Abbey Chase Residential and Nursing Homes Limited

Abbey Chase Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

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

Abbey Chase Nursing Home accommodates a maximum of 62 older people in one adapted building. There were 58 people living at the home at the time of our inspection.

The inspection took place on 23 and 30 August 2018. The first day of the inspection was unannounced. We gave notice of the second day of inspection as we wanted to ensure the registered manager was available to meet with us.

There was a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run.

At our last inspection in January 2018 we found the provider was breaching regulations in relation to safe care and treatment, privacy and dignity and governance. The home was not adequately secure as people were able to enter the building unchecked. Standards of fire safety were not adequate. Some medicines and potentially harmful chemicals were not stored securely and staff did not always follow appropriate infection control procedures. Some staff did not engage with people when providing their care and support. We observed that two people were not supported to eat safely and that staff did not always respect people's choices about the food they ate. The provider's quality monitoring systems had not always been effective in identifying concerns.

The provider sent CQC an action plan in March 2018 setting out the action they would take to meet the regulations.

At this inspection we found the provider had implemented the action plan, which had led to improvements in safety and the way in which people were cared for. Standards of security and fire safety had improved. Medicines were stored securely. On the first day of our inspection, the temperature in one clinical room was too high for the safe storage of medicines. The provider had addressed this by the second day of the inspection and moved the medicines to a safe environment. The home was clean and hygienic and staff maintained appropriate standards of infection control. Although we saw some cleaning products accessible in a communal area on the first day of the inspection, the provider's monitoring data demonstrated that improvements had been made and maintained and that this represented an isolated incident.

The provider had worked with staff to ensure they considered people's needs holistically, not just their care needs. People received the support they needed to eat and drink safely. The provider had improved the

systems used to monitor quality and safety.

People felt safe and secure at the home. Staff understood safeguarding procedures and knew how to report any concerns they had. There were enough staff on each shift to keep people safe. People were protected by the provider's recruitment procedures because checks were carried out on staff before they began work. There were safe systems of medicines administration and recording. Staff who administered medicines were trained and their competence observed before they were authorised to do so. There were plans in place to ensure people would continue to receive their care in the event of an emergency. Staff carried out health and safety checks were carried out regularly. Accidents and incidents were recorded and action taken to improve when things went wrong.

People's needs were assessed before they moved into the home to ensure staff could provide the care they needed. Staff had an induction when they started work and had access to the training they needed to carry out their roles. Staff met regularly with their line managers to discuss their performance and training needs. The home employed a training officer to plan, co-ordinate and deliver the training staff needed.

People's care was provided in accordance with the Mental Capacity Act 2005 (MCA). Staff sought people's consent before providing their care. Applications for Deprivation of Liberty Safeguards (DoLS) authorisations had been submitted where people were subject to restrictions in their care. On the first day of inspection, we found some areas in which the provider could improve. For example, some of the measures put in place to keep people safe, such as bedrails, could have been less restrictive and some mental capacity assessments were not decision-specific. The registered manager had implemented these improvements by the second day of the inspection.

Staff monitored people's healthcare needs and supported them to access treatment if they needed it. People said staff supported them to see a doctor if they felt unwell and care plans demonstrated that healthcare professionals were involved in people's care where necessary. Most people enjoyed the food provided and were satisfied with the choice of meals available. Relatives told us staff encouraged their family members to eat and drink to ensure they maintained adequate nutrition and hydration. People's nutritional needs were assessed and information about individual dietary requirements was communicated to catering staff. The home was suitable for people's needs. Adaptations had been installed to keep people safe and people were able to personalise their own space. The provider had refurbished some parts of the home since the last inspection, including redecorating some of the communal areas and installing new flooring.

At our last inspection we observed that some staff behaved in an uncaring way and that some staff made decisions for people without establishing their wishes, for example at mealtimes. Two people's meals were interrupted for healthcare appointments and a member of staff and a healthcare professional discussed people's needs in a communal area. One person who was being supported to go to the bathroom was not adequately covered which compromised their dignity. At this inspection we found the provider had taken action to improve. 'Protected mealtimes' had been introduced so that meals would not be interrupted by professionals' visits. Staff had attended Dignity training workshops and observations and audits had been implemented.

