Acer Healthcare Operations Limited

Abingdon Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 17 and 25 October 2017. This was an unannounced inspection.

Abingdon Court Care home is registered to provide accommodation for up to 64 older people, some of them living with dementia who require personal or nursing care. At the time of our inspection there were 57 people living at the service.

Abingdon Court was taken over by a new provider and registered as a new service as of 23 November 2016. The provider had made several changes on how the home was run and introduced different processes. This had resulted in high staff turnover with a lot of staff leaving and a lot of new staff recruited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager worked closely with the deputy manager as well as the area operations manager.

Abingdon Court had staff vacancies and staff told us they focused on keeping people safe and did not have enough time to spend with people. People told us staff did not always have time to spend with them, however, they were attended to without unnecessary delay. The registered manager told us a lot of staff had left when the provider took over and they were actively recruiting. They had reduced the use of agency staff. The same agency staff were used to maintain continuity. They had also introduced new staff roles to support care staff. The registered manager told us they were doing all they could to ensure safe staffing levels. The home had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

Risks to people's well-being were assessed and managed safely to help them maintain their independence. Staff were aware of people's needs and followed guidance to keep them safe. Staff clearly understood how to safeguard people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines. People received their medicine as prescribed. However, some people who required when necessary (PRN) medicines did not always have PRN protocols in place.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. Staff did not always have a good understand the Mental Capacity Act 2005 (MCA). Where people were thought to lack capacity, mental capacity assessments had not been completed. Some people did not have any records to show that best interest process having been followed. There was no evidence of guidance from a pharmacist on how best to administer the medicines covertly. The registered manager told us they understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

The provider's systems and processes to monitor and improve the quality and safety of the service were not always effective in identifying areas for improvement. Accidents and incidents were recorded and followed up. However, trends identified were not always followed through.

People were supported by staff that had the right skills to fulfil their roles effectively. Records showed staff did not always receive regular supervisions (one to one meetings with their line manager). However, they told us they felt supported by the management team.

People were supported to meet their nutritional needs and maintain an enjoyable and varied diet. Meal times were considered social events. We observed a pleasant dining experience during our inspection.

Staff worked closely with various local social and health care professionals. Referrals for specialist advice were submitted in a timely manner. Staff knew the people they cared for. People's choices and wishes were respected and recorded in their care records. Where people had received end of life care, staff had taken actions to ensure people would have as dignified death as possible.

People were supported to access a variety of group activities. However, people who required one to one support where not always protected from the risk of social isolation. Staff did not always have time to spend with people.

People had their needs assessed before living at Abingdon Court to ensure staff were able to meet people's needs. People's care plans gave details of support required and were updated when people's needs changed. People knew how to complain and complaints were dealt with in line with the provider's complaints policy. People's input was valued and they were encouraged to feedback on the quality of the service and make suggestions for improvements.

The registered manager informed us of all notifiable incidents. People and staff spoke positively about the management and leadership they had from the registered manager.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The home had staff vacancies and used regular agency staff. Staff did not always have enough time to spend with people.

Medicines were administered safely. However, people did not always have when necessary (PRN) protocols in place.

Risks to people's well-being were assessed and recorded.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff had limited knowledge of Mental Capacity Act (2005). Where people were thought to lack capacity, there were no mental capacity assessments completed nor best interest decisions followed.

Staff had the skills to meet people's needs. However, staff did not always receive supervisions as planned.

People were supported to have their nutritional needs met.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

People were seen to be relaxed and calm in the presence of staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received group activities and stimulation which met their needs. However, some people did not receive one to one activities.

People's records were current and reflected their needs. The provider was in the process of changing records from paper to electronic.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality assurance systems were not always effective.

Accidents and incidents were recorded. However, trends identified were not always actioned to reduce the risk of further occurrence.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

Abingdon Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 October 2017 and was unannounced. We visited the home again on 25 October 2017 and this was announced. The inspection team consisted of three inspectors and two Experts by Experience in the care of older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from one social and health care professional who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We also obtained feedback from commissioners of the service.

