints to make improvements to the service. The changes that had been introduced since our last inspection had been documented and any lessons learnt fed back to staff. We saw from the minutes of staff meetings the reasons behind any failings had been explained and staff were encouraged to ensure their practices changed to improve the safety of people.

Good

Is the service effective?

Our findings

At our last inspection of the service between 7 and 13 July 2017, we found evidence of a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, gaining peoples' consent.

The provider did not send us a plan of action following the last inspection to state when they would be compliant.

We found there had been improvements at this inspection and people's consent to care and treatment was sought in line with legislation and guidance. One person said, "They always knock and yes they will ask consent. I get help when I need it." One relative said, "Yes they ask [named] for consent before they do anything." We heard people being asked for their consent before the staff offered care and support. For example we heard staff asking if people wanted their clothes covering before lunch. Some people were unable to consent directly to staff when they were approached, however we saw people were relaxed when staff offered care and support. This demonstrated staffs' approach was effective and did not cause people concern or anxiety. We observed people were offered the support detailed in their care plan and risk assessments, which met their cultural and individual needs and choices.

Records showed that where needed people who used the service had mental capacity assessments in place with regard to making certain choices and decisions. People were asked for consent to agree the care they were offered prior to being admitted to the home. When people lacked capacity to give their informed consent, the law required registered persons to ensure that important decisions were taken in their best interests. A part of this process involved consulting closely with relatives and with health and social care professionals who have known a person and have an interest in their wellbeing.

The registered manager, nurses and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager had ensured that nine people were protected by the DoLS. Records showed that the registered manager had applied for the necessary authorisation from the relevant local authority. Some people had been represented by a family member. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person, adhere to the main principles of the MCA and act as a safeguard for the person's rights.

People's needs and choices were assessed to provide effective care plans that guided staff to providing the

correct levels of care that met people's cultural needs. The registered manager explained how people's needs were assessed prior to them moving into the home. This assessment then formed the basis of the care plan, which is developed as the person's stay lengthens. We saw that care plans were updated regularly.

Staff were trained and provided effective support to people. A relative said, "The staff have adequate training I've watched them." A second relative said, "The staff have the training they need, they know how to use the hoists."

Staff commenced their training with an induction and then had access to courses which directly related to their role within the staff team. This training covered safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and dementia care. The registered manager confirmed the staff induction training and on-going training were now linked to the care certificate, which is a nationally recognised training course. A member of staff said, "There seems to be more training each year." A second member of staff said, "We have a lot of training."

We saw evidence in the training matrix that all staff had updated training. The registered manager kept the training matrix updated; this ensured management staff knew when updates to staff's training was required. We saw the registered manager had started to plan further training for the forthcoming year.

Staff confirmed that they had regular supervision. Supervision is one way to develop consistent staff practice and ensure training is targeted to each member of staff. We spoke with the registered manager who showed us the record of staff supervisions that had been undertaken and the future planned dates. Part of the supervision included ensuring the competency of staff. For example the nursing staffs' competency when administrating medicines was overseen annually.

We saw there were daily handover meetings which provided staff with updated information about people's health and wellbeing. Staff also told us they were supported through regular staff meetings with the registered manager. Staff supervision is used to support and check staffs' knowledge, training and development by regular meetings between the management and staff group.

We found people were provided with a balanced and varied diet that met their cultural needs and helped maintain their weight. We observed staff offered a variety of drinks throughout the day which were accompanied by snacks.

One person said, "There's more than enough food! Yes plenty of drinks." A relative said, "They're very good – they will tell you whether [named] is eating well, whether their appetite is up or down a bit." A second relative said, "The cook has a great attention to detail – she's caring and interacts with residents and talks to them about their likes and dislikes. She's an asset." A third relative said, "I would like more fresh fruit around." We spoke with the registered manager about this who said they had fruit bowls placed around the home but these were removed because this was not considered safe as there were people with swallowing difficulties living in the home. The registered manager said fruit was offered to people by the activity co-ordinator and at times drinks were served, however they would ensure staff were reminded they needed to offer fruit to people regularly.

Staff had referred people to medical professionals where people had lost weight. Records relating to nutrition and hydration were completed where people were at risk of malnutrition or dehydration. We saw that monitoring of some people's food intake was on-going due to them being at risk of malnourishment. For people whose appetite was restricted, we saw the staff had sought the assistance of the GP in prescribing food supplements. However not everyone was having the supplements they were prescribed. We

spoke with the registered manager who said, she would ensure that the supplements would be provided to people who required them. We also saw staff had approached the dietician to provide information about fortifying meals and drinks, again for those with a restricted appetite. We saw that full fat milk was being used along with cream added to deserts and milk shakes provided for additional calories.

