Abbots Care Limited

Abbots Care Buckinghamshire

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Abbots Care Buckinghamshire is a service providing care and support to people in their own home. At the time of the inspection the service was supporting 8 people, some of whom received support from a live-in staff member. People supported included both children and younger adults, people with physical or sensory impairments, and older people. Some people using the service lived with dementia.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not provide care or support for anyone with a learning disability or an autistic person who required personal care. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

People told us staff were genuinely caring and provided safe and dignified care. Staff supported people to maintain their independence where possible and involved people in day to day decisions about their care and support.

People's needs were holistically assessed to identify goals and consider what was important to them. People received person-centred care which was responsive to their needs. Staff could speak in detail about people they supported, with knowledge about people's likes, dislikes and preferred routines. People were supported to participate in social and leisure activities in line with their interests. People told us they were in control of their care and that staff respected when they needed space and privacy in their own home.

People were cared for by staff who were suitably inducted, trained and supported. Staff deployment aimed to provide continuity of care, and the service worked to match people with suitable staff, based on factors such as staff skills, experience, personalities and shared interests.

Staff, people and families told us the service was well-managed. The service was supported by an established provider with a clearly defined quality management system in place to ensure the service identified and acted on areas for continuous improvement and learning.

We found safe care and treatment was provided. People were safeguarded from risks of abuse and risks of infection. We found staff had a good understanding of risks, however risk management records lacked sufficient detail and we have made a recommendation about this. We also identified additional detail was required in relation to medicines records and the service was responsive to our feedback.

Staff were safely recruited and there was a focus on recruiting staff with the right values to deliver person-centred care. The provider also focused on maintaining safe staffing levels, including through the provision of staff support and recognition schemes to maximise staff retention.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service did not consistently evidence how people's mental capacity to initially consent to the service was assessed, and we have made a recommendation.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 16 January 2019 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Recommendations
We have made recommendations in relation to risk management and recording consent to care. The provider was responsive to our feedback and informed us of actions they planned to take.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Abbots Care Buckinghamshire

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a short notice period of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 5 May 2023 and ended on 23 May 2023. 1 Expert by Experience made telephone calls to people and their relatives on 9 May 2023. We visited the location's office on 15 and 16 May 2023. We continued to review evidence until 23 May 2023.

What we did before the inspection
We reviewed information we had received about the service since registration. We also sought feedback from local authorities in areas where the service operated. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 2 people using the service and 3 family members. We also received email feedback from 1 additional person.

We spoke with 12 members of staff, including 7 care assistants, the care coordinator, the community facilitator, the service user liaison officer, the registered manager and the operations manager.

We reviewed a range of records. This included 5 people's care and support plans, as well as people's medicines records where they received support with this task.

We looked at 3 staff files in relation to recruitment, training and supervision. We reviewed a variety of records relating to management of the service including policies and procedures, accident and incident records, compliments and complaints and audits of the service. We received feedback from 3 local authorities including 1 service commissioner.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessment processes were inconsistently operated. Some required risk assessments, such as for the control of substances hazardous to health (COSHH), had not been completed for all people where this was relevant. Some risk assessments lacked sufficient detail. For example, 1 person's environmental assessment of fire risks did not consider the barrier posed by a safety gate at the front door or the use of emollient creams. Emollient creams can be easily transferred from skin on to clothing and bedding, and testing has shown increased fire risks when fabrics are contaminated. Risk assessments were not documented in relation to the use of drink thickener, use of an electric shaver and 1 person's history of distressed behaviours.
- We reviewed accident records. One person had experienced a recent fall. A staff member closed the incident record citing "no further concerns", however no falls risk assessment had been documented to consider risk reduction measures, and the person's care plan had not been responsively updated, and stated the person had no history of falls.

We recommend the service review their approach to ensure risk management information consistently and reliably informs staff of risks to people's wellbeing and how to manage them.

The service was responsive to our feedback and immediately commenced reviews to ensure risk assessments were updated. A new electronic system had been recently introduced and the operations manager demonstrated how this would be used to evidence the response to accidents and incidents.

