Serene Care (UK) Ltd

Abbey Rose

Inspection report

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Date of inspection visit:
02 August 2016
04 August 2016

Date of publication:
20 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 02 August 2016 and was unannounced. The inspection continued on 04 August 2016 and this was also unannounced.

Abbey Rose provides accommodation and personal care for up to 24 people. The home provides care for older people which includes people living with dementia. Communal facilities in the home include a lounge, dining room and an enclosed rear garden.

Our last inspection on 22 and 23 November 2014 found that processes did not operate effectively to investigate an allegation of abuse. We found that people did not always receive care that was appropriate or that met their needs and that care and treatment did not always meet people's needs. We identified that systems and processes were not in place to monitor and mitigate risks to people; medicines were not always managed properly or safely and there were not always enough suitably trained staff on duty. We also saw that the registered manager had not acted in accordance with the Mental Capacity Act or notified the Care Quality Commission (CQC) of their absence from the service for long periods of time. During this inspection we found that improvements had been made.

The service had a registered manager in place. 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.

People ate dinner in the dining room on both days of the inspection. We observed people eating their dinner in the dining room on both days of the inspection and saw staff taking it in turns to stand in the kitchen doorway and be available should anyone need support. Once people had finished their meals plates were collected, people were asked if they liked what they had and if they wanted dessert. We noted that there was very little interaction between people and staff during meal times which resulted in it being mainly silent.

People's social and emotional needs were not consistently met and people were not actively supported to be involved in making day to day choices and decisions. People were presented with drinks as opposed to being asked what they would prefer and during lunch people were only given a glass of water to accompany their meals.

People's changing needs were not always reflected in their care plans and staff relied on verbal updates when changes occurred. Communication systems in place were not used effectively and staff told us that communication between the management and themselves could be better.

Staff were not all aware of what people liked to participate in. People's interests, likes, dislikes and hobbies had not been identified or recorded in the care files. This meant that planned activities were not always

reflective of things the people were interested in.

People, relatives and staff told us that the service was safe. Staff were able to tell us how they would report and recognise signs of abuse and had received training in safeguarding.

Care plans were in place which detailed the care and support people needed to remain safe. Each person had a care file which also included guidelines to make sure staff supported people in a way they preferred. Risk assessments were completed, regularly reviewed and up to date.

Medicines were managed safely, were securely stored, correctly recorded and only administered by staff that were trained to give medicines.

Staff had a good knowledge of people's physical health needs and received regular mandatory training identified by the provider. Staff told us they received regular supervisions which were carried out by the care manager. We reviewed records which confirmed this. Staff told us that they found these useful.

Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. Capacity assessments were completed and best interest decisions recorded as and when appropriate.

People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with ongoing care needs. Records we reviewed showed that people had recently seen the GP, District nurse, mental health team and a chiropodist.

People had their care and support needs assessed before being admitted to the service and care packages reflected needs identified in these.

There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them. We saw that there were no outstanding complaints in place. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

People, relatives and staff felt that the service was well led. The registered and care manager were both working hard to encourage an open working environment. A staff member told us, "The care manager leads us really well and is so approachable".

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

Quality monitoring audits were completed by the service manager and staff competency assessments took place on staff carrying out different tasks. The registered manager had action plans in place and there were clear goals set to improve the service. This showed that there were good monitoring systems and plans in place to ensure safe quality care and support was provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff available to meet people's assessed care and support needs.

People were at a reduced risk of harm because staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were at a reduced risk of harm because risk assessments and emergency contingency plans were in place and up to date.

People were at a reduced risk of harm because medicines were managed safely, securely stored, correctly recorded and only administered by staff that were trained to give medicines

Is the service effective?

Good

The service was effective. Capacity assessments were completed and best interest decisions were recorded by the service. This meant any decisions made on people's behalf were in the person's best interest and the least restrictive.

People's choices were respected and staff understood the requirements of the Mental Capacity Act 2005.

Staff received training and supervision to give them the skills they needed to carry out their roles.

Staff were supported and given opportunities for additional training and personal development.

People were supported to access health care services and other professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always supported by staff that spent time and regularly interacted with them.

People were not always supported by staff that used person centred approaches to deliver the care and support they

provided.

Staff did not have a good understanding of the peoples interests.

People were not always supported to make day to day decisions about how they liked to spend their time.

Staff did not all get down to people's level when communicating with them.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care file's and guidelines did not reflect recent changes to people's needs.

