Europe Care Holdings Limited

Abraham House

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Abraham House is a residential care home providing personal care for a maximum of 30 older people with dementia. The accommodation is over two floors with a passenger lift to both floors. There are 26 single rooms and two double rooms. Communal areas comprise of two lounge areas, a conservatory and a dining room. There is an enclosed garden and a car park.

The last inspection of the service was carried out on 23 May 2013. During that inspection the service was found to be fully compliant with all the areas we assessed.

This inspection took place on 21 July 2015 and was unannounced.

The registered manager was present throughout the inspection.

Summary of findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at the service told us that they felt safe.

Relatives told us that their loved ones were safe, however two relatives told us that they had found people who lived at the service to be in soiled clothing when they visited and staff were not always available to respond in a timely manner.

We have made a recommendation for the provider to consider improved ways of working around maintaining people's dignity.

We looked at how the service provided care that was tailored to people's individual needs. We found that a person centred ethos was not fully embraced at the service.

We were concerned about poor organisation at meal times. We observed people to wait 45 minutes for their meal and this caused them to become restless. We observed two people to become distressed and staff did not respond to their way of communicating.

We asked staff about people's dietary needs and found that not all staff were aware of individuals needs. We looked at diet and fluid intake records for two people and found that their intake had been substantially low, staff were not able to explain why this was or tell us about how they had responded.

We looked at care records and found that risk assessments and care plans were undertaken and reviewed. However we found that identified risk was not always included in the associated care plans and some risk assessments had not been completed in full.

We found that some care plans had been written in a negative way and did not always represent people's strengths.

We found that the service had put in place some design aspects and activities that were dementia friendly but that these did not seem to be understood or actioned by all staff.

We looked at the way medicines were managed and found that the service had robust systems in place for the safe administration of medicines.

We looked at infection control standards and found that the provider did not have suitable systems in place for the management of soiled waste. The provider made immediate plans to improve waste management and was responsive to our concerns.

We found that the environment was clean. However, we found that the main lounge area had a significant malodour. The registered manager told us that this issue was being addressed and replacement flooring had been considered.

We found that the service did not always record decisions made when people are deprived of their liberty and care planning did not reflect how the person's mental capacity had been assessed prior to such decisions being made.

We observed staff interaction with people who lived at the service and found them to be caring and respectful. However there were significant delays in time for people's immediate care needs to be addressed. For example, we saw people walked around the service in unclean clothing and we had to request that staff attended to their needs.

We identified four breaches in fire safety, fire doors had been wedged with furniture that included large lounge chairs and bedroom cabinets. This placed people at risk of harm.

We looked at staff training records and found that training was provided as outlined in the providers policies and procedures.

The service issued customer surveys on an annual basis. We looked at survey results from 2014 and 2015 and found people were substantially pleased with the service being provided. Both 'Residents' and 'Relatives' scores came out as 'very good' for overall rating of the service in 2014 and 'excellent' in 2015.

We looked at recruitment processes and found that the provider did not always ensure that robust checks were undertaken prior to staff being appointed.

Summary of findings

People told us that the manager is approachable and listens to their concerns. We looked at systems in place to monitor care standards at the service and found that the manager undertook audits on a regular basis.

We found the provider was in breach of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to person centred care, safety and meeting people's nutrition and hydration needs.

You can see what action we have asked the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Fire safety was compromised due to poor practice at the service. Four fire doors had been wedged open with furniture.

Staff were aware of their responsibilities to safeguard people from abuse and were confident to report any such concerns.

We found recruitment processes were not robust. Employment references did not show proof of authenticity and did not represent most recent employer contact.

Arrangements for the management of medicines were robust. People received their medicines as prescribed, which helped to promote their good health and wellbeing.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

The rights of people who did not have capacity to consent to certain elements of their care or support were not promoted because staff were not working in accordance with the Mental Capacity Act 2005.

We observed meal times to be disorganised and this had a negative impact on people's experience of dining. Staff were not always aware of individual's nutritional risks.

Is the service caring?

Requires improvement

The service was not consistently caring.

Whilst we saw some examples of kind care, people were not always provided care in a timely manner and this negatively impacted on their dignity.

People who used the service and their relatives spoke highly of staff and managers. People told us staff were kind and they were happy living at the service.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

We observed staff interacted with people and this was not always in a person centred way. Task focused care regimes negatively impacted on people's individual needs.