People told us staff respected their choices about their care. Relatives said staff supported their family members to make decisions in their day-to-day lives. Staff encouraged and supported people to maintain their independence. Relatives were able to visit their family members whenever they wished and to attend events at the home. Relatives told us they were made welcome by staff when they visited. People had access to a wide range of activities, which they told us they enjoyed. However, we found that people who were

cared for in bed may be at risk of social isolation. We have made a recommendation about this.

People's care plans were personalised and reflected their individual needs. People and their relatives had opportunities to contribute to the development of their care plans. Although the majority of care plans we checked addressed all areas of people's lives, some had not recorded people's wishes regarding end-of-life care. We discussed this with the registered manager, who agreed to address the issue.

People who lived at the home and their relatives had opportunities to contribute their views at residents' and relatives' meetings. People told us they knew how to complain if necessary and said they felt confident to raise concerns. Any complaints received had been investigated and responded to appropriately by the registered manager.

Quality monitoring systems had improved since our last inspection, including the introduction of regular spot checks and quality audits. The registered manager and heads of departments attended a daily meeting to plan the day ahead. We received positive feedback about the registered manager from professionals and staff. Staff said they were well-supported by the registered manager and senior staff. Professionals told us the registered manager and staff worked co-operatively with other agencies and adopted any guidance they recommended. The manager had notified CQC and other relevant agencies of significant events when necessary.

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.

Risks to people had been assessed and suitable steps taken to minimise any risks identified.

Medicines were managed safely.

There were sufficient staff deployed to keep people safe.

People were protected by the provider's recruitment procedures.

Staff understood their role in keeping people safe and their responsibility to report any concerns they had.

There were plans in place to ensure people would continue to receive care in the event of an emergency.

Staff maintained appropriate standards of infection control.

Is the service effective?

Good

The service was effective.

People's care was provided in accordance with the Mental Capacity Act 2005.

People's needs were assessed before they moved to the home to ensure staff could provide their care.

Staff had an induction when they started work and the training they needed to carry out their roles.

Staff had opportunities to discuss their performance and training needs.

People enjoyed the food provided and were satisfied with the choice of meals.

People's dietary needs were assessed and communicated to catering staff.

Staff monitored people's healthcare needs and supported them to access treatment if they needed it.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and maintained their privacy and dignity.

People's choices about their care were known and respected by staff

Friends and families were able to be involved in the life of the home and were made welcome when they visited.

Staff supported people in a way that promoted their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People who were cared for in bed may be at risk of social isolation.

People had opportunities to take part in group activities, events and occasional outings.

People's individual needs and preferences were reflected in their care plans.

People and their relatives had opportunities to contribute their views about the home.

Complaints were managed and investigated appropriately.

Is the service well-led?

Good

The service was well-led.

Systems of quality monitoring had improved.

Staff worked effectively with other professionals and implemented any guidance they advocated.

Staff told us the registered manager and senior staff were approachable and supportive.

The manager worked co-operatively with other agencies when required and had notified CQC of any significant events.	

Abbey Chase Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 30 August 2018. The first day of the inspection was unannounced and was carried out by two inspectors, a specialist nursing advisor and an expert-by-experience. An expert-by-experience is someone who has a relative who has used this type of care service. The second day of the inspection was announced and was carried out by two inspectors.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also received feedback from the local authority and from healthcare professionals who had an involvement in the home.

During the inspection we spoke with 12 people who lived at the home, three relatives and a visiting healthcare professional. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff. We spoke with 11 staff, including the registered manager and care, nursing, catering and housekeeping staff.

We looked at the care records of six people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We checked five staff recruitment files and records relating to staff support, supervision and training. We also looked at records used to monitor the quality of the service, such as audits of different aspects of the service.

Good

Is the service safe?