- People and families told us staff were aware of risks and used equipment aids safely. Comments from family members included, "They know before they come how to use the equipment. She had bed rails fitted and they were risk assessed", "[Person] is a high risk of falling, they assessed the environment" and "[Person] has a [equipment aid]; they have had training in this. It wasn't always used properly but now that's been sorted."
- People were involved in managing risks to themselves and in taking decisions about how to keep safe. This helped form a positive approach to risk management which encouraged independence. For example, staff supported 1 person to use specialist equipment which helped to build their core muscle strength.
- Staff we spoke with knew people well and could describe people's needs in detail and how risks were managed. Staff understood their role and responsibilities should accidents or incidents occur when they were supporting people. Formal handover processes were in place to ensure incoming live-in care staff were fully informed about any changes to a person's needs on arrival. Staff had electronic access to care plans and risk assessments and told us they read these before supporting people.
- The provider had formal systems in place to regularly analyse data such as accidents, incidents,

complaints and safeguarding concerns. This monitoring to identify trends or themes formed part of a commitment to comply with the quality management standards of the British Standards Institution, which is a national standards body. A risk register was maintained by the provider to ensure regular oversight of risks to the business, people and staff, such as setting targets for recruitment and retention of staff to maintain planned service levels.

● The provider's 6 monthly quality report demonstrated how the results of analysis was used to improve the service. For example, in response to complaints the provider had introduced a performance monitoring system for staff identified as being at risk of underperformance, to enable any concerns of conduct, time keeping or attendance to be quickly addressed. In another example, the provider had identified the need for improved communication, and had introduced measures including liaison officers and customer service training.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. One person advised, "Of course I feel safe with them, they are professionals." Two relatives added, "It's all going very well, [person] is safe and happy with the live-in carer" and "I feel safe with the service; the carers are pretty trustworthy."

● People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

● Systems were operated to seek regular feedback which provided opportunities to check people's welfare and safety. For example, regular courtesy calls asked people how they were getting on with their regular care staff and checked their needs were being met.

● People and families received advice about how to stay safe and information such as a service guide informed people how to raise concerns. A relative commented, "We have been given lots of contact details and advised to contact seniors if we have any concerns, I think they would respond." A person added, "I would let the company know if there were any problems. They let me know about what to do."

● Appropriate action was taken in response to potential safeguarding concerns. The registered manager understood their responsibility to report concerns to the local safeguarding authority. Records showed the registered manager had investigated and provided appropriate feedback to the local authority when concerns arose, including actions taken to reduce risk to people.

● The provider maintained monthly oversight of safeguarding information. Safeguarding data was used as part of trends analysis by the provider to consider areas for further improvement.

Staffing and recruitment

● We found information was not accessible during our visit to explain gaps in staff employment histories. This information for 2 of 3 staff was provided following our visit, and the operations manager confirmed systems would be reviewed. All other required pre-employment checks had been carried out. These included references from previous employers, a medical questionnaire and disclosure and barring service checks (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The service also obtained overseas criminal record checks where staff were recruited from abroad.

● The service had enough staff, including to support people requiring live-in support. Staff were given sufficient travel time and safety was promoted in the management of rotas. For example, office staff promptly responded to alerts if a staff member was running late or had not logged in at the correct location.

● Rotas were developed to match people with suitable staff, considering factors such as staff training and competencies, experience and personality. A service user liaison officer worked with the care coordinator to ensure knowledge gained of people's preferences and family feedback was considered. Staff were provided with opportunities to meet people and shadow more experienced staff to learn about people's needs. One

person had been actively involved in the recruitment of suitable staff to meet their requirements, advising us, "I've had the same 2 carers since they started. They got me involved in a Zoom meeting for their recruitment."

● An electronic system had been recently introduced which enabled managers to have improved oversight of staff deployment. The system collected data such as staff punctuality, which at the time of our visit showed 85% of visits had started within 30 minutes of the planned start time, demonstrating a good level of punctuality.

● One person told us they had always received consistent staff, and other people and families reported continuity of care was improving. One relative advised, "There are now 2 main carers but, there had been 23 over the last 18 months. There is a handover on change of main carer, this has improved." One person advised, "They are not too bad at arriving on time…It has settled down in the past few months. Initially I was complaining all the time…they do stay for the correct time."

● A business continuity plan was in place to ensure people's needs could be met in emergency situations, such as poor weather. The registered manager attended daily on-call handover meetings to ensure day-to-day risks were monitored, such as ensuring rotas were covered in response to staff absences.