Care planning did not always focus on what people could achieve.

People who used the service were not always provided with the opportunity to take part in fulfilling activities that met their individual needs or preferences.

Summary of findings

People told us that they felt confident to raise concern and we found that people had access to the complaints procedure.

Is the service well-led?

Requires improvement

The service was not consistently well led.

We observed the provision of care and support to be disorganised. The registered manager was not able to reassure the care team throughout the inspection and this meant that staff were uncertain and their performance was chaotic.

The registered manager had robust monitoring systems in place for quality assurance of the service.

People who use the service and relatives told us that the manager wasapproachable.

Staff told us that they felt supported.

Abraham House

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 21 July 2015 and was unannounced.

The inspection team comprised of two adult social care inspectors, a specialist advisor in dementia care and an 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. The expert by experience had personal experience of caring for a relative who lived with dementia.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection.

We spoke with district nurses, general practitioners, a community dietician, a community mental health nurse and an infection control nurse. Their feedback is included within this report.

We asked for feedback from two further general practitioners and a social worker. We did not receive any feedback from these professionals.

At the time of our inspection of this location there were 29 people who lived at the service. We spoke with five people who received care and six relatives. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We observed how staff interacted with people who used the service and viewed nine people's care records. We spoke with three care workers, one cook, one domestic worker and the registered manager during the course of our inspection.

We also looked at a wide range of records. These included; the personnel records of five staff members, a variety of policies and procedures, training records, medication records and quality monitoring systems.

Requires improvement

Is the service safe?

Our findings

People who lived at the service told us that they felt safe. People told us “I feel very safe, there are always people about”. “I am among all these people who live here, I am not on my own”. And "Yes I feel safe, I can get bored but these people care about me".

We asked visiting relatives if they felt their loved ones were safe living at Abraham House Care Home and they told us "Yes I think (name) is safe here I visit every day, if I thought (name) was not safe I would take her home. I feel safe knowing she is here". And "Yes it is a safe home, the staff are very nice people and caring. If anything they sometimes don't get there in time and (name) can be wet when I get here. The staff do try their best, they are busy".

We looked at how the service protected people from bullying, harassment, avoidable harm and abuse. We found that the service had robust systems in place for reporting and recording incidents or allegations of abuse.

We asked staff if they felt confident to raise concerns and they told us "The manager is very supportive, I can go to her with any worries. I trust her". "Yes I once had to tell the manager about another carers attitude towards the residents and she responded straight away". And "Yes I understand about abuse and I know the channels to take if I need to report abuse".

The provider had a policy and procedure in place for identifying and reporting abuse and staff had access to this.

The registered manager told us that there had not been any recent safeguarding incidents, however they were able to demonstrate referral processes to the local authority safeguarding team.

We looked at nine people's care records.

We saw that people had risk assessments within their care records. We found these were updated on a regular basis, however individuals risk were not always detailed in care plans.

We found that risk assessments had not always been completed in full. For example; weight records were being recorded as part of a MUST assessments (Malnutrition Screening Tool), however we found that the completed MUST calculation was not always recorded. This meant that the risk of malnutrition was not always checked.

We saw that a person at the service used bed rails. We looked at their risk assessment which told us ‘Family have requested bed rails to ensure safety’. We could not see that a mental capacity assessment or best interest decision had been undertaken. We found that there was no detail to show how the service had considered the person's individual need for bed rails or that they had involved external health care professionals in this clinical decision.

We looked at a care plan for a person ‘at risk of self-harm and harm to others’. We saw that an action of this assessment was to monitor the person closely. We asked staff if they recorded this. They told us they did not but “kept an eye” on this person.

We observed a person who lived at the service with bruising to their forearms. We looked at this person's care records and found that there was no record of this bruising and that a body map had not been completed. We looked at the person's accident reports and could not see any recent accident that could have caused this bruising. We also looked at other people’s care records and found that body maps and accident reports had been fully completed.

We saw a risk assessment for a person who was at ‘medium risk’ of choking. The assessment told us the person puts objects in their mouth. We saw that a corresponding plan around their ‘medical condition’ stated the person was at a ‘high risk’ of choking. The person had a safety care plan in place, however it contained no information around the management of the person’s identified risk.