Our findings

At the last inspection we found that the home was not always kept adequately secure, which potentially posed a risk to people. A member of staff opened the front door remotely when we arrived and the inspection team walked into the home without being approached by staff and without staff checking our identification. At this inspection the identification of team members was checked and we were asked to sign in.

At the last inspection we found that medicines were not always stored securely. At this inspection we found that all medicines were stored securely. On the first day of our inspection we found that the temperature in one clinical room was too high for the safe storage of medicines. The provider had addressed this by the second day of the inspection and transferred the medicines to a more suitable environment.

Staff who administered medicines received training in this area and their practice was observed before they were authorised to do so. There appropriate arrangements for the ordering and disposal of medicines. The medicines administration records (MAR) we checked were clear and fully completed. The records demonstrated that people were receiving their medicines as prescribed and any reasons for people not taking their medicines were recorded. The medicines audits we checked indicated that medicines were managed safely. Where medicines were prescribed 'as required' (PRN), individual protocols were in place to give staff guidance about when these medicines should and should not be given.

A healthcare professional who had worked with the home reported that staff managed medicines safely. The healthcare professional told us, "The staff we worked with had a good understanding about the safe storage of medication, the trolley was always secured when not in use and the keys were held on the person of the responsible nurse." The healthcare professional also reported, "MAR charts are completed fully and in a timely manner. Medication is given at appropriate times to ensure efficacy."

People were supported to manage their own medicines where they were able and wished to do so, which increased their independence. A healthcare professional told us, "On review, we found one resident who could be more involved with his medication but who didn't realise he had the choice. His analgesia and sedatives were all changed to 'when required' and he was given the chance at each medication round to decide what he wanted to take. This has increased his confidence and has resulted in several medications being stopped."

At our last inspection we found that cleaning products and other potentially hazardous items were not stored securely. On the first day of this inspection we found that some items which could have posed a risk to people if ingested were accessible in a communal bathroom and a sluice room had been left unlocked. This risk was mitigated by the fact that most people living in this part of the home were unable to mobilise independently, which meant they would not be able to access these rooms without staff support. The provider acted promptly to address these issues when we pointed them out. A more robust lock was fitted to the bathroom and any potentially harmful items were removed immediately. The provider ordered an audible warning system for the sluice room door which would alert staff if the door had not been locked.

At our last inspection we found that that standards of fire safety required improvement as a fire door did not shut properly and a fire door was obstructed by a chair. Surrey Fire and Rescue Service also identified shortfalls in fire safety then they visited the home in March 2018 and issued a letter of fire safety matters requiring the home to improve. Surrey Fire and Rescue Service revisited the home in May 2018 and were satisfied that the improvements required to ensure adequate standards of fire safety had been made.

At this inspection we found that the provider had maintained adequate standards of fire safety. The home's fire risk assessment had been reviewed and updated in May 2018 and all doors that were not fire rated had been replaced. Staff we spoke with said they had received training on emergency procedures when they started work at the home and some of the home's staff had been trained as fire marshalls. The fire alarm system was tested each week by staff and each person had a personal emergency evacuation plan (PEEP), which outlined the support they would need in the event of an emergency.

There were sufficient staff deployed to keep people safe. The registered manager used a dependency tool to calculate the numbers of staff required to meet people's needs. This included ensuring there was an appropriate skill mix of staff in each area of the home. The registered manager said they reviewed the dependency tool regularly to take account of any changes in people's needs. At the last inspection staff did not always respond promptly to call bells when people needed attention. At this inspection we found that the registered manager had implemented spot checks of call bell response times to ensure that staff responded in good time when people needed them. The results of these spot checks indicated that people did not have to wait for unacceptably long periods when they needed support from staff. The number of staff on duty on each shift was calculated according to people's needs and kept under review.

At the last inspection we witnessed two incidents where people were at risk of harm because they were not adequately supervised whilst eating. The risks to these people associated with eating had not been assessed or mitigated. At this inspection we found that the provider had taken action to address this concern. Risks in relation to eating and drinking had been assessed and care plans put in place where people had needs in these areas. People who needed support with eating and drinking received this from staff.