● To ensure safe staffing levels were maintained, the provider placed an emphasis on continuous recruitment and staff retention measures. There was a low staff turnover rate which was regularly monitored. Recruitment was managed by a team of recruiters at the provider's head office. The provider also employed staff liaison officers whose role was to maintain regular contact with staff to check on their welfare and work to resolve any concerns.

Using medicines safely

● Staff received medicines training, and their competency was assessed. Staff described providing safe medicines support, and new staff confirmed their competency had been checked before they provided medicines support without supervision.

● Families told us safe medicines support was provided. Comments included, "There are no issues with medicines, they keep [medicine] charts. I think [person] gets them on time" and "They give [person] all their medicines. It's all documented. They have explained to [person] what it is for. They got the pharmacist to explain things to [person] over the phone, when [person] was reluctant to take it."

● Monthly audits of medicines administration records (MARs) were completed. We found audits did not reference actions required or taken when concerns were identified. For example, 1 person's MAR audits in February, March and April 2023 had identified recording errors. The audits did not state what action was planned or taken. Following our visit we were advised the recording issues had been informally followed up with staff and additional competency assessments were planned. The operations manager confirmed audit processes would be updated to evidence actions taken.

● We found some records contained insufficient guidance for staff in relation to the use of as and when required medicines. One person was prescribed a psychotropic medicine at a variable dose, due to anxiety . There was no protocol in place to advise staff what strategies to use before administering the medicine, or how to determine which of the 2 dosages was appropriate. MAR and daily records did not accurately record the dosage administered or rationale for each administration. The operations manager was responsive to our feedback, confirmed further clarification would be sought from the prescriber and explained the service was planning to implement electronic medicines administration records, which would improve management oversight.

Preventing and controlling infection

● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The provider had assessed risks in relation to COVID-19 for both staff and people using the service.

● Staff had access to sufficient supplies of personal protective equipment (PPE). People and their relatives told us staff used PPE effectively and safely. One person told us, "They wear PPE, masks, gloves and aprons."

● The service had good arrangements for keeping homes clean and hygienic. People and families confirmed staff provided support, with comments including, "They are meant to do light cleaning, some do this. The current carer is very good", "They help with cleaning, everything is fine" and "They keep the place immaculate."

● During the pandemic the provider trained a dedicated staff team to support people who had tested positive for COVID-19 or were isolating due to contact with someone who had COVID-19. The registered manager explained this team had supported 1 person using the Buckinghamshire service in 2020. This meant the person continued to receive care, however the local staff team could continue working with other people, reducing the risk of infection spread.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● Care records supplied for some people during the inspection did not adequately evidence why family members had signed key documents, including consent to receive care, on their behalf. Records also failed to demonstrate how potential restrictions, such as the use of an electronic monitor to check on someone's welfare overnight, had been discussed and agreed with people.

We recommend the service seek advice from a reputable source in relation to the requirements of the Mental Capacity Act 2005, to ensure the service evidences effective practice to obtain consent to care, including for any restrictive practices, to ensure that people's human and legal rights are respected.

The service was responsive to our feedback and the operations manager told us they planned to liaise with the service's care software provider to explore how mental capacity decisions were recorded.

● Staff empowered people to make their own day-to-day decisions about their care and support. One person told us, "They get my consent, they pretty well know what I need, it's all routine now." Relatives added, "They do ask her and try to involve her. They explain things to her" and "Consent to care was covered on the initial assessment. Then they have involved her. It was [person's] decision to have home care."
● Staff knew about people's capacity to make decisions through verbal or non-verbal means. For example, a staff member who supported someone living with dementia described how they offered choices of clothing and drinks to try to determine which options the person would prefer. The staff member explained the

person could not always verbalise a choice but they were familiar with the person's preferences, such as which colour clothing they liked best.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to the delivery of care. An initial assessment explored people's physical, social and mental wellbeing needs, also identifying some areas of risk. The assessment explored the person's background, things which were important to them, and what outcomes they wanted to achieve by having care and support at home.

● People and families told us they were involved in assessments. A relative advised, "We were involved in inputting details for the initial assessment, were asked questions, it was quite thorough. I have not seen the care plan." People's comments included, "I had an initial meeting, they went through the care and the care plan with me…I don't remember being involved with the care plan recently. I have quite a lot of freedom to influence my care. It is left to me what is changed" and "They came out for an assessment, there were lots of questions. I have seen and agreed with my care plan."