People were supported by staff that recognised and responded to their changing needs but management and staff communicated these changes verbally. This meant that some staff may not be aware of certain changes.

People were not always supported to take part in activities they had interests in within the home.

People had opportunities but the service could not demonstrate that changes had been made in response to people's feedback or comments.

A complaints procedure was in place. People and relatives told us they felt able to raise concerns with staff and the manager.

Is the service well-led?

Good

The service was mainly well led. The registered and care manager were working hard to promote and encourage an open working environment.

The care manager was flexible and worked regular care shifts to ensure quality care was being provided and any shortfalls were actioned promptly.

Regular quality audits and staff competency checks were carried out to make sure the service was safe and that staff had the skills they needed to do their job.

Abbey Rose

Detailed findings

Background to this inspection

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

This inspection took place on 02 August 2016 and was unannounced. The inspection continued on 04 August 2016 and this was also unannounced. The inspection was carried out by an inspector and a Specialist Advisor who had skills in dementia, nursing and elderly care.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with seven people who use the service, three relatives and one health professional. We received feedback from a relative through the share your experience survey.

We spoke with the registered manager and care manager. We met with seven care workers and one of the chef's. We reviewed six people's care files, policies, risk assessments, health and safety records, quality audits and the 2016 quality survey results. We observed staff interactions with people, two meal times and a staff handover. We looked at three staff files, the recruitment process, activity records, resident meeting notes, complaints, training, supervision and appraisal records.

Good

Is the service safe?

Our findings

At the previous inspection on 22 & 23 November 2014 we found that arrangements around safeguarding people were not in place. We also found that there was not an effective system in place to manage risks to people, staffing levels were not sufficient and medicines were not being managed safely. Following the inspection the provider wrote to us and told us that they would make improvements. During this inspection we found that improvements had been made.

People commented to us that they felt safe living in the service. One person said, "I have a clean room, not a bad place at all. I feel safe here". Another person told us, "Yes I'm safe here, staff are nice".

Relatives and friends were positive about the safety of the service. One relative told us, "I feel my relative is safe at Abbey Rose because staff care and will look after them. I have no fears of safety". Another relative mentioned, " Yes I feel my relative is safe". A relative fedback to us through a share your experience survey saying; 'there is a very welcoming and a "homely" feeling. We have confidence in this home'.

Staff were able to tell us how they would recognise if someone was being abused. Staff told us that they would raise concerns with management. A staff member said, "Abbey Rose is a safe service. Staff are nice to people. People are well looked after". Staff were aware of external agencies they could contact if they had concerns including the local safeguarding team and Care Quality Commission. Staff told us that they had received safeguarding training and that it was regularly updated. We looked at the training records which confirmed this. The service had a copy of the Local Authority safeguarding policy in place which detailed definitions, preventative measures, the external investigation process, and key external contacts. The service told us they were putting a local policy in place to accompany this one and provide contacts of the owners and management team.

Risks to people were managed and appropriate assessments completed. We reviewed six care files which identified people's individual risks and detailed control measures staff needed to follow to ensure risks were managed and people were kept safe. We were told that management complete risk assessments and share these with the staff. Staff we spoke to told us people had risk assessments in place and were able to direct us to these and explain them when asked. This demonstrated that staff were aware of people's risks and actions they needed to follow to minimise risk and harm to people and themselves.

A staff member told us, "There are safe systems in place to reduce risks to people. For example; waterlow scale assessment to measure risks of pressure sores, risk assessments for people and equipment like the hoist. We also constantly assess the environment".

People had Personal Emergency Evacuation Plans in place as part of their care plans. These plans detailed how people should be supported in the event of a fire. We reviewed the fire safety record which recorded regular fire alarm and equipment tests. The service were addressing areas of their fire safety risk assessment which had been raised by the local fire safety officer as part of a recent fire safety audit. We noted that there were emergency contact details for services such as the gas and electricity providers.

The registered and service manager told us that they used a staff dependency tool to assess staffing levels. The service care manager told us how many staff were required throughout the day. We reviewed four weeks of the rota which reflected the numbers given to us by the care manager. People, staff and relatives told us that there were mainly enough staff. One person told us, "There is enough staff; they are here because they want to be. They're nice". Another person said, "There are enough staff for me". A staff member told us, "There are enough staff especially in the afternoon's. It's ok in the morning just busy". A relative said, "There is enough staff to meet my family member's needs". Another relative told us, "From what I observe when I visit there are enough staff".