People told us they felt safe at the home. Relatives said staff understood any risks involved in their family members' care and took action to minimise these risks. One relative told us, "They move her regularly and she has never had a bed sore." People told us staff supported them to mobilise safely. One person said, "I can't walk and they help me into my wheelchair." Another person told us, "They support me with movement. They will transfer me from bed to wheelchair and bring me in here." Relatives confirmed that staff kept their family members safe when supporting them to mobilise. One relative told us, "They use a hoist to move her, always two [staff] at a time." We observed during our inspection that staff were competent in using the equipment involved in people's care, such as slings and hoists.

At the last inspection we found some parts of the home had not been adequately cleaned. We also observed a member of staff support a person in a way which was not good infection control practice. At this inspection we found the provider had taken action to improve standards of hygiene and infection control. Following our last inspection, staff had been reminded about infection control policy and procedures and checks introduced to monitor hygiene and infection control. People and relatives told us staff kept the home clean and hygienic. People said staff used gloves and aprons when providing their care and told us they saw staff wash their hands regularly. Staff said there were always sufficient stocks of personal protective equipment available. There were appropriate arrangements for the disposal of clinical waste. We advised the registered manager that one member of housekeeping staff had been unclear about some elements of infection control procedures when we spoke with them during the first day of the inspection. The registered manager agreed to address this with the member of staff.

The provider operated safe recruitment procedures. Applicants for employment were required to submit an application form and attend a face-to-face interview. The provider carried out appropriate checks before staff began work, including obtaining references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate. The DBS helps providers ensure only suitable people are employed in health and social care services. All staff were required to provide proof of their right to work in the UK and nursing staff were also required to provide evidence of current professional registration.

Staff understood their role in keeping people safe and their responsibility to report any concerns they had about people's safety or well-being. They were aware of the different types of abuse people may experience and knew how to report concerns if they suspected abuse. Staff said the manager had reminded them that they should report any concerns they had and confirmed they would feel confident in speaking up if they suspected abuse or poor practice. If concerns had been raised about people's care these had been referred to the local authority where necessary.

Staff carried out regular health and safety checks in the building and any equipment used in delivering people's care, such lifting equipment, was serviced regularly by engineers. The provider had developed a business contingency plan to ensure people's care would not be interrupted in the event of an emergency. Accidents and incidents were recorded and action was taken to improve when things went wrong. For example, one person was able to access the garden without staff noticing they had done so. Following the incident, door alarms were fitted and additional staffing put in place each evening when the person was known to become more anxious.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights under the MCA were respected. People told us that staff asked for permission before providing their support and respected their decisions about their care. Staff attended training in the MCA and understood people's rights to make decisions about their care for themselves. One member of staff told us, "We have training in MCA and DoLS every year. We have to be able to demonstrate knowledge and awareness following the training and we are encouraged to question." A healthcare professional who had worked with the home reported, "Within Abbey Chase, staff fully understand and consistently apply the principles and practice of the MCA, best interest decisions and DoLS. We saw that consent is always obtained before anything happens." The healthcare professional also said, "The best interest of the resident is at the forefront of everything the staff at Abbey Chase do."

Applications for DoLS authorisations had been submitted to the local authority where necessary and there were appropriate procedures in place for people who received their medicines covertly (without their knowledge). These procedures included communication with the healthcare professionals responsible for prescribing the medicines and those responsible for ensuring the medicines were administered in the person's best interests.

Assessments had been carried out where appropriate to establish whether people had capacity to make decisions. If people lacked capacity, appropriate procedures had been followed to ensure decisions were made in their best interests, including consulting families and relevant professionals. Some of the mental capacity assessments we saw were not decision-specific, instead seeking to assess people's capacity to make decisions about several aspects of their care, which did not reflect good practice. On the second day of the inspection the registered manager was able to demonstrate that appropriate mental capacity assessments had been carried out in relation to specific decisions and best interests procedures followed where necessary. We saw evidence that assessments had been reviewed to ensure that the least restrictive options had been considered when imposing restrictions upon people to keep them safe.