People are offered a diet which effectively meets their needs. One relative said, "They prompt [named] to eat, they have a laugh with her."
Information about people's likes and dislikes of food and drink were recorded in their care plans, which were available to staff. This information included any known food allergies was made available for catering staff.

People had the choice to eat in the dining room, lounge or their bedroom. We observed people at lunchtime who looked relaxed throughout the meal. We saw some people were encouraged to eat independently where others required to be prompted and some needed one-to-one assistance to complete their meal. This was done at a pace to suit the person, and staff were positioned appropriately to provide good eye contact, which supported the positive relationship between the person and member of staff. Where people required specific support to eat and drink, plate guards, special cutlery and beakers were provided and staff supported people to eat and drink at their own pace. This demonstrated staff were aware how to make the meal time pleasurable for the person and maintain an effective relationship.

People were supported with a choice of meals. Where people were unable to decide from the menu with pictures on each table or staff offering them a verbal choice, people were offered different plated meals. That demonstrated staff provided people with effective choices. Staff were able to tell us about people and their individual likes and dislikes, allergies and specific dietary needs such as a liquidised diet and thickened fluids.

We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any changes to people's dietary needs were managed in line with professional guidelines. Some people were recorded as having a poor appetite. Records showed how much the person ate and drank which ensured they had sufficient foods and fluids to maintain their health. The registered manager said if they had concerns about the health of anyone monitored this way, they would seek further medical advice. This approach ensured that people received effective support with their food and fluid intake.

One person said, "They will call the health professionals if needed." One relative said, "Yes they're quick to act if you need any [healthcare professionals]." A second relative said, "If [named] needs the doctor – they'll phone to tell me."

People were supported to maintain their health and wellbeing. People's relatives told us and care records demonstrated that people received effective health care support from a range of health care professionals such as GP's, specialist nursing staff, hospital consultants SALT and dentists. People were accompanied by relatives and staff to routine medical appointments.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by a caring staff group. One person said, "In general I'm very well looked after." One relative said "They [staff] go out of their way," and explained how the staff provided an exceptional caring service for their relation." A second relative said, "The staff are marvellous – they go above and beyond. They're friendly and kind and helpful."

People and their relatives told us the staff group were compassionate and caring. We observed interactions with people throughout the inspection which showed that staff were caring and people were treated respectfully. One relative said, "They speak nicely to [named], they're kind, caring and patient. A second relative said, "They're kind, caring, knowledgeable and discrete."

We observed staff who assisted some people, and saw where others were prompted to eat their lunch time meal. We asked a member of staff why there was a difference, and they told us some people just needed a gentle reminder to complete their meal. We saw staff helped to protect people's clothes and their dignity by protecting people's clothes from food spillages. Staff were heard asking them if they agreed to the covering being placed and again before it was removed. That demonstrated staff took steps to promote people's dignity.

We observed care staff had a good rapport with people and engaged in conversations throughout the day. One person said, "[Named is] much happier here she was lonely before [moving here]."

A relative said, "I wouldn't put him anywhere else and he wouldn't go anywhere else." A second relative said, "The staff know me now – they chat when they can. Some of their English isn't good."

We spoke with the registered manager who said that a recent quality assurance questionnaire raised the point of communication between service users and staff. There were no negative comments that were raised at the time, but due to the comment will redistribute the questionnaire of people in the home and their relatives.

The staff had introduced an enhanced communication system as part of the information provided to people and their relatives. The 'progress and evaluation' sheets were situated in people's bedrooms and gave the opportunity for people and their relatives to be aware what on-going communications have been recorded.

The registered manager told us care plans reflected people's needs and were being reviewed monthly. However some people were unable to express their views and opinions. Records confirmed that family members had been involved in care plan reviews, where the person was unable to.

We observed that staff checked on people's well-being throughout the day. Individual choices, preferences and decisions made about people's care and support needs were recorded. These daily records included the care and support people received, and demonstrated that staff supported people's decisions about how they wanted their care.

People's privacy and dignity were recognised. One person said, "They [staff] are kind and caring, they're nice. A relative said, "I've been here when they get [named] up in the morning and it's done with care and dignity."

We observed staff respected people's privacy and dignity, and heard staff knocking on people's bedrooms and toilets before entering throughout our inspection. That demonstrated staff were aware of the need to ensure people's privacy and dignity. However we found some toilet doors did not fully close and some did not lock which did not fully ensure people's privacy. We spoke with the registered manager who said they would ensure the doors were adjusted to allow people to ensure their privacy.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their individual needs.