Recruitment was carried out safely. Checks were undertaken on staff suitability before they began working at the home. Checks included references, criminal records checks with the Disclosure and Baring Service (DBS), identification and employment history. Where gaps in employment history were apparent on the member of staff's application form, these gaps were explored and documented as part of the recruitment process.

People's medicines were managed safely. Medicines were stored securely and keys to medicine storage were held by authorised staff. Upon arrival the care manager was undertaking the medicines round. We wandered around the building and saw that the medicines trolley was unattended on the first floor. We found the trolley to be locked and parked in the corner out of people's access routes. This demonstrated that medicines were stored safely whilst being administered to people in their rooms. People's medicines were signed as given and absent from the medicine packages indicating that they had been administered. When medicines had not been administered there was a recorded reason for this on the medicine administration record. The registered manager told us that medicines were audited which included checks on stock and recording of administration.

Good

Is the service effective?

Our findings

At the previous inspection on 22 & 23 November 2014 we found that arrangements around providing care to people who lacked capacity to make decisions about their care were not in place. We also found that there were insufficient numbers of suitably skilled staff deployed to meet people's needs. Following the inspection the provider wrote to us and told us that they would make improvements. During this inspection we found that improvements had been made.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered and service manager told us that five Deprivation of Liberty Safeguards (DOLs) applications had been sent to the local authority.

People care files evidenced that consent to care was sought; capacity assessments were completed with people which included day to day tasks. Best interest decisions were made with input from professionals, relatives and the staff. We saw that one person had been showing signs of anxiety and wanting to leave the home. The service had assessed their capacity and applied for an urgent DOLs. We noted that a best interest meeting had been recorded and took place with the person, relatives, an independent mental capacity assessor from the local authority and the service. This demonstrated an effective response to the persons needs by Abbey Rose which followed the legal framework. Other DOLs applications had been applied for and were with the local authority. The registered manager told us that they had been following these up.

A staff member told us, "The MCA is in place to protect people from decisions being made for them. Capacity is assessed and if necessary best interest decisions are made with the appropriate people like relatives, local authority, advocate. The best interest decision will always be the least restrictive. I have done MCA training". We checked the training record which confirmed this. We also noted that there was information and guidance for staff regarding the MCA and DOLs hung up on the notice board in the staff area. This showed us that staff had easy access to information and an understanding.

Staff were knowledgeable of people's physical health needs and received regular training which related to their roles and responsibilities. A plan for staff training was in place and kept up to date by the registered manager. There was a variety of training such as fire, health and safety, food hygiene, infection control, MCA, moving and handling and safeguarding. The majority of training was delivered using workbooks. A staff member told us, "We receive training but it is mostly workbooks which we can struggle with. Face to face training is better. I did fire training which was face to face and took so much knowledge from it". The manager said that basic life support, manual handling, safeguarding and fire training is delivered face to face. Staff told us that they found face to face training more informative and felt that it was a more effective

way of learning. We discussed this with the manager who told us they will look into delivering more face to face training and mentioned upcoming dementia and person centred approaches. Another staff member said, "I have completed my level two in health and social care and am interested in doing my level three. I found this really helpful". We reviewed the training matrix and found that nine staff had currently achieved diplomas between level two and five.

We saw that all supervisions were completed by the manager. The registered and care manager told us they aim to do these monthly and complete annual appraisals. All supervisions were on a 1:1 basis. A staff member told us, "I receive regular supervisions. I find them useful".

People were supported to maintain a healthy diet and food and fluid charts were maintained where appropriate. A person told us, "It's good food. We have a trained chef". Another person said, "its bog standard food". We found that there was a large amount of tinned fruit and peas There was also a number of value products purchased for example; tuna, beans, tomatoes and eggs. We discussed this with the registered manager who told us that they needed to be cost effective. They went onto say that they have recently introduced crisps as when they started this was not an option to people at tea time. We reviewed menus and saw that there were two lunch and tea options. We saw that in a recent resident meeting people had been asked if they liked the food and that those attending had fed back saying yes. We found that the menu was a four week rolling one which was last reviewed 12 months ago. Staff told us the chef suggests options and the owner decided.