People's needs were assessed before they moved into the home to ensure staff had the skills and knowledge to provide their care. Staff received the training and support they needed to meet people's identified needs

and carry out their roles effectively. All new staff attended an induction which included all elements of mandatory training. Staff were appointed initially on a probationary basis and were observed during this period to assess their competence. Competency assessments were carried out for care staff in areas including personal care, communication, infection control and moving and handling.

Following successful completion of their induction and probationary period, staff received regular one-to-one supervision with their line manager and refresher training in mandatory areas. Staff also received training in areas relevant to the needs of the people they supported. For example, a healthcare professional told us they had delivered training to staff which had improved their ability to support people with diabetes. The healthcare professional said, "Training was provided on diabetes, particularly around diet, to ensure greater understanding around the condition." Nursing staff had access to appropriate clinical training and support and opportunities to maintain their Continuing Professional Development (CPD).

Most people said they enjoyed the food provided at the home. They told us they had a good choice of meals and could have alternatives to the advertised menu if they wished. One person said of the food, "It's very good. There are enough choices." Another person told us, "When we were offered either fish pie or chicken pie I told them I didn't want chicken again so asked for egg and chips, which they did for me." Relatives said their family members usually enjoyed their meals and told us that staff encouraged their family members to eat. One relative said, "The food is pretty good. They encourage her to eat to keep her weight up." Another relative told us, "I have no complaints about the food. She enjoys most of what she is given."

People's nutrition and hydration needs were assessed and kept under review. Where necessary, staff had consulted healthcare professionals about people's nutritional needs, including GP and dietitian. Any guidance given by professionals was recorded in people's care plans. People's nutritional needs were regularly evaluated to ensure they received the support they needed. If people required texture-modified food or thickeners in their drinks, this information was recorded and shared with catering staff. The chef told us that they were given a weekly update on people's dietary needs, including allergies or food intolerances, by care staff.

On the first day of the inspection we were given information which indicated that people who needed a texture-modified diet did not have the full range of choice that was available to other people. On the second day of the inspection the chef advised that the meal ordering form used by staff to establish people's choices had been amended to ensure that people who needed a texture-modified diet had access to the full range of meal options.

The home was suitable for people's needs. Adaptations and equipment were in place where necessary to keep people safe while moving around the home and receiving their care. People were able to personalise their own space and to bring items of importance with them when they moved in, such as photographs, ornaments or small pieces of furniture. The provider had made improvements to the environment since the last inspection. These included the redecoration of some of the communal areas and the installation of new flooring on the ground floor. New furniture had been purchased for some parts of the home and new equipment installed in the kitchen and laundry.

People had access to healthcare professionals' advice and treatment when they needed it. A GP visited the home each week and people told us staff arranged for them to see the doctor if they felt unwell. Staff consulted relevant professionals if people developed needs in particular areas. For example, staff had obtained the input of a tissue viability nurse for people who had needs related to the integrity of their skin. People also had access to specialist professionals including a speech and language therapist and an occupational therapist

Good

Is the service caring?

Our findings

At our last inspection, although we saw some staff displaying kind and caring behaviour, we also observed some staff behaving in an uncaring way. For example, some staff did not communicate with people while supporting them or respond when people asked them questions. Some staff made decisions for people without establishing their wishes, for example at mealtimes. We also found that people's privacy and dignity was not always respected. Two people's meals were interrupted by staff bringing a healthcare professional to see them. Staff and a healthcare professional discussed one person's care needs in the dining room, which meant the person's right to confidentiality was not upheld. We witnessed one person being supported by a member of staff to go to the bathroom in a wheelchair. The person was not dressed from the waist down and the towel which had been placed on their lap was not big enough to cover them.

At this inspection we found the provider had taken action to improve this aspect of people's care. This included introducing protected mealtimes so that people's meals would not be interrupted by professionals' visits, arranging Dignity training workshops for staff and carrying out spot check observations on staff practice and engagement. The registered manager had conducted 'protected mealtime' audits to evaluate people's mealtime experience. The home's trainer told us that dignity and respect had been discussed in team meetings and individual supervisions with staff. The trainer told us that the communication and engagement of all new staff was observed during their probationary period before they were signed off as competent.