We spoke with 19 people and seven relatives. We looked at 12 people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager and 14 staff which included nurses, care staff, housekeeping, activities coordinator, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

On the day of our inspection, we found Abingdon Court had staff vacancies and staff did not always have time to spend with people. People told us they felt there were not enough staff. They said, "Alright in the day but at night there aren't enough staff to supervise people. Some have wandered in to my room during the evening", "Staff are very busy so they don't really have time to stop and talk" and "No, they don't have enough staff. We see a lot of agency staff. We see a lot of new faces". People's relatives also told us they were not enough staff. One person's relative said, "No, I was chatting to one of the staff here when we had to fill out a survey and they told me that they are short staffed and the regular staff just come and go, and they do have a big turnover of staff". Another person's relative said, "I think during the night no but during the day yes".

Staff told us they often did not have time to interact with people. They said, "We do not have enough staff to give best quality care and spent time with residents", "We do not have enough staff and we raised these concerns with the manager who raised them with the provider", "One nurse at night is not adequate. We need at least two, it's not safe" and "Staffing levels are getting better. We need more carers. One nurse at night is not enough for the whole home". One healthcare professional told us, "The standard of care from the carers is ok but there's not enough of them. There's not enough trained nurses".

During the inspection we saw staff were focused on assisting people with care and hardly had time to spend with them. However, we saw people were attended to without unnecessary delay. Call bells were answered in a timely way. Staff rotas for care staff showed the home used regular agency to cover staff shortages and allow continuity of care.

We spoke to the registered manager about staffing levels. They explained to us, these concerns had been brought to the attention of the provider and there had been a big drive and improvement in recruitment. They said, "Since the provider took over, we lost a lot of staff but we have been successfully recruiting into those posts. We introduced a pool of bank staff and reduced our use of agency staff from 70% to 30%. We are reviewing staffing levels at night and introducing new roles to lessen the workload". The registered manager showed us evidence they had recruited five members of staff who were waiting for clearance before they could start working.

People told us they felt safe living at Abingdon Court. One person told us, "Lovely place, can't grumble about anything. Yes it does feel safe, lots of nice people always around". Another person said, "An alright place to live, safe because people [staff] take care of me". People's relatives had mixed views about safety. They said, "Well looked after. From what I've seen [person] is safe" and "No I don't think he's safe but that's only at night. He's ok during the day as he has a one on one carer from 8am till 8pm, all his falls have happened at night".

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their

responsibility to report and record any concerns promptly. One member of staff said, "We report any concerns to the nurse and follow the safeguarding process".

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom and independency. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person fell and fractured their hip. The person was referred to the care home support team (CHSS) and physiotherapist. Staff were advised to sit the person out of bed for a few hours every day. Records showed staff followed this guidance. This person's risk assessments and care plans were reviewed promptly to reflect the changes. People had personal evacuation emergency plans in place (PEEPs). These contained detailed information on people's mobility needs and additional support required in the event of a fire.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

During our inspection we looked at medication administration records (MAR) charts for people who were prescribed when necessary medicines (PRN). We found some people did not always have PRN protocols in place. These are meant to provide guidance for staff on safe administration of PRN medicines. However, when we observed staff administering PRN medicines, they asked people if they were in pain and if they required the medicines. Staff knew how to safely administer PRN medicines. We discussed our concerns with the registered manager who took immediate action.

People received their medicine as prescribed. The provider had a medicine policy in place which guided staff on how to administer and manage medicines safely. We observed staff administering medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken the reason why. People taking as required medicines received them safely. People understood the reason and purpose of the medicines they were given.

Abingdon Court looked clean and equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. One person's relative told us, "Every time I come in it is clean and tidy". Staff were aware of the providers infection control polices and adhered to them.

The provider for Abingdon Court had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation.

Requires Improvement

Is the service effective?

Our findings

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

The registered manager and staff did not always follow the MCA code of practice and make sure that the rights of people who may lack capacity to make particular decisions were protected. Where people were thought to lack the capacity to consent or make some decisions, staff had not carried out mental capacity assessments. For example, we saw an urgent Deprivation of Liberty Safeguards (DoLS) authorisation had been made to the supervisory body with an application for a standard authorisation. DoLS provide legal safeguards for people who may be restricted of their liberty for their safety. There was no evidence of a mental capacity assessment having been completed to underpin the DoLS application.

Where people received medicines covertly, no mental capacity assessments had been completed. Covert allows for administering of medicine when people are either resistant to take them or they refuse and the medicine needs to be given to them in their best interest. One person was thought to lack capacity and received medicines covertly. There was no record of a mental capacity assessment having been completed.