We were told that the chef visits people each morning to identify their chosen meal for the day. We reviewed the record book for this and saw that it was up to date. People's dietary needs were known by the staff who worked in the kitchen and we noted that these needs were displayed on the back of the pantry door. The care manager told us that night staff prepare people's breakfasts, the chef cooks and prepares main meals and the afternoon staff prepare tea and supper.

We observed people eating their dinner in the dining room on both days of the inspection and saw staff taking it in turns to stand in the kitchen doorway and be available should anyone need support. On several occasions we witnessed one staff member approaching people to check they were ok and see if they needed any support. Once people had finished their meals plates were collected, people were asked if they liked what they had and if they wanted dessert. We noted that there was very little interaction between people and staff during meal times which resulted in it being mainly silent. A relative told us, "Staff bring my family member their meal then they go away. They don't really talk to them". We fed this back to the registered manager and asked them if they had ever sat in the dining room during meal times. The registered manager told us that they had not but will do this and observe what we had found.

People had access to health care services as and when needed. One person had a fortnightly telephone call with a local professional; we found that these were recorded and up to date. This demonstrated that the service was empowering the person to maintain their own independence.

Health professional visits were recorded in people's care files which detailed the reason for the visit, the outcome and any actions which needed to be taken by the care staff. Recent visits included; District Nurse, GP, Chiropodist and hospital appointments.

Requires Improvement

Is the service caring?

Our findings

Abbey Rose was not always caring because people's social and emotional needs were not consistently met and people were not actively supported to be involved in making day to day choices and decisions. For example, when the tea trolley came out people were presented with drinks as opposed to being asked what they would prefer and during lunch people were only given a glass of water to accompany their meals. There were no water or juice jugs placed on people's tables. This did not promote choice to people. We noted that by the medicine trolleys there was a table plan identifying where people sat at meal times. We observed people being supported to these seats without being given choice of sitting somewhere different. When we asked about the table plan we were told it was used by the medicine administrator. We asked the registered manager who had put the table plan together. The registered manager told us that she would hope that people had but could not be sure of that as it had been in place before their time. They went on to say that a staff member had approached them at lunch time and said that one lady had asked to sit in a different seat. The staff member felt they needed to check it was ok with the registered manager before supporting them to sit there. This demonstrated a lack in promoting choice and decision making.

We saw that the TV was turned on however the volume level was low, subtitles were not on and we observed staff choosing the channel and when to turn it on and off. We did not observe people being given the choice of what or when to watch. We observed on a number of occasions especially during the medicine round that staff stood over people whilst talking to them. This did not demonstrate a positive caring approach during interactions.

During the afternoon on the first day we heard people being told to sit down on seven occasions but not given anything to occupy themselves with. We observed staff supporting people to sit and then leaving them there whilst they completed other tasks. Although there was mainly at least one staff member present in the communal living/dining area we noted that there was little social interaction between people and staff which showed us again that the service being delivered to people was mainly task driven as opposed to person led.

We asked new staff how they got to know people and develop positive relationships with them. One staff member told us, "I ask people questions about their interests and what I can help them with". Staff told us that people had a life map in the care plans which identified things such as people's likes, dislikes, interests, hobbies and past. We reviewed six life maps and found that five were incomplete and that one person did not have one. Those that were incomplete held very limited information. For example, one person's said they liked reading but it did not say whether this was things like books, magazines, fiction or newspapers. This showed us that there were no person centred systems in place to detail things that were important to the people staff were caring for. This meant new and existing staff did not have the information they needed to really relate to people.

We did however observe staff being respectful when they had interactions with people. For example, we observed two people being transferred from wheelchairs to armchairs. This was done appropriately by staff who talked the people through what they were doing and by checking that they were comfortable before

leaving. We observed one staff member commenting on how nice a person's hair looked after visiting the hairdresser; we noted from the person's response that they appreciated the comment. We also saw one person approach a staff member upset, the staff member showed compassion and reassurance to the person this demonstrated that a positive caring relationship had been built between them.

We noted a number of relatives and friends visiting people in the home. A relative told us, "Staff are always pleasant and happy". Another relative fed back through a share your experience survey that staff were caring and always welcoming".

People, staff, relatives and health professionals all said that the service was caring. One person told us, "I know the staff are here because they want to be. They are nice". Another person said, "People here are nice and so are the staff".

A staff member told us, "I'm caring. I was bought up caring. I like being nice to others and believe my colleagues are caring too". Another staff member said, "We all care for each other here, it's a caring environment".