We looked at a care plan for a person who lived at the service with a soap allergy. The plan told us that if the person puts a bar of soap near their mouth they have a reaction where their mouth and airway would swell. We looked in this person’s bedroom and found a bar of soap. We removed this from the bedroom immediately and informed the registered manager that the person was at risk should they come into contact with soap. The person was immobile, however we saw that this person was living with dementia and his care plan told us he was confused.

We identified four breaches in fire safety, four fire doors had been wedged with furniture that included large lounge chairs and bedroom cabinets. This placed people at risk of harm.

Requires improvement

Is the service safe?

These shortfalls in safe care and treatment amount to a breach of Regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing rotas and found that the service had maintained safe staffing levels in accordance with its stipulated staffing ratios. The registered manager told us that staffing levels were determined on the dependency of people living at the service.

A relative told us “Staff can be very sparse at the weekend. Staff do not always have the time to interact with the residents. Residents get left for long periods when they need assistance. We have gone looking for staff to help people who were distressed or needed to go to the toilet".

A staff member told us "I feel there is a sufficient amount of staff, evening can be very busy but if we tell the manager she will either stay and help or another care assistant will".

We looked at five staff personal files and found that systems were in place to recruit new employees. However, two personal files showed inadequate proof for receipt of previous employment referencing. We discussed this with the registered manager who agreed that more robust methods in collating reference information was required.

We looked at medicine management and found that the service had robust systems in place to ensure that people received their medicines as prescribed. We checked medicine stocks and records and found that a good standard of record keeping had been maintained.

We looked at training records and found staff that administer medicines had received appropriate training. A senior carer told us "It is a good system, the manager is very good at auditing the medicines so we never make errors".

We looked at medicine audits and found that the manager undertook an audit of medicines weekly. We looked at the most recent audits and found that areas for development are followed through by the manager.

We looked at infection control standards. The service used a registered disposal company to dispose of used continence products. Two people who lived at the service required the use of a bed pan. Bedpan waste was disposed of via communal bathroom facilities, washed and disinfected. The provider agreed that a dedicated bedpan sanitising machine would be purchased to improve waste disposal systems. No outbreaks of infectious disease had been reported by the service.

We found that the provider had assembled wall mounted containers for stock of protective clothing in communal bathroom areas. Protective clothing was not stored in a sealed container. This increased the risk of cross contamination of infectious disease or infection. We discussed this with the registered manager who agreed to look into improved storage containers.

We asked a domestic worker how they protect people from cross contamination of disease or infection and they showed us how colour coded systems are used for cleaning. The domestic worker had a good knowledge of infection prevention.

We looked at training records and found that staff had undertaken video training and then completed a questionnaire that demonstrated their understanding.

Requires improvement

Is the service effective?

Our findings

People told us "Everyone tries their best for me, yes I have seen the doctor when I need to". And "I have been to hospital a few weeks ago, someone took me".

We asked visiting relatives if they felt the service was effective in meeting the needs of their loved ones. A relative told us "Whenever (name) needed the doctor they would ring us and tell us the doctor was at the home and did we want to be present. We asked for a Chiropodist to see (name) and they arranged that. Whenever they did anything for (name) the staff always asked him first and told him what they were doing".

People's care plans included their medical history and detailed any health care support they required. Care plans also provided evidence that staff at the home worked positively with external professionals, such as GPs and mental health workers to ensure people's needs were met.

We gained feedback from health and social care professionals that visited the home and they were positive. A district nurse told us "The home is really good, I have been coming here for six years. The staff are very caring and they are quick at noticing changes in peoples health". A general practitioner told us "No problems at all with the home, people always seem fine when I visit and requests for GP visits are always appropriate".

We looked at staff training records and found that mandatory training was provided for staff in accordance with the providers policies and procedures.

Staff are trained in a variety of areas that enables them to understand their role and responsibilities. For example training records showed that the following courses had been completed; moving and handling, first aid, safeguarding, mental capacity act, food hygiene and end of life care.

Staff told us that they felt supported in their role and received regular training, supervision and annual appraisals.

We looked at staff files and found that supervisions were undertaken on a regular basis.

We looked at how the service considers peoples ability to consent to care and treatment.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager.

The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

We saw that the service had applied for multiple DoLS authorisations. This is when the service feels that someone is being deprived of their rights. The registered manager told us that applications were submitted following recent high court rulings and authorisations were in regards to people at the service living under continual control due to being in a locked building.