Another person was also given covert medicines. They had a best interest record in the care plan which had involved the GP and a legally authorised family member. There was no record of a mental capacity assessment having been completed. For both people, there was no evidence of the pharmacist having been consulted to ensure that it was safe to administer the medicines in this way. This was not in line with national guidelines that state 'A best interests meeting should be attended by care home staff, relevant health professionals including the prescriber and pharmacist' and 'the medicines must be review by the pharmacist to advise the care home how the medication can be covertly administered safely'.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had a good understanding of the MCA and Deprivation of Liberty Safeguards. They told us, "We assume capacity in the first instance then complete a mental capacity assessment", "If a person does not have capacity, we make decisions in their best interest" and "MCA is about ability to make certain decisions. If a person lacks capacity we will do things in their best interest". However, some staff members had limited knowledge of the MCA and Deprivation of Liberty Safeguards. We asked staff how they would support people in line with the MCA and some of them referred to safeguarding procedures. Staff told us they received MCA training online. We discussed these findings with the registered manager told us they had identified the need for staff training in the MCA and they had requested face to face training which would include behavioural challenges training. We saw this was planned.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Staff sought verbal consent whenever they offered care interventions. Staff told us they sought permission and explained care to be given. For example, when people were supported with personal care. One member of staff said, "We ask the residents how and when they want their care".

People received care from staff who were skilled and confident in their practice. People said, "I need to be hoisted out of bed in to my chair. Staff know what they are doing, never any concerns about it", "I have a hoist. Gentle and careful carers, must be well trained, never any problems" and "The girls [carers] are alright. They know what they are doing".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. One member of staff told us, "I've done all the induction and shadowed for two weeks. All the time I worked with an experienced carer".

Records showed and staff told us they received mandatory training before they started working at Abingdon Court. They were also supported to attend refresher sessions regularly. Mandatory training included; manual handling, safeguarding, living in my world, fire safety and information governance. Nursing staff were supported to attend specific training to their roles which included use of syringe drivers used during end of life care as well as venepuncture.

Records showed staff did not always receive supervisions (one to one meeting) with their line manager. Supervisions had not been carried out in line with the provider's supervision policy. However, staff told us they felt supported. They said, "I have not had any supervision. I can go to manager anytime, they are very supportive" and "We didn't have supervisions for a while. I do feel supported though. I can call or see the manager anytime".

People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed. One person's relative told us, "Yes, the GP has been into do check-ups, the Optician and the Dentist have been in here as well as the Chiropodist".

People told us they enjoyed the food and were able to make choices about what they had to eat. Comments included; "I'm a poor eater, I eat to live. Plenty to eat, often too much. They serve the stuff I like", "Food is absolutely perfect. Never turned anything down" and "Food is good, mostly you get something you like. Nice and hot". One person's relative said, "I eat here with (person) and the food is excellent and a good choice".

People's dietary needs and preferences were documented and known by the chef and staff. The home chef knew people well and was aware of their dietary needs. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support (CHSS) if they had concerns over people's nutritional needs. Where people were identified as being at risk of malnutrition a malnutrition universal screening tool (MUST) was used to assess, monitor and manage this risk. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. There was conversation and chattering throughout. A three course meal was served hot from the

kitchen and looked wholesome and appetising. Soft diet food was presented in an appetising manner. People were offered a choice of drinks throughout their meal and, where required received appropriate support. People were encouraged to eat and extra portions were available. Some people chose to have meals in their rooms and staff respected that. People had the same pleasant dining experience despite where they were.

The provider's equal opportunities policy was available in the home. This stated the provider's commitment to equal opportunities and diversity. This included cultural and religious backgrounds as well as people's gender and sexual orientation.

Good

Is the service caring?

Our findings

People told us received care and support from staff who were caring, compassionate and kind. They commented; "Staff- all of them are fine, very good care", "Staff are very kind and very understanding. It goes without saying that they are extra helpful" and "Care staff are wonderful". People's relatives told us that staff were caring. They said, "Well looked after-good thing, [person] is here to be looked after. Staff are friendly, they do all they can for her" and "Carers are lovely and work hard".

Throughout our inspection, we observed many caring interactions between staff and the people they were supporting. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of light appropriate humour throughout the day. People received care and support from staff who had got to know them well. One member of staff told us, "You know the residents well. You know what they wish. You know how to speak with them".