● People's cultural, religious and other protected characteristics were identified, and care plans contained more detailed information where this was found to be of particular relevance to their care and support. For example, 1 person's assessment identified their religion was important to them and staff supported them to attend a regular church service.

● Staff were trained in equality and diversity to enable them to support people appropriately.

● Systems were in place to gather regular feedback and carry out reviews at 6 monthly or yearly frequencies unless required sooner, determined by people's needs and wishes. However, we found some care plans and risk assessments were not updated in a timely manner when people's needs changed. For example, 1 person's review in March 2023 identified a risk assessment was required in relation to their behaviour. This was not in place at the time of our visit and staff confirmed the person experienced distressed behaviours including pushing staff, describing de-escalation strategies they had developed to support the person.

Staff support: induction, training, skills and experience

● People were supported by staff who had received relevant and good quality training in evidence-based practice. A structured induction was in place, which included shadowing opportunities, and was based around the core knowledge of the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● The service offered a tailored induction programme for internationally recruited staff. This included support and information to help staff adapt to life in the UK. A staff member explained how this had benefited them, advising, "[Service] did welcome us [new staff]…supported us very well…model me to be a better carer every day, always training us."

● Staff were offered further opportunities for learning to meet the needs of people they supported, with courses including catheter care and bowel management. Staff could describe how their training and personal development related to the people they supported. The service checked staff competency to ensure they understood and applied training and best practice. Staff received support in the form of supervision, appraisal and recognition of good practice.

● The service had clear procedures for team working and peer support that promoted good quality care and support. This included the use of liaison officers to maintain regular supportive contact with staff.

● Updated training and refresher courses helped staff continuously apply best practice. The training matrix indicated some training topics were not identified for refresher training at frequencies in line with best practice guidance. The registered manager confirmed our feedback had been shared with the training team for their further consideration.

● Most people and families were satisfied staff were trained to meet their needs. Comments from relatives

included, "Yes they are trained, they absolutely know what they are doing" and "I'm not aware of their training, but they were not great with personal care. It has improved. I have seen new staff shadowing". People commented, "I feel they have had the right training" and "I'm not sure how much training they get, there is shadowing and learning from existing staff. Regular staff have learned from me and the main carer. Sometimes new people don't know the first thing about me."

● One person's risk assessment for a health complication instructed staff to "Check blood pressure every 5 minutes" when symptoms developed. The person's regular staff member confirmed they had not received training to operate a blood pressure machine. The service responded immediately to our feedback and confirmed training had been booked for staff to attend.

Supporting people to eat and drink enough to maintain a balanced diet

● People received support to eat and drink enough to maintain a balanced diet. People were involved in choosing their food, shopping, and planning their meals. Staff supported people to be involved in preparing and cooking their own meals in their preferred way. Staff encouraged people to eat a healthy and varied diet. For example, 1 staff member explained the person they supported was not able to chew harder fruits so they supported them to make fruit purees.

● Where people received support from live-in staff, we found staff showed commitment to providing home-cooked meals in line with people's preferences. A family member told us, "They provide all the food and drink for her and encourage her to eat it. The main carer cooks everything from scratch. Her care plan includes her food preferences." Another relative added, "They 'bulk out' soups and make light meals she likes…she gets all the drinks she wants."

● Staff understood the importance of providing social companionship during meal times to encourage people to eat and drink well. For example, a staff member supporting someone living with dementia explained how they would sit, talk and eat with the person to avoid them becoming distracted and leaving the table. Another person who also ate with their regular staff member told us, "We prepare and cook the meals and eat together. We all like the same foods."

● Staff received training to help them understand the key principles of nutrition, hydration and food safety practices, including the importance of safe infection control procedures for food handling.

● We found 1 person's care plan did not accurately reflect their assessed needs in relation to food and drink. Staff told us the person required prescribed drink thickener and staff also pureed foods to a safe consistency. The person's care plan was promptly reviewed in response to our feedback.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People played an active role in maintaining their own health and wellbeing and staff supported them to do so. For example, staff supported 1 person to use home gym equipment to maintain their physical health.