We looked at a care plan for three people who had a DoLS applications in progress. The care plans did not tell us what this deprivation application was for. We looked at how the service had assessed people's capacity. We saw a capacity assessment completed on 24th May 2015. It told us that the person could make basic decisions but was not clear about the specific decision the assessment had been completed for. There was no detail in the assessment about how the assessment process had been undertaken.

We looked another mental capacity assessment. The reason for assessment was recorded as 'application for deprivation of liberty authorisation'. There was no detail in the assessment about what specific decision was being assessed. The quality of the mental capacity assessments indicated that staff completing them had limited knowledge of mental capacity issues.

We spoke to three staff about who they support at the service that has a DoLS authorisation in place. None of the staff were aware. One staff member told us "I would have to look on the computer system". All staff told us they had completed e-learning on mental capacity and DoLS over the last few months. The registered provider has confirmed staff have received training in mental capacity and DoLS. Including E-Learning, class room learning and work books.

We were concerned about how people were being supported to meet their nutritional and hydration needs.

Requires improvement

Is the service effective?

We looked at the care plan for a person who had been living at the service for one month. We saw a care plan was in place that told us the person had low levels of potassium in their blood and needed a diet rich in foods that are high in potassium. We saw that the GP (General Practitioner) had visited this person on 14th July 2015 and prescribed a medicine to boost potassium levels as this person's levels had remained low. We saw a risk assessment was in place that identified a high risk of malnutrition “due to poor dietary intake following refusal to eat at meal times”.

We spoke to five staff including the chef about specialist diets. None of the staff we spoke with told us they had a person on a high potassium diet. We found that this person was not having their daily diet monitored on a diet and fluid chart. We looked at this person’s weight records and saw that they had lost 3.7kg in weight since admission to the service.

We looked at the records for three people who were having their diet and fluid intake recorded on a daily basis. We looked at one person’s records for the past seven days. We saw that on all days this person drank less than the recommended 1500mls of fluid per day. We saw that on 16th July the person had only drank 350mls of fluid and eaten one slice of toast and two biscuits. On 17th July we saw that the person had received 700mls of fluid, four biscuits and a bowl of porridge.

We looked at another person’s record that had three day's records missing from the past week. We did see that on 20th July they had been given a ‘fortified milkshake’. We saw that on each day the person received less than 1500mls of fluid.

The chef told us he did not know who needed fortified drinks. He told us that he made up a “batch” and the care staff gave them out to whomever needed them. The chef told us he catered for two diabetic diets, one liquidised diet and three soft textured diets. We received different feedback from other staff about the kinds of diets that people needed. We did not find that staff had a clear understanding of the needs of people’s specialist diets. The chef told us that he did not cater for snacks for people on soft textured diets but that yoghurts were always available.

We found that nutrition care plans did not always identify prescription detail regarding the thickness of fluids for people with swallowing difficulties. We found one plan for a person who was on thickened fluids. The plan told us that ‘fluids should be thickened to an appropriate consistency’. We could not determine what this was from the plan. We asked staff what consistency fluids the person needed and one care assistant told us that they were not sure, another told us "syrup thick".

We observed lunch time in the main dining room. People were assisted into the dining room 45 minutes before a drink or their meal was served. Tables had not been set and people became restless and distressed. We observed one person to vocally call out for a prolonged period, their attempt to communicate was ignored by staff and the level of distress caused other people to become restless. We spoke with relatives during the inspection and they told us that meal times were generally well organised.

The dining room had not been set and therefore did not help orientate people to meal time. People were offered a choice of meal however everyone was given a plastic blue cup with two handles. It was apparent that people were not being treated in an individual way.

We observed that during the lunch time period, four people remained in the lounge area. We observed a cleaner come into the lounge and clean the chairs. We saw that the cleaner did not engage any of the residents. We saw that one person was offered a choice of where to eat her meal and she was supported to remain in the lounge area.

These shortfalls in meeting people's nutritional and hydration needs amounted to a breach of Regulation 14 (1) (2) (3) (4) & (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a dietician that attends the service on a regular basis. They told us “I found the home to be really responsive to people nutritional needs. They are excellent at communicating and stay in touch. I was approached by the manager to undertake training around completion of MUST assessments and this is scheduled for next week. I have no concerns”.

We asked people if they enjoyed their lunch. People told us "Yes it was nice". "A little bland". And "Lovely thank you".

We found that the service had made efforts to make the service a dementia friendly environment and the director of the service informed us of links with centres of best

Requires improvement

Is the service effective?

practice such as Stirling University and The King's Fund. However, our observations during the inspection found that this was not considered throughout the service nor made aware to all staff.