The care files we reviewed held pen profiles of people, recorded key professionals involved in their care, medicines and medical conditions. This information supported new and experienced staff to understand important health information about the people they were supporting.

People's privacy and dignity was respected by staff. Communal toilets and bathrooms had locks on them. People's individual records were kept securely in locked cabinets to ensure sensitive information was kept confidential.

Staff we observed were polite, treated people in a dignified manner throughout the course of our visit and knocked on doors before entering people's rooms or communal bathrooms. We asked staff how they respected people's privacy and dignity. One staff member told us, "I knock on people's doors, close doors behind me, talk people through personal care activities and seek consent".

During a discussion with a staff member they heard a person getting upset out in the corridor. The staff member stopped the discussion to go and check on them, after some reassurance and interaction the person was fine. This demonstrated a caring approach.

Requires Improvement

Is the service responsive?

Our findings

Abbey Rose was not consistently responsive to people or their changing needs. Staff told us about one person who had a change in their behaviour which required staff to use a different approach and additional personal protective equipment however this was not reflected in their care plan or guidelines for staff. We were also told about another person who was requiring additional staff support for transferring and mobility. We reviewed their file and found that this was not reflected in the persons care plan either. We asked staff how they were informed about these changes and they said that the care manager had updated them verbally. This did not demonstrate a responsive approach and meant that new and agency staff would rely on experienced staff to inform them. We discussed this with the registered manager who told us that a review of peoples care plans and files was on the top of their priority list.

We saw in the staff area that there was a care plan update book. We asked staff when this book was used. Some staff told us that management use it to communicate when care plans had been updated and other staff said they were not aware of it being used. We noted that the last update logged was dated 09/05/2016. Next to the care plan update book was a communication book. We asked staff what this book was used for. Some staff told us that it was introduced for management to communicate key messages to them. Other staff said that anyone can write in the book and communicate to each other. We noted that the last message to staff was dated 17/06/2016 and referred to staff checking a person's draws for dirty clothing. The message prior to that and dated 15/05/2016 referred to a person attempting to leave the building and staff needing to follow the protocol in place. We asked the registered manager if we could see the protocol. The registered manager told us that it was not an official written protocol it was a verbal one. We asked staff how often they looked at these books. We were told by some that they looked at them every few weeks and others said every couple of days. We noted that only four staff had initialled the last few logged communications. During our inspection we were told that communication between management and staff could be better. These findings demonstrated that important information was not always being read by all staff or written down and shared with all staff using the systems they had in place. We discussed this with the registered manager who told us that the diary is used more. We reviewed entries recorded in the diary and found that these reflected planned appointments, visits, staff sickness and hospital discharges. There was no evidence of key messages or communications being recorded in there. This evidenced that staff relied on verbal updates from managers and colleagues which meant that some information may not be passed on and people may not always receive personalised care that was responsive to their needs. The registered manager acknowledged this and will review how to improve communication. We found that no harm to people had resulted from this.

We observed staff choosing activities to do with people rather than people being asked what activity they would like to take part in. For example one activity involved people throwing a bean bag onto a sheet on the floor which had letters on. Whichever letter the bag landed on the person had to think of a word beginning with that letter. Some people were engaged and taking part where as others weren't. A staff member said, "We try to do activities with people but they don't want to join in. An external person came in yesterday to do exercises with people. A few joined in". Another staff member told us, "We had a baking day which was successful. It was a long time ago now". They went on to say, "We have gardening days, people like these

especially the ladies".

We noted that activities such as board games, jigsaws, colouring, knitting and dominoes were shut away inside a cupboard in the staff area. We also saw that there were no magazines or newspapers in the communal areas. This meant that people did not have easy access to activities which may be of interest to them. We did see that in the quiet area there was a library with a good collection of different books. We asked staff why the other activities were not kept in the quiet area in sight for people to pick and choose from. Staff said that they were told they should be stored in the cupboard. Staff told us that they felt it would encourage people to use them more if they could see and access them easily. We asked staff if people were asked if they would like to take part in activities stored in the cupboard. We were told that some staff offer this verbally but may not show people different choices. We saw that on the people notice board different activities were displayed. These included resident meetings, church communion, summer fun and when the hairdresser was next visiting.