● Consistent staff deployment enabled staff to identify potential health concerns or changes in need in a timely way. A relative advised, "They keep me informed about her wellbeing. They offer advice if they think [person] may need a GP." Another family member stated, "They know her very well. [Person] gets a little light headed, so they encourage her to have a lie down…They notice every little thing." A person added, "They always ask how I am. They do care about my welfare. They are good at monitoring my skin integrity." One relative felt the service's involvement with other agencies could be more proactive when referrals to other agencies were required.

● The service supported people to attend appointments as required. For example, during the pandemic people were supported to attend COVID-19 vaccination programmes.

● The service worked with children's social care to support the delivery of care for 1 young person.

● People were encouraged to maintain their preferred routines and be active in their community. For example, at the time of our inspection the service user liaison officer was exploring social and learning

opportunities for 1 person. Another person was supported to attend social and sporting events.

● Electronic systems enabled staff working in different parts of the organisation to support the effective delivery of care. The service user liaison officer worked with the care coordinator to match staff to people's needs, and the rota software could be used to identify preferred staff and skills matches.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People felt valued by staff who showed genuine interest in their wellbeing and quality of life. Staff spoke with warmth and respect about the people they supported. It was evident they had built positive relationships, cared about people's wellbeing, and were proud of people's achievements. Comments from people included, "In general it's all very positive. They are compassionate, they ask how I am in a genuine way" and "They are definitely caring; they [staff] are meant to be in this job."
- Staff had a good understanding of the people they supported, and took time to get to know people's likes and dislikes, their life history and interests and incorporated these into their care. For example, staff supporting 1 person living with dementia were aware they enjoyed shopping, explaining if the person was unsettled before receiving personal care they could be calmed and their attention diverted by talking about things they would like to buy.
- Staff were attentive to people's emotions and support needs. For example, a staff member supporting 1 person following a bereavement showed insight into how the person's behaviour may be influenced by their emotions and understood the importance of providing companionship and supporting the person to remain active and engaged in a daily routine.
- The service aimed to ensure people were well matched with their regular care worker to ensure people were at ease, happy, engaged and stimulated. One person told us, "They know exactly what I need or don't need. We are all the same age and have shared interests." Comments from family members included, "[Staff are] excellent, very understanding and engaging" and "They are kind towards [person]. They go above and beyond; they are like a family friend. They are so attentive."
- The service focused on recruiting kind and compassionate staff. A values-based recruitment assessment tool was used to determine whether the applicant would be person-centred and caring as a care assistant. Staff received training in relevant topics such as equality and diversity, and privacy and dignity.
- We identified some of the language used to describe people's needs was not respectful. For example, the provider's 'Behaviour that's challenging' policy referred to people having 'violent temper tantrums' and the staff handbook stated, "Many Learning Disabled people have difficult behaviour". The service was responsive and confirmed the content would be reviewed.

Supporting people to express their views and be involved in making decisions about their care

- People felt listened to and valued by staff. Staff took the time to understand people's individual communication styles and develop a rapport with them. Staff supported people to express their needs and wishes. Family members told us, "They have got to know her quite well" and "They asked in the beginning about her likes and dislikes."
- Staff involved people in day-to-day decisions about their care and learnt about people's likes, dislikes and

preferred routines. This helped people retain choice and control over their lives. Comments from people included, "I'm in control, I'm involved all the time with decisions. I tell them what to do" and "I take a lead on things." A relative also added, "She is involved in decisions on a daily basis. When they take [person] food shopping, they show her foods in the freezer so she can choose."

● Staff supported people to maintain links with those that are important to them.

Respecting and promoting people's privacy, dignity and independence

● People received dignified care. A person advised, "They provide intimate care with a good manner, they are very professional." Comments from people's relatives also included, "I think they treat her with dignity, she is always very well dressed…they are very respectful of [person's] personal space" and "A couple of times they left the curtains open when [person] was using the commode…it's been sorted now. Absolutely [person's] dignity is preserved. They are good on confidentiality."

● Staff described supporting people to maintain their independence as much as possible by encouraging and supporting them to do as much as they could for themselves. For example, 1 staff member described encouraging a person to assist with meal preparation to help them retain daily living skills.

● People and families confirmed staff promoted independence. A person advised, "They encourage me to be independent if they know I can do it, I do a lot for myself." A family member added, "They encourage her independence; they get her to put her own shoes on. She has different abilities on different days."