People told us staff treated them with respect. They said staff maintained their privacy and dignity when providing their care. Most people reported that they had established good relationships with the staff who supported them and enjoyed their company. Two people told us they had not been happy with the approach of two members of staff who had supported them. They said they had reported their feelings about these staff and that their views had been listened to and acted upon.

Relatives told us that staff supported their family members in a respectful way. They said staff maintained their family members' privacy and dignity. A healthcare professional told us that their team had observed staff interactions with people and as they went about their daily jobs. The healthcare professional said that staff provided, "Intervention to prevent or relieve anxiety" and engaged in "Individual discussions with residents."

People told us their choices about their care were known and respected by staff. Relatives said staff supported their family members to make decisions in their day-to-day lives. One relative told us, "They help her make choices; what she wants to wear, when she wants to get up, what she wants to eat." People and their relatives said they were able to be involved in their care, including care planning and reviews. One person told us, "I have no family members involved to speak for me, I make my own decisions." Another person said, "They allow me to make my own decisions." A third person told us, "My son helps me when I need to make decisions about my care. We discuss it together." A relative said, "We had a recent assessment. [Family member] is unable to communicate without our being there."

Relatives said they could visit their family members whenever they wished and that staff made them welcome when they visited. They told us they were invited to events at the home and that they valued these opportunities to enjoy occasions with their family members. One relative said, "We are made very welcome when we visit." A healthcare professional told us that staff were, "Welcoming of families."

People were supported to be independent where they wished to be. One person told us, "Member of staff] has taught me to walk again. Mostly I use a wheelchair but [member of staff] encourages me to walk short distances with her support. When I'm tired they will follow me with a wheelchair in case I need it." Relatives reported that staff encouraged their family members to maintain their independence. One relative said, "They encourage her to do things for herself." A healthcare professional told us that staff provided people with, "Encouragement to do tasks for themselves and praise for a completed task." Another healthcare professional reported that when they and their colleagues visited the home, "We saw that independence is encouraged."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we observed that, although the activities co-ordinator interacted with people, some care staff did not engage with people as they should have. Some staff provided people with food, drink and support but withdrew when they had completed these tasks and had conversations with one another rather than the people who lived at the home. The local authority had found at a monitoring visit that people were served breakfast from 5.30am, which was not their choice. The local authority also found that people had little engagement with staff and did not always have access to drinks.

At this inspection we found the provider had taken action to address these concerns. Breakfast was now served from 7.00am and at a time that people chose to eat. Staff had been reminded of their responsibility to consider people's social and emotional needs in addition to their care and support needs. The provider had introduced monitoring systems to record and evaluate people's engagement with other people, including staff, and the activities they took part in. We observed that staff engaged positively with the people they supported and maintained good communication with them. A healthcare professional who had worked regularly with the home told us, "I have found staff to be very responsive to individual needs."

The home employed activities co-ordinators and there was a weekly programme which included in-house activities, visiting school groups, entertainers and occasional outings. Many people told us they enjoyed the activities provided and the activities which took place during our inspection were well-attended. Relatives said staff encouraged their family members to take part in activities and a healthcare professional told us that staff provided, "Encouragement to join in activities or provision of an individual quieter activity where required."

Although people had access to group activities, we found that people who were cared for in bed may be at risk of social isolation. For example, one person's next-of-kin had expressed concerns at a care review in July 2018 that the person was at risk of social isolation as they spent all their time in bed. The member of staff carrying out the review with the relative had written an action plan in response to the relative's concerns. The action plan stated that staff should provide one-to-one activities for the person as they were unable to access group activities to engage with others. However, the person's care records contained no evidence that this had been implemented.

We recommend that the provider ensure all the people living at the home have opportunities for engagement with others to protect them from the risk of social isolation.

