Abbeyfield Ferring Society Limited (The)

The Abbeyfield Ferring Society

Inspection report

Cornwell House
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Worthing
West Sussex
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Tel: 01903240313

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21 September 2016

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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

The inspection took place on 20 and 21 September 2016 and was unannounced.

The Abbeyfield Ferring Society residential care home, also known as Cornwell House, is registered to provide accommodation and care for up to 20 older people with a variety of needs. At the time of our inspection, 20 people were accommodated at the home, including one person who was receiving respite care. Cornwell House is situated in Ferring, a village approximately three miles to the west of Worthing. The home is detached with an accessible garden and summer house to the rear of the property. Communal areas include a large lounge downstairs, and a smaller upstairs lounge, dining room and conservatory. All rooms have en-suite facilities comprising a toilet and washbasin. Upstairs accommodation is accessible via a lift.

A registered manager was 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.

People told us they felt safe living at the home and that they were protected from abuse or harm by trained staff. Risks to people were identified, assessed and managed safely and guidance provided to staff on mitigating people's risks. Risk assessments were reviewed monthly or more frequently if an accident or incident sustained by a person required earlier review. Staffing levels were sufficient to meet people's needs and safe recruitment practices were in place. Generally, people's medicines were managed safely.

Staff had been trained in a range of areas, usually by the registered manager, who had appropriate training qualifications. New staff studied for the Care Certificate, a universally recognised qualification. Staff had regular supervision meetings with the registered manager which included observations of their work and spot checks. Team meetings were held twice a year. Staff had a good understanding of the requirements of the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards, and put this into practice. People were involved in decisions relating to their care and had signed consent forms. People were supported to have sufficient to eat and drink and to maintain a healthy diet. They spoke positively about the menu choices on offer. People had access to a range of healthcare professionals and services. People were encouraged to personalise their rooms.

People were cared for and supported by kind, friendly staff who knew them well. People spoke highly of the care staff and we observed staff engaged with people in a warm and empathic way. People were encouraged to express their views and to be involved in making decisions about their care. They told us they were treated with dignity and respect by staff. Some people had made decisions about their end of life care.

A range of activities was on offer to people and these reflected people's interests which had been identified through a questionnaire sent out in January 2016. Minibus outings were organised each month and people

were also supported by staff to access the gardens surrounding the home and out into the community, for example, a visit to the shops or down to the beach. Care plans provided comprehensive, detailed information about people and guidance to staff on how they wished to be cared for. Complaints were managed in line with the provider's policy.

People were actively involved in developing the service through residents' meetings which were held three or four times a year and through formal questionnaires. Their relatives were also involved and invited to residents' meetings. Feedback was obtained from relatives through annual questionnaires which asked for their views about the quality of care delivery, staff and management and about the premises. Overall, feedback was very positive. Staff were also asked for their views about the home and they told us they felt they were listened to by the registered manager. Staff felt the home was well managed and led effectively. The quality of care delivery was measured through a robust system of audits and checks which the registered manager had implemented. Any areas for improvement were identified and acted upon.

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.

People's safety was ensured because staff had been appropriately trained. People's risks were identified, assessed and managed appropriately.

Staffing levels were sufficient to meet people's needs. Safe recruitment practices were in place.

Generally, people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had been trained in a range of areas and were skilled and experienced to look after people effectively. Staff had regular supervisions with the registered manager and attended team meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had sufficient to eat and drink and were encouraged to maintain a balanced diet. They had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well.

People were encouraged to express their views and to be involved in decisions about their care. They were treated with dignity and respect.

Some people had made decisions about their end of life care.

Is the service responsive?

Good

The service was responsive.

Activities were organised for people based on their expressed interests. Monthly minibus outings were organised.

Care plans included comprehensive, detailed information about people and guidance for staff.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff were asked for their views about the home. Their feedback was analysed and appropriate actions taken to drive improvement.

Staff felt the home was well managed and well led; they told us the registered manager listened to their suggestions.

A range of audit systems measured the quality of care delivered and identified any areas for improvement which were acted upon.

The Abbeyfield Ferring Society

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.

The inspection took place on 20 and 21 September 2016 and was unannounced.

One inspector and an expert by experience undertook this inspection. 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 at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with ten people living at the service and spoke with one relative. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager, a senior care assistant, a care assistant and the

cook.