● Staff knew when people needed their space and privacy and respected this. For example, 1 person receiving live-in support told us, "They are respectful. I have privacy in my own home. I can be on my own…I can call them [when support is needed]."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff provided person-centred support with self-care and everyday living skills to people. People were supported to participate in their chosen social and leisure interests. The service identified people's known interests and encouraged people to continue hobbies and access their local community. A relative advised, "The regular carer goes out of her way to do things, she takes [person] to church and plays dominoes with her. They go out to the pub and in the gardens." A person added, "We watch TV, like football and go out and about, see friends."
- Staff helped people to have freedom of choice and control over what they did. For example, live-in care staff respected and learnt people's preferred routines and helped people to maintain these. One person told us, "I do as I please, there are no restrictions." A relative added, "Getting up and going to bed times are in response to mum's needs, she likes to stay up late and get up late."
- Staff knew people well and the service sought to match appropriate staff to meet people's needs, considering factors such as personality, shared interests and skills. This also helped staff to build a rapport with people which supported personalised care. People told us, "I make conversation with them [staff], get to know them, they have got to know me. They treat me as a person" and "I have built up a good friendship with both of them [staff]."
- People were encouraged and motivated by staff to reach their goals and aspirations. Care needs assessments considered what outcomes people wished to achieve and progress was checked during review meetings. Comments in relation to reviews included, "No reviews, that I'm aware of, none lately. But I would let them know if there were any changes. They make phone calls [from the office] to see if things are okay with outings and activities" and "There is a very detailed care plan. If anything changes it's put straight in the care plan. There was a big review a month ago, every last detail was covered."
- We received variable feedback as to whether care needs assessments had explored if people would feel more comfortable supported by male or female staff and how consistently any preferences were met. A person told us, "I was asked if I prefer female to male, which I do, however males are sent anyway on occasion and they were comfortable to work with otherwise I would have said something." Comments from relatives included, "We were asked about gender, [person] wasn't bothered" and "There was no choice on gender of staff, there is a male carer on occasion, which is okay, but we were not asked."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get

information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff had good awareness, skills and understanding of individual communication needs, they knew how to facilitate communication and when people were trying to tell them something. For example, the staff member supporting 1 person living with dementia explained when the person sat where they usually ate lunch or if they became agitated this could signal they were thirsty, and the staff member told us they monitored to see if the person became calm after being offered a drink.
● People's care records indicated where they experienced impairments of their hearing, vision or speech. At the time of our inspection the service did not provide personal care to anyone with a learning disability or autistic people. We were advised staff would be trained to use Makaton, a type of sign language used by some people with learning disabilities, if they were required to support people who used this form of communication.

Improving care quality in response to complaints or concerns
● People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. Staff explained to people when and how their complaints would be addressed and resolved. A family member advised, "I have no complaints…but would feel confident in doing so. Any matters have been dealt with straight away."
● People and relatives told us the service had been responsive when complaints were made. One person stated, "I'm aware of the complaints procedures. I wrote to complain about 1 particular carer, it all got sorted." A relative who had raised concerns about the quality of care received added, "They were quick to react and responded to the concerns. Things are improving."
● The service treated all concerns and complaints seriously, investigated them and learned lessons from the results. Analysis to consider any trends or themes within complaints formed part of the provider's strategy for quality management.
● The service had a complaints policy in place, and people received information about how to complain as part of a guide to the service. The policy was accessible, meaning people could raise a complaint in a manner that best suited their communication needs.