Requires improvement

Is the service caring?

Our findings

People told us "I am very happy here". "I like everyone here". And "I am happy, sometimes I feel like there is not much to do".

We asked relatives if they thought the service provided for their loved ones was caring and dignified. We received mixed feedback. Relatives told us "They are very gentle with the residents. They never rush them or lose patience with them. One of the residents I got to know well was on end of life. The staff were on the ball with them." “Two weeks ago I came into the home and found (name) had soiled himself. I took him upstairs to his room and started to clean him up. I couldn’t find any wipes or pads to change him into. A carer came and helped me with him after she had found the equipment needed elsewhere”. "The care is exceptional". And "Every time we come into the home (name) is in the wrong clothes, clothes that don’t belong to (name)”.

Staff did not always attend to people's individuals needs after meal and snack times and we saw people left in unclean clothing for long periods of time. We did not see staff offer to support people to get changed into clean clothing.

We observed staff discuss people's personal needs in communal areas. For example one staff member said "(name) needs changing, they are wet through".

We felt that people were not always sufficiently supported to maintain their dignity.

We observed care workers engaged with people in a sensitive and respectful way when they were undertaking care interventions.

The service provided care for people who were at the end of their life. We received positive feedback from relatives and external professionals about the standard of end of life care at Abraham House. A relative told us "Care for (name) was brilliant, I knew (name) was in the right place".

We received feedback from a district nurse. They told us "The care given to end of life patients is exceptional. Many of the resident's have been within the care home for many years and have made many friends and are almost part of the family to many of the carers. The management are keen to look after the end of life patients rather than they be moved to an unfamiliar environment which could cause more distress. Working in partnership with the district nurses, GP's and cancer support nurses I feel the patients receive a dignified death within this care home".

We asked the registered manager if people had access to advocacy services. The registered manager told us that this service was available and had previously been accessed for a person living at Abraham House.

We recommend that the provider considers ways to improve dignity awareness at the service.

Requires improvement

Is the service responsive?

Our findings

There were processes in place to assess people's needs prior to them starting to use the service. We looked at pre-admission assessments and found that the registered manager assessed people before placement at the service was agreed.

People told us "Yes I feel that staff know me, well I would hope so by now". And "I can be me".

We received feedback from a district nurse. They told us "Within my role as a district nurse I regularly attend to the residents of Abraham house. I find the manager and care staff to be extremely attentive and caring towards their residents. The staff work very hard in what can be a very challenging environment. The welfare of the residents is always their number one priority. I feel the residents are very well looked after in terms of their physical and psychological needs".

We felt that improvements were required around person centred care planning. Care plans did not always provide comprehensive person centred detail that would enable the reader to be able to care for the person in accordance with their individual needs and preferences.

We looked at care plans for six people who lived at the service. We saw that care plans were updated monthly and daily entries were made on each shift.

We looked at a care plan for someone who had been living at the service since 2012. We saw that they were on medications for helping their bowels to function regularly. We saw that a care plan was not in place to detail this person's need.

We looked at a care plan for a person who was on inhaler medications. Staff told us this person was asthmatic. We found no reference to asthma in the care plan.

We looked at a care plan for a person with behaviours that challenge. The plan told us the person had a problem with 'noisy behaviour'. We saw that the plan indicated that this person should be 'isolated' from others as a way to manage this behaviour. We could not see that the service had tried to look at why behaviours were being displayed and how they could minimise distress for the person. We found this plan was not person centred. We looked at another person's care plan around behaviours that challenge, this instructed staff to "remove the person from communal areas".

We found that care plans did not always use positive language. We saw examples such as 'can be very demanding', 'is very temperamental' and 'they are non-compliant' written in plans. We also saw staff use phrases such as 'softs' and 'walkers' when referring to people.

We saw that care plans contained records on likes and dislikes. We saw examples where these records were blank and other examples that were not filled in correctly and had comments such as 'requires assistance' and 'needs prompting'. We could not determine from these records what people's likes and dislikes were. We found inconsistencies in the providers computerised care recording system. The provider told us that some records had been discontinued. However these had not been removed from individual care records and therefore the likes and dislikes document was found to be blank.

We saw one record where likes and dislikes were well recorded. This told us the person liked spicy food, curries and jerk chicken. We asked staff if this person ever received these meals. Staff told us that they did not recall that they had.