One relative said, "[Named] doesn't have to wait long if they press the buzzer." A second relative said, "I've seen them use the hoist and they do it slowly not rushed. The staff know how to handle people."

Care plans were person centred and each contained a detailed medical history and health needs of the person, details of their family and who was important to them, work history, hobbies and interests.

Care plans also include an accident and emergency grab sheet which included details such as their medical history and activities of daily living. Also included were personal evacuation plans (PEEP's) which were also kept securely and were placed near a fire board near the main entrance from the home and along with care plans were reviewed regularly. Care plan reviews took place regularly and there was evidence that relatives were involved where people were unable.

People's care plans were detailed and guided staff on how to provide pressure area care including the use of pressure relieving mattresses. However, we noted the pressure of the inflatable mattresses were not set correctly. These need to be adjusted to match the person's body weight, and reduce the likelihood of people developing pressure areas. We found these were set to high, no matter what the person's weight was. We brought this to the attention of the registered manager who arranged for the mattresses to be adjusted and set up regular checks to ensure they remained at the correct pressure. Though the pressure was incorrect, we noted there had been no recorded pressure area issues. We have not been able to assess the effectiveness of the system to check mattresses.

Where people required assistance with personal care, care plans were detailed how the support was to be provided, what the person's abilities were and what support they required.

We found people were happy with the level of activities offered. One person said, "There's a lady who comes to do activities – I always join in I like to do something. We had a sparkle day last week when we all had to dress up with something sparkly." A second person said, "Someone from the church donated a piano and [someone] comes and plays it." The activities provided included games, puzzles, arts and crafts and going out into community, a particular favourite was a trip to the local pub.

However people's relatives had mixed opinions about the activities offered to people. One relative said, "I think there are plenty of activities, they're marvellous. There are quizzes and they can go to the pub if they want to across the road." A second relative said, "I think they could do with more activities, they could do with more stimulation and the TV is left on all day." We spoke with registered manager about this who said a recent quality assurance questionnaire raised the point of activities. These were also discussed at 'friends of Abbey Court' meetings which included the people who lived in the home relatives and management staff. That demonstrated people were given opportunity to add to the activities on offer.

We saw the activity co-ordinator maintained a log of activities people were interested in, the activities provided, how people were engaged and the outcome. This was being adapted to provide an individual record for each person and would include information where a person decided not to participate in their preferred activity.

People's care plans reflected their individual needs and we saw evidence of information on allergies, likes, dislikes, wishes and aspirations, and past life histories completed by people and their families. We saw where the staff had responded to the changes in people's lives, and made application to the local authority for DoLS restrictions.

Staff had access to people's care plans and received updates about their care needs through daily handover meetings. Staff told us a handover's took place at the start of each shift, so staff could be updated about people's needs and if any changes in their care had been identified.

The provider responded promptly to complaints and had systems in place to record and deal with complaints. People and their relatives told us they were aware how to make a complaint.

People knew the provider, registered manager and deputy manager and had seen them around the home; people felt they could approach them or other staff with any concerns. One relative said, "I would feel comfortable raising a concern they [staff] are very approachable. I did raise a concern once and I'm happy they dealt with it because it hasn't happened again." A second relative said, "I don't have any concerns." A third relative said, "No issues with staff at all. If I did I'd speak to matron or other senior carer or the owner."

Staff felt confident to raise concerns and issues with the manager and were confident these would be listened to and acted upon. The registered manager told us they were aware of four complaints in the last 12 months, one of which was sent to the local health authority. An outcome had been provided for each, and where necessary changes were made to the service. Complaint information was fed back to staff through staff meetings or individual supervision sessions, so that staff were aware of any issues and any changes that had been required. Analysis by the registered manager did not reveal any patterns or themes with these or previous complaints.

People had the opportunity to discuss their wishes of how they wanted to be cared for when they were unwell or at end of life. Staff recorded people's wishes in their care plans. For example one person expressed they did not wish to go to hospital, but to remain at Abbey Court care home. Care plans also had information supplied by people's relatives who could no longer speak for themselves where they had previously spoken about their wishes for their place of care.

Staff involved people's GPs to assess people for symptoms that may require additional medicines towards the end of their lives. People had advance decisions care plans in place and a do not attempt resuscitation (DNACPR) advance decision. These had been agreed with people when they had full capacity or their relatives where they were unable to assist. That meant staff were clear about the people's wishes, and could inform any other appropriate authority of this, for example if the person was admitted to hospital. That demonstrated people were supported to have a planned ending to their life that reflected their wishes.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard, for example, large print and easy read documentation.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service between 7 and 13 July 2017, we found evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We asked the provider to ensure that systems were established to ensure regular monitoring of the quality of the services to identify, assess and manage risks relating to the health, welfare and safety of people using the service.