We observed people being attended to and assisted in a caring and patient way. Staff offered choices and involved people in the decisions about their care. People told us staff treated them respectfully and maintained their privacy and dignity. One person said, "My door is always open but they still knock and ask me if it is alright to come in". People received care in private. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing. One member of staff said, "We give personal care in private. If it was me, that's what I would want".

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their communication. For example, one person's care record stated, 'Speak clearly and slowly using short and simple sentences. Use picture cards if necessary'. We saw staff followed the guidance. The person was relaxed and clearly comfortable with staff.

We saw people were given choices in day to day things which included food, activities, when to get up or go to bed. This gave people control of their lives. People told us, "Yes we can choose male or female carers" and "I go out in the garden when I want to and I feel I can do what I want".

Staff spoke with us about promoting people's independence. They said, "We encourage residents to do what they can" and "We do not take over care. We encourage independence". Records showed people's independence was promoted. For example, one person's record emphasised on allowing enough time during transfers. We observed staff supporting another person from a wheelchair to a chair using a standing hoist. Staff took time to encourage the person and praised them throughout the process.

Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality. Staff told us, "We do not discuss residents with other residents" and "We keep our records online and they are password protected. The nurses station is always locked where we keep the paper

records". Records were kept in locked offices only accessible to staff.

People's preferences relating to end of life were recorded. This included preferences relating to support. People and their relatives where appropriate were involved in advanced decisions about their end of life care and this was recorded in their care plans. For example, one person had a care plan for 'My wishes for the future, end of life and palliative care plan' (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. One member of staff told us, "We involve the GP and palliative care team during end of life care. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort.

Requires Improvement

Is the service responsive?

Our findings

People had access to a range of activities which they could be involved with, including group and one to one activities. For example, quizzes, reminiscence, craft sessions, skittles and cinema. People were supported to access the local day centre. Outside entertainers which included a vintage scene group, toddler groups and a variety of musicians visited the home. Some people preferred to remain in their rooms and staff respected that and supported them in their rooms to reduce the risk of social isolation. However, on the day of the inspection we found people who required one to one activities on the first and second floors did not receive any. Staff told us they did not have enough time to do one to one activities.

The provider employed two activities coordinators, one during the week and the other over weekends. They told us some of the activities had positive impact on people. They said, "When a resident first arrived they were very withdrawn and scared-not mixing. At a residents tea party they started to sing along with the music- a really big thing for them. Now they do lots of singing". People told us they had access to a variety of activities which they enjoyed. They said, "I could join in with things if I wanted-quite a lot going on and at weekends", "Plenty of things you can take part in. Like the quizzes and the musical things" and "Our activity person comes in for a chat. I don't like many group things but enjoy the trips out". Abingdon Court had established links with the local community via the activity programme. A local school choir visited regularly and several schools provided volunteers.

People's needs were assessed before they came to live at Abingdon Court to ensure their needs could be met. Records showed people, their relatives and other professionals had been involved in these assessments. This information from the assessment informed the plan of care.

Care plan records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. The care plans covered areas such as personal care, eating and drinking, mobility, emotional well-being, elimination and communication needs. The provider used a 'My Life' document to capture people's past experiences. This information was used to inform each person's care planning process. People's care plans were descriptive and reflective of their individual support and care needs. For example, people's preferences about where they wanted to spent their time or when to go to bed. We asked people and their relatives if they were involved in planning and review of their care and we received mixed views. Comments included, "They talk through the care plan with me. Always asking me if there is anything I want [care] or if I have any problems", "Not seen a care plan, not had a review-don't rate the administration highly" and "No, I haven't been involved but it's something to consider".

Records showed care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes and the service sought appropriate specialist advice. For example, one person developed swallowing difficulties. Staff referred the person to the SALT team and the person was commenced of soft diet. Staff updated the person's care plan to reflect those changes.

The provider was in the process of changing from paper to electronic records. These care records were current and reflected people's needs in detail. We saw daily records were maintained to monitor people's progress on each shift. The language used in care plans and daily records was respectful. Staff were positive about the change in records. One member of staff told us, "It's better. You're not going to lose any time. It's a good thing".

Handover between staff ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care, maintaining consistency. One member of staff told us, "We have detailed handover at the beginning of every shift".