We looked at a plan for a person's night time care. It was blank where the record told us what time they got up and went to bed. We also saw a plan about a person's behaviour. It told us that staff should be aware of 'triggers'. It did not tell us what the triggers were.

We could not see that people who used the service had been involved in their care planning or reviews.

We observed the care people received. We found that care was task focused and did not always focus on people's individual needs or preferences. For example we observed one person sitting at the dining room after lunch time. They had spilled the contents of their cup onto the table and had become very distressed by this. Two members of staff came into the dining room, one made a drink and sat at another table for ten minutes. The other got a drink from the kitchen and then sat and talked to the other member of staff. Both staff members did not acknowledge or respond to the person's expression of distress or need for help. The inspector had to prompt staff to assist this person.

Requires improvement

Is the service responsive?

We observed people go for long periods with unmet care needs. For example one person was seen to walk around the service for one hour with trousers heavily stained with urine, the inspection team had to prompt staff to assist the person and this negatively impacted on the person's dignity.

We felt that the delay in response times for people's needs, especially around incontinence was due to disorganisation at the home.

These shortfalls in person centred care amounted to a breach of Regulation 9 (1) (2) &(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed care interactions in main communal areas throughout the inspection. We did not find that people were engaged in meaningful activities. People were able to watch the television however no one appeared engaged. We did not find that people were engaged in a way that was meaningful or that people were encouraged to fulfil their time with activities that were of interest to them.

We saw that the service had an activities schedule displayed in the corridor area and multiple activity items were stored in the conservatory area, however throughout the inspection we did not observe staff utilise equipment to engage with people who lived at the service.

The service issued customer surveys on an annual basis. We looked at survey results from 2014 and 2015 and found people were substantially pleased with the service being provided. Both 'Residents' and 'Relatives' scores came out as 'very good' for overall rating of the service in 2014 and 'excellent' in 2015.

We received positive feedback from a community mental health nurse. They told us "Our team have been involved with residents at Abraham House for approximately three years now, and have consistently gained a good impression of the home". And "Abraham House have worked very well with us throughout this period. Our suggestions have been implemented quickly and with enthusiasm for the approach, which usually results in a reduction in the use of antipsychotics to manage difficult behaviour. Over this period of time we have seen how the staff treat the residents with respect, warmth, compassion and humour, where appropriate".

People had access to information about the service. The manager told us that a service user guide was issued when people viewed the home and these were available for people living at the service to access.

Requires improvement

Is the service well-led?

Our findings

There was a long term registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the health and social care act and associated regulations about how the service is run.

We received some very positive feedback about the registered manager during the inspection. People told us they found the manager to be very supportive and approachable. One person said; "I can go to the manager with any problem and be she will help me out".

Staff told us that they were confident in the managers actions to resolve problems at the service. A care worker told us "If we get this inspection wrong, the manager wont stop until we have improved".

A relative told us "The manager is excellent, very involved and caring".

Prior to the inspection we looked at notifications the registered manager had sent us with regards to incidents at the service. We found that the manager worked in a transparent way.

There were processes in place to monitor quality across the service which included scheduled audits. We found evidence these were undertaken as planned and effective. For example, the manager completed weekly medicine audits, monthly infection control audits, audits of the environment and care files.

Abraham House was awarded gold status with Investors In People. Investors In People is an internationally recognised accreditation that defines what it takes to lead, support and manage a staff team well for sustainable results.

During the inspection we found a lack of organisation at the service, staff were not well led and the atmosphere was chaotic. We discussed this with the manager who told us that staff were overwhelmed by the inspection process and felt under pressure by the amount of people inspecting the service.The manager told us that this had negatively impacted on observation of care.

We saw that a meeting had taken place for people who lived in the home in May 2015, minutes indicated involvement of people who used the service. A relative meeting was held 12 may 2015. Action plans were formulated following these meetings.

Relatives told us that they felt involved in the running of the service and felt their opinions were valued.

We looked at staff meeting minutes and found that a meeting was last held 13 May 2015. Minutes showed staff involvement and an action plan was formulated following the meeting.

We spoke with visiting professionals who told us that the service works in partnership with external agencies.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not always have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences. Regulation 9 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider did not have suitable arrangements in place to protect service users from malnutrition, risk of choking and dehydration. Regulation 14 (1) (2) (3) (4) & (5).