End of life care and support
● People were supported to express their needs and wishes as part of end of life care planning, where this was appropriate at the time of assessment.
● At the time of our inspection the current staff team had not received end of life care training, however we were advised training and support would be offered to staff if they needed to support someone receiving end of life care.
● The service shared positive feedback received from a family member following the death of a person. The registered manager explained the service had worked to ensure the person could achieve their wish of being discharged from hospital to spend their final days at home with people who were important to them.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager had a clear understanding of the provider's vision and person-centred values, and explained how they promoted these within the service. The registered manager and provider had clear goals for how the service would drive quality alongside growth in the Buckinghamshire area. For example, the registered manager stated the service now planned for people receiving 24 hour care, including live-in support, to receive quarterly rather than 6 monthly reviews and targets were set for continuity of staff deployment.
- People and families told us the culture of the organisation was open and responsive. People commented, "I don't have much involvement with them. But they do listen" and "They respond okay to things." Comments from relatives included, "They listen and have done everything asked of them…I asked for a change in [staff] break times, they sorted it and emailed back straight away" and "I'm not sure who the manager is but [staff names] have been very responsive, open and honest. They do come out every now and then to check on things."
- Staff spoke highly of people they supported and demonstrated care and empathy. Management and staff put people's needs and wishes at the heart of everything they did. There was a focus on supporting people to achieve good outcomes, such as identifying opportunities for social activities in the community, and supporting people to remain in their own homes as independently as possible.
- Staff gave honest information and suitable support, and applied duty of candour where appropriate. A duty of candour policy was in place, and the service notified CQC of incidents and information they were required to.
- Staff told us they were treated equally, and the service was committed to promoting inclusion in the workforce. For example, the service had adapted its induction process and showed genuine care in their approach to meeting the needs of internationally recruited staff.
- Staff felt respected, supported and valued by senior staff which supported a positive culture. The provider had invested in initiatives to support staff wellbeing and recognise staff achievements. This included a staff awards ceremony and an Abbots Care Wellbeing App, which was used to share and receive compliments, and update staff about best practice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager had the skills, knowledge and experience to perform their role. The provider

operated a 'leadership academy' to provide staff with opportunities for career progression, and the registered manager was undertaking further study at the time of our inspection.

● The service was supported by an experienced and long established provider leadership team. The provider's managing director had been awarded the first ever Chief Nurse for Adult Social Care Gold Award in 2021. The scheme recognises outstanding achievements and performance, and was awarded to the managing director for their work throughout the pandemic to support people, staff, the NHS and partner organisations.

● The service benefited from support provided by centralised staff at the provider's main Hertfordshire based location. For example, the provider employed a recruitment team, HR, centralised training team, and liaison officers for staff and people using the service.

● Staff were committed to reviewing people's care and support on an ongoing basis as people's needs and wishes changed over time. A system of courtesy and quality assurance calls and visits, in addition to periodic care plan reviews, was operated to ensure people's feedback about the quality of care provided was gathered on a regular basis.

● Staff were able to explain their role in respect of individual people without having to refer to documentation. This meant we were satisfied staff had a good understanding of how people's needs should be met.

● The service and provider used technology effectively to monitor the quality of the service. The service had recently moved to a new electronic care software provider. The operations manager demonstrated how the software would improve oversight, such as data collected about staff punctuality.

● The provider had a clear strategy for quality management. Systems were in place to regularly audit the service and analyse information gathered to consider areas of learning and further development. This included learning from quality assurance questionnaires, complaints, safeguarding, and accidents and incidents. There was external oversight of the quality management system via the British Standards Institute, to assess that systems were effectively operated to support the achievement of provider objectives, and statutory, regulatory and contractual requirements.

● We found staff documentation did not always provide a full account or evidence actions taken when potential concerns arose. For example, medicines audits did not reflect actions taken, and accident/incident records did not consistently document how events had been explored with staff. We also found staff daily records did not consistently provide a full account of how people's needs were met, with some records consisting of a 'ticked' list of tasks. This meant records for support such as live-in care did not describe how staff had supported people throughout the day or outline how incidents such as people's distressed behaviours had been managed. The service was responsive to our feedback and explained how records would be reviewed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider sought feedback from people and those important to them and used the feedback to develop the service. The feedback gathered, including the results of reviews and regular questionnaires, was analysed to consider trends or themes as part of the service's quality management processes. A 6 monthly report outlined actions taken, and feedback was shared with people, families and staff via quarterly newsletters.

● Staff encouraged people to be involved in the development of the service. For example, one person had been involved in the recruitment of regular staff to support them.

● Staff told us they were given opportunities to provide feedback and could participate in staff meetings and attend 'hubs' which provided an opportunity for staff to meet with members of the management and staff support team, as well as collect personal protective equipment (PPE). The registered manager told us the system of staff 'hubs' would be expanded as the service grew within the Buckinghamshire region.

● At the time of our inspection, most people and families had direct contact with other agencies, such as GPs or physiotherapy. The service had worked in partnership with children's social care in relation to 1 person's needs. We received positive feedback from 1 professional who had worked with the service, who advised, "The quality of the care is good…communication between the manager and social care is good."