We saw that people meetings take place regularly. At the last one nine people attended and were asked what activities they wanted to do. People were not forthcoming with suggestions or choices. We asked staff if they knew what each person enjoyed doing in their spare time. Staff said that they weren't sure. A relative told us, "If there is activity here it is not what my family member likes. There is not much activity going on here". This demonstrated that activities were not always planned or offered in response to people's hobbies, interests, likes or dislikes. The registered manager told us that they had recruited an activity coordinator however this person had decided not to take on the role. We were told that another activity coordinator will be recruited as soon as possible.

The purpose of meetings had also been discussed with people in a meeting that took place in June. We noted that people had been informed that these were an opportunity for them to discuss concerns or complaints as well as say what people feel is working well. We noted that meals were discussed. Two people had fed back that they felt there was plenty of variety. We did not see that menu's had been discussed with people and we found that the menu had not been reviewed for 12 months. The registered manager told us that they hoped people were involved in menu reviews however they could not be sure they were. Staff told us that the chef and owner reviewed this. The registered manager told us that they will look into it. Although resident meetings took place actions which came from these were not clearly identified or set within a plan. We discussed this with the care manager who leads them. The care manager told us that they will review the template and add an action plan to it.

We observed staff promptly responding to peoples call bells on several occasions. These approaches demonstrated a responsive approach by staff.

Care files had completed pre admission assessments which formed the foundation of basic information sheets and care plans. We noted that there were actions under each key area of care which detailed how staff should support people. We observed a staff handover which took place in the staff area. The shift leader led the handover and updated the afternoon staff on the main events which had occurred that morning. They then discussed each person individually and covered key areas for example; activities, personal care and health concerns. Logs were also checked and completed. A family member told us, "The staff respond to my relatives needs in a way that does not restrict them".

The service had a complaints system in place which captured complaints and reflected the steps taken to resolve them. We found there to be no outstanding actions. People, relatives and staff we spoke to all said that they would feel able to raise any concerns they may have. A relative said, "If I had any concerns I would see the care manager and am confident it would be dealt with". A person told us, "I would tell staff if I wasn't

happy".

Good

Is the service well-led?

Our findings

At the previous inspection on 22 & 23 November 2014 we found that the home did not notify the CQC of the manager's absence from the service. During this inspection we found that improvements had been made.

The registered manager had added Abbey Rose to their registeration which meant that she was registered to manage two services for the provider. They spend three days a week at Abbey Rose and two days at the other service. The care manager worked full time during the week and at weekends managing the day to day running of the service. The registered manager told us that the provider came to the service on a weekly basis and that they felt supported.

We identified that the management at Abbey Rose were working hard to improve and promote a positive, open and empowering culture within the service. The registered manager told us that they have a clear vision, number of goals and action plans in place to fulfil. We reviewed the action plans which demonstrated that areas had been identified and improvements were planned to take place. These included for example, person centred approach training, the recruitment of an activities coordinator and a review of people's care files. The registered manager told us that their aim with the person centred training was to help the service bring in changes which will benefit the people they support.

The care manager worked a mix of care and management shifts which staff told us worked well. This allowed them to support both the staff and the manager. We saw that the care manager conducted task observations on staff as well as formal supervisions. The observations covered areas such as personal care, mobility, nutrition and privacy. Staff were then either signed off as competent or underwent further support to ensure they were competent in the areas identified as needing improvement. The observations we reviewed evidenced that staff were competent in the areas they had been observed in. This demonstrated good management, leadership and quality monitoring by the care manager. A relative told us, "I would give the service an eight out of 10".

Staff told us that they felt the care manager was a good leader and that they explain things well. One staff member said, "The care manager is lovely, they can really relate to the care staff. I never feel under pressure around them". Another staff member told us, "The registered manager is often in the office. They seem nice but I don't really see them much". A relative said, "The care manager is fantastic. I don't really see the registered manager".

The registered manager told us that audits are completed regularly. We reviewed these and found that they covered areas such as medication, air mattresses, first aid and environment. We noted that there were no outstanding actions. We saw that provider monitoring visits took place however these were currently completed by the registered manager and then signed off by the provider. The registered manager told us that the provider now recognises that they need to complete these.

We reviewed the services quality assurance survey results. This was carried out March 2016. There were a variety of aspects looked at including food, staff, environment, management. People, visitors and relatives

were sent these surveys. An action plan had been created for aspects which were not rated positively, eg poor food and limited breakfast options. Actions included discussing this at staff and resident meetings. We noted that better quality meat and bread was purchased however breakfast choices did not include a cooked one. The registered manager told us they will look into this with a view to offer it.

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.