The provider used a key worker system. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

Abingdon Court is a purpose built home accommodating older people some who lived with dementia. We saw there were people's pictures and names on their bedroom doors. Corridors were decorated differently to aide easy identification of different areas. People could move freely in the communal areas of the building and large gardens. We saw people in the garden siting area or being offered the choice of going out. There were several sitting areas which offered a choice of where people spent their time. People's bedrooms were personalised and contained personal effects each person wanted in their bedroom. However, the décor could be improved to make it more dementia friendly. We spoke to the registered manager and she told us plans were already in place to improve the home and they were making consultations.

People's views and feedback was sought through residents and relatives meetings, suggestion boxes as well as through quality monitoring surveys. Records of family meetings showed that some of the discussions were around what changes people wanted, updates and planned improvements.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People told us, "Not felt the need to complain but I suppose that if I did then I could talk to staff or the manager", "I tell them [carers] if anything is wrong. If they won't listen then talk to somebody who would" and "Could talk to anybody if I had a problem". We looked at the complaints records and saw complaints had been dealt with in line with the provider's policy. There were many compliments and positive feedback received about the staff and the care people had received. Staff told us they used complaints and compliments as learning points.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems in place. However, some of these systems were not always effective. For example, record keeping audits had not identified the shortfalls we found in care plans. People who were thought to lack capacity did not have any mental capacity assessments done. There were inconsistent practices regarding the best interest processes.

Medicine audits were not always effective enough to pick up any of the concerns we found. People on covert medicines did not always have any guidance from pharmacists on how to safely administer the medicines covertly. People did not always have PRN protocols in place when they were on when required medicines.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, investigated and actions were followed through to reduce the risk of further incidents occurring. Staff knew how to report accidents and incidents. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. However, these trends were not investigated and there were no action plans to address them. For example, a trend was identified as accidents occurring 'evening/night'. However, there was no action plan to follow through to reduce the risk of further accidents occurring at the same time. We spoke to the registered manager and they told us they would address this.

Abingdon Court was led by a registered manager who was supported by a deputy manager and a regional manager. At the time of our inspection, the registered manager had only been in post for 10 months. We saw significant changes had been made since the registered manager's appointment. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service. On the first day of the inspection, the registered manager was away. The home ran smoothly in the registered manager's absence.

There had been changes within the last year since the provider took over. Staff were appreciative of some of the changes the provider had implemented, for example, change to electronic records. One member of staff told us, "We went to online records in August and it's still a struggle. We are working through it but it takes time. It will be better when up and running". However, some staff felt the provider was not taking into consideration requests for more staff. Staff told us, "It feels like the organisation sees us as just numbers" and "We asked for more carers but still no response from the provider".

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff spoke positively about their work and we observed open communication between staff and members of the management team. Staff felt that they could approach the registered manager or other senior staff with any concerns and told us that management were supportive and made themselves available. Staff told us, "I can discuss anything with the manager, even bad practice and we will work out an action plan" and

"The management team is supportive".
We asked people if the service was well managed and we received mixed views. Comments included, "Well run by very nice people", "I don't know who the managers are", "I don't think [manager] doing a good job she never comes to see me, and the staff aren't that happy here" and "I don't think she's doing a bad job I think its budget restrictions" and "I think manager is doing a good job. I don't have any reason not to think so and [manager] told me her door is always open".

Staff were complimentary of the registered manager, the support they received and the way the home was managed. They told us, "Manager is straight, open and welcoming", "Manager tries to meet our requests" and "Manager has an open door policy, very supportive".

The registered manager told us their main challenge had been staff recruitment. They said, "It's been difficult recruiting the right staff to meet people's needs. I am in charge 24/7. We are getting there and have introduced new roles for more support". One healthcare professional commented, "The manager is on 24 hour call and I think it's too much for her. She's trying to do a good job and there are corners that are being cut".

People described Abingdon Court as having a good and positive atmosphere. They told us, "Everyone seems to get on. Nice feel to the place" and "A friendly atmosphere, laughter and some smiley people". People's relatives also commented; "Such a nice place, a home from home" and "The atmosphere is very welcoming".

Staff described a culture that was open with good communication systems in place. Team meetings were regularly held where staff could raise concerns and discuss issues. Records showed discussions were around suggestions on how to improve care. For example, the choice of décor in communal areas. The meetings were recorded and minutes made available to all staff.

The provider had a whistle blowing policy in place that was available to staff across the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager and staff did not always follow the MCA code of practice. Where people were thought to lack capacity, no mental capacity assessments had been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was inconsistent recording in people's care plans. The provider's quality assurance systems were not always effective.