The service was last inspected on 31 October 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe and protected from abuse or harm. One person said, "It's lovely here, I feel very safe. The staff are very kind and good; I haven't got any complaints". Another person told us, "The staff make me feel very safe" and a third person said, "The lady in charge is wonderful. People make me feel safe and the cleaning ladies are a lovely bunch!" In one person's care plan we read, 'I feel safe because I spend every day with my door open". Staff had been trained to recognise the signs of potential abuse and had completed training in safeguarding. One member of staff explained that safeguarding was, "There to protect the resident" and gave two examples of abuse such as, "Physical or emotional". They told us that if they had cause for concern, "I'd report to the senior on duty or the manager. I'd investigate and find out where and when it happened. It could be another resident". They added they would also notify the local authority if needed. Another member of staff said, "Anything I noticed I would write it down and I would go to the manager".

Risks to people were managed so they were protected from harm. A range of risk assessments had been drawn up and were contained within people's care records. These included: skin integrity, pain management, medicines management, behaviour that posed a risk to others, moving and handling, falls prevention, bedroom environment, continence, nutritional health, sleeping and night care, going out, smoking, alcohol and/or drug use, finances, self-harm and fire safety. Each risk assessment identified the area of risk, possible risk factors, the level of risk (low, medium, high), the actions to be taken by staff and control measures in place. Risk assessments were detailed and provided clear guidance to staff. For example, we read a risk assessment relating to personal hygiene for one person which read, '[Named person] is resisting staff assistance when care is given and the hoist is used. [Named person] exhibits behaviour such as pushing staff away, grabbing at staff, pushing back on staff and attempting to remove herself from the sling. Behaviour chart commenced and, at all times, two staff are present'. The assessment included guidance and information to staff on how to manage the risk.

Assessments had been made in the safe use of bed rails and Personal Emergency Evacuation Plans (PEEP) should people need to be evacuated from the building in the event of an emergency. Accidents and incidents were logged separately and people's risk assessments updated as needed. Risk assessments were reviewed monthly. Staff had received training in moving and handling. We observed staff supporting one person to transfer from their walking frame to a wheelchair. The staff member said, "Swing yourself round, take a couple of sideway steps and there you are, that's lovely. I've made the seat comfortable for you". People's weights were monitored routinely on a monthly basis, whether or not they were at risk of malnourishment. We noted that, whilst people's weights were recorded, their height had not been included on the monitoring charts. This would have made it difficult for staff to ascertain whether people's weight was within normal limits for their height. We drew this to the attention of the registered manager who immediately contacted staff to ensure that people's heights were recorded within their care plans.

We checked the staffing rotas which confirmed there were sufficient numbers of suitable staff to keep people safe and meet their needs. During the day, there were always at least one senior care assistant and three care staff on duty; at night, there were two waking staff. An additional member of staff worked the

'twilight' shift between 8pm and 10pm, a busy time of day when people needed support to get ready for bed. We asked people whether they felt there were enough staff and they confirmed there were. We also asked staff the same question and one staff member felt that staffing levels were good, adding, "Some days are busier than others, but generally there are enough staff". We checked staff files to look at how new staff were recruited safely. Staff files contained two references, identity checks and input from the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people.

Generally, people's medicines were managed so they received them safely. However, whilst observing one member of staff moving the medicines trolley at the start of their medicines round, we found a pod which contained one person's medicines on the floor underneath the trolley. The medicines were dated as to when they should have been given. Clearly, the person had not received their medicines as prescribed. We discussed this issue with the registered manager who referred to the staffing rota to see which staff member had been responsible for administering medicines on the day in question. On the second day of our inspection, the registered manager confirmed they had discussed the issue with the staff member, who stated they must have inadvertently left the medicine pod on top of the trolley, intending to administer the medicine to the person, but had forgotten about it. At some point, the medicine pod must have slipped off the top of the trolley and rolled underneath. The registered manager immediately sent a memo to all staff responsible for administering medicines, reminding them of the importance of ensuring that people took their medicines as prescribed and that Medication Administration Records (MAR) should only be signed by staff after people had actually received their medicines.