People's care plans were personalised and reflected their individual needs. People and their relatives told us they were consulted about their care plans and had opportunities to contribute to their development. A healthcare professional said, "Care plans are well written and individual needs clearly identified." We found that care plans detailed the support people required and how they preferred their care to be provided. For example, care plans had been developed to address people's needs in relation to communication, nutrition, mobility, continence and pressure ulcer care.

Most of the care plans we checked recorded people's wishes about the care they would receive towards the end of their lives. There was evidence that people and their families had been asked about their choices regarding care and treatment and their preferences about where they wished to be cared for. The home held anticipatory medicines for some people, which had been prescribed by a doctor should they be needed to reduce pain. Information was provided to staff about when and how these should be used. However, some of the care plans we checked had not recorded people's wishes regarding end-of-life care. We discussed this with the registered manager during feedback, who confirmed they would take action to address the issue.

The provider had a written complaints procedure, which was given to people and their relatives when they moved into the home. The procedure detailed how complaints would be managed and listed agencies people could contact if they were not satisfied with the provider's response. People and relatives told us they knew how to complain and were confident any concerns they raised would be taken seriously. The complaints log demonstrated that the registered manager investigated and responded to complaints appropriately and took action to improve where necessary.

Good

Is the service well-led?

Our findings

At our last inspection we found that the provider's quality monitoring systems were not always effective as they had not identified some of the risks we found. At this inspection we found the provider had improved quality monitoring systems. Spot checks were carried out and the registered manager conducted a daily 'walkaround', during which they made their own checks. There had been a focus on improving the information given to staff beginning their shifts at handovers. A daily briefing had been introduced, which was attended by the registered manager and heads of departments, to discuss the day ahead and any challenges to the delivery of care. Regular audits were carried out in areas such as infection control and fire safety.

Although we found some shortfalls during the first day of our inspection, the provider's monitoring data demonstrated that these were isolated incidents and that the systems introduced by the provider since the last inspection had been effective in reducing risks to people. These issues had been addressed by the second day of the inspection.

The home had established links with other health and social care agencies to improve the quality of care provided. For example, the local Clinical Commissioning Group's Care Home Support Team had been working in the home once a week since April 2018. The feedback we received from professionals indicated that staff had welcomed their input and advice. A healthcare professional from the Care Home Support Team told us, "The staff at Abbey Chase were a pleasure to work with. Any query raised was answered immediately and staff showed an excellent understanding of the residents in their care."

The feedback we received from healthcare professionals indicated that staff worked effectively with them and implemented any guidance they advocated. One healthcare professional told us, "On review, we found that all patients who had a diagnosis of diabetes had their blood glucose measured on a weekly basis. For some people this was not necessary although for others this was not sufficient testing. Guidelines were discussed with the manager and the nurses and appropriate monitoring implemented immediately."

Professionals also provided positive feedback about the registered manager. One healthcare professional told us, "It has been a pleasure to work with [registered manager]. She has an excellent understanding of the whole home, the staff and the residents. She is intuitive of the residents' needs, has an extremely reassuring and sensitive manner and responds to concerns and needs promptly. She has high expectations of her staff, born out of a genuine concern for the health and wellbeing of the residents." The registered manager was aware of their responsibilities in terms of informing CQC and other relevant agencies when notifiable events occurred and had submitted statutory notifications when necessary.

Staff told us the registered manager and senior staff were approachable and supportive. One member of staff said of the registered manager, "Her door is always open." Another member of staff told us, "They give you the time to talk, especially [line manager]. You can always go to her." A third member of staff said, "I can say I have good managers; I am happy with them." Staff told us there was an open culture at the home in which they felt able to speak up or raise concerns. Staff said team meetings took place regularly and they

were encouraged to contribute their views. One member of staff told us, "It's an open forum. We can raise any concerns and they give us feedback."

The provider had not distributed any satisfaction surveys since our last inspection but residents' and relatives' meetings took place at which people had opportunities to give their views. People and their relatives told us their feedback about the home was encouraged and listened to. One person said, "We are asked [for feedback] at the residents' meetings, which I always go to" and another person told us, "I have been to residents' meetings and given feedback." A third person said, "My sister attends the meetings; she says they are quite informative."