The provider did not send us a plan of action following the last inspection to state when they would be compliant.

At this inspection we found some of the areas that we previously identified as required improvement had now improved.

We found the provider's audit processes to monitor the quality of the service provided, had improved and if continued would ensure people received safe levels of care on a consistent basis.

The registered manager demonstrated the quality assurance audits that had been introduced following our last inspection, and the corresponding records which demonstrated people were safe and well cared for. These included regular checks on the medicines system, care plans, risk assessments, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. These had resulted in follow up appointments being arranged for people at risk of malnutrition. That meant the registered manager and staff had undertaken audits that demonstrated how the service protected people.

However the overall safety of people in the home was compromised by chemicals that were not locked away securely, and doors that required to be locked for people's safety had been left unlocked. Other areas of the home did not preserve people's dignity as not all toilet doors closed or locked. The registered manager had not implemented a suitable system to identify these environmental issues.

The provider monitored and assessed the quality of the service directly as well as through other staff in the home. The registered and deputy managers' carried out a range of scheduled checks and monitoring activity to provide assurance that people had received the improved care and support they needed. Further monitoring was performed by other staff in the home including the nurses, kitchen staff and handyperson.

The provider and registered manager were regularly overseeing staff and speaking with people, visitors and staff whilst in the home to ascertain how effective the staff group were. They said to us they also operated an 'open door' policy, where any visitor or staff could speak with them at any time.

We asked the registered manager for the records of safety tests. The periodic test of gas and electrical appliances and water safety tests were in date. Regular tests of the fire alarm system, emergency lighting were also in place and tested by staff on a weekly basis. That demonstrated the registered manager ensured the home was safe and demonstrated good management skills. Staff were aware of the process for

reporting faults and repairs, and had access to a list of on call contact telephone numbers if there was an interruption in the provision of service. Other information included in the facilities folder in the main office and also held by the nurse on duty included instructions where the gas, electrical and water isolation points were located. Staff were aware who to contact in the event of an emergency out of normal office hours.

One relative said, "We haven't had a formal questionnaire about his care for more than a year. There's more informal chats." The person went on to say they were satisfied with the outcome of these conversations.

We found people who lived in the home and their relatives were regularly asked to comment through the quality questionnaires that were distributed. The most recent were distributed in June, September and October 2017 and covered the appearance and manners of staff and expanding the food choices offered at meal times. The numbers returned were on average about eight of the thirty-two and outcomes were shared with the entire staff group at staff meetings and changes made where necessary. The registered manager said there were further questionnaires that would be circulated later in the year, but regarded the low number returned indicated that people were satisfied with the service provided. The provider added they and the managers' would continue to have an open door policy and meet with relatives to gauge people's opinions and ascertain the need for change.

People's relatives' told us they had good relationships with the provider, manager and staff in the home. One person said, "Yes I think it is well led. It's not chaotic. They use the same staff and not agency staff. Lots of staff who have left for other jobs have come back here." A second relative said, "I think the important things are managed well."

Staff told us the management team regularly assisted in the day to day running of the home. One member of staff said, "The manager and senior nurse are out on the floor a lot of the time." A second member of staff said, "The seniors [managers] always oversee what we do, it's one way of them checking we are doing things correctly."

The registered manager understood their responsibilities and displayed a commitment to providing quality care. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required. Staff felt the registered manager was approachable and understanding, and told us they were supportive.

We spoke with the registered manager about the visions and values of the provider. They said there was an emphasis on openness and honesty throughout the home. They told us about the open agenda at staff meetings where staff could add items for discussion. There was a suggestion about improved communication, and this resulted in the implementation of the 'progress and evaluation' sheets. These are in place for all people who agree and are in addition to the daily and nursing records.

The registered manager told us that nurses and staff were supported to improve their practice though individual supervision sessions. They said staff had responded positively through these and that these were used develop the staff and people's care plans. That demonstrated the registered manager used staff's long term knowledge of people to develop and improve their care plans and their experience of care.

The registered manager understood their responsibilities and ensured that we were notified of events that affected the people, staff and building. The registered manager had a clear understanding of what they wanted to achieve for the people at the home and they were supported by the deputy manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff were provided with detailed job descriptions and had regular supervision and staff meetings. The registered manager explained individual supervision was used to support staff to maintain and improve their performance. Staff confirmed they had attended supervision sessions and had access to copies of the provider's policies and procedures, which are updated regularly.

Prior to our inspection visit we contacted the local authority commissioners responsible for the care of people who used the service. They had positive comments about the registered manager, the staff and the quality of care provided.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were put at risk from unlocked doors and chemicals that were not stored properly.