We continued to observe one member of staff as they administered the lunchtime medicines to people. The staff member locked the trolley between administering each medicine. MARs had been completed and signed appropriately by staff. The pharmacy responsible for supplying medicines had completed an audit in August 2016 and no issues were identified in the management of medicines.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Essential training was delivered in a range of areas including safeguarding, dementia awareness, infection control, mental capacity, moving and handling, health and safety and first aid. Essential training was refreshed annually and the training matrix confirmed this. The registered manager said that some staff still had to complete moving and handling training, health and safety and infection control and training sessions had been organised. Staff told us about the training they received and one staff member said, "We have the training. [Named registered manager] is always on top of that. Things change – policies and things". They added that it would be useful to have training on Parkinson's disease and the registered manager told us they were in the process of arranging this. Another member of staff said they were studying for their National Vocational Qualification (NVQ) Level 3 in Health and Social Care and told us that all staff were encouraged to take additional qualifications. The majority of training was delivered to staff by the registered manager who had appropriate training qualifications, was an NVQ assessor and updated her knowledge on various topics as needed. The registered manager told us that when she delivered training to staff she also used the sessions as an opportunity to look at the provider's policies and procedures with staff.

Staff told us they received supervisions with the registered manager on six occasions throughout the year. Supervisions consisted of a formal 1:1 meeting, spot checks or observations of staff delivering care and we looked at some records of supervision meetings that had taken place. We asked staff about their supervision meetings. One staff member explained they discussed areas they were good at and areas that might require improvement. They added, "And how we feel we're doing and any suggestions we have. We want to progress". Another member of staff confirmed they received supervision and said, "We all work as a team. We have observations as part of supervision all through the year really. If there's something not right, she [referring to registered manager] would speak to you about it". Team meetings were held twice yearly and we saw the minutes of team meetings held in March and April. Separate team meetings were held for day and night staff. Senior care staff had monthly team meetings at which residents, recruitment, events and training were discussed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. 'Consent to care and treatment' forms were contained within people's care plans and people had signed to confirm their consent. In one person's care plan it was recorded, '[Named person] is able to make day-to-day decisions, though prefers her son to be present when complex/financial decisions are made'. We asked staff about their understanding of mental capacity and one staff member said it was, "To make sure that the residents who don't have capacity are not put in vulnerable situations. Some people with dementia have capacity at different times of the day and not others". Another member of staff explained mental capacity as, "For people at the time who can't make their own decisions. We can intervene in that moment. They're protected by the Act". No-one living at the home was subject to DoLS and everyone was free to come and go as they pleased, although in practice, the majority of people needed the support of family, friends or staff to access the community safely.

People were supported to have sufficient to eat, drink and maintain a balanced diet. We checked one person's care plan and this showed they received a pureed diet. The care plan stated, '[Named person] has a small appetite and she prefers her food to be soft/pureed. Family have requested that [named person] has soup at lunchtime and supper. This has been documented in her care plan'. However, a previous assessment from a speech and language therapist advised this person should have a 'mashed and fortified diet'. We met with the person and asked them about their diet. They told us, "My teeth make eating difficult and my mouth hurts a lot" and added they would like it if they could eat more easily. We observed this person's dentures did not fit properly and kept dropping from their gums; they did not appear to be comfortable. We discussed our concerns with the registered manager who told us that it had been at the family's request that the person had been placed on a pureed diet. However, this was at odds with the advice provided by the speech and language therapist who advised a mashable diet. During our inspection, the registered manager contacted a dentist to arrange a visit to the person; the registered manager also obtained advice from a GP who advised trying the person on a soft diet initially and to be weaned off the pureed diet. Food and fluid monitoring charts were completed for everyone as a matter of course, regardless of whether they had been assessed as being at risk of malnourishment. We saw that some food and fluid monitoring charts had not been completed fully and discussed this with the registered manager. She was aware of the issue and said she constantly reminded staff to complete the charts appropriately. The inadequacy of some recording in the charts did not have an adverse effect on people's health and welfare.

We talked with the cook about the catering arrangements at the home. They had only recently come into post and were in the process of learning the job and in planning new menus. The cook told us they planned to introduce more fresh food into people's diets, for example, home-made soups. People could choose cereals or toast for breakfast or they could have a cooked breakfast. The main meal of the day was served at lunchtime and we looked at how the menus were planned over a four weekly cycle. On the day of our inspection, the lunchtime choice was fresh salmon, mashed potato, tomatoes and peas with fresh fruit salad to follow. Some people had chosen to have an omelette instead. In the evening, supper choices comprised sandwiches, soup or a light snack with dessert to follow. The cook told us, "I think to be honest they're good here and will try and accommodate people's choices". Vegetables and fresh fruit were delivered to the home on a daily basis. A roast lunch was prepared on a Sunday and the cook told us, "Everyone likes that". We observed people sitting down to lunch on the first day of our inspection. Tables in the dining room were laid attractively with cloths, cutlery and flowers and the food looked appetising. A large bowl of fresh fruit was on the table and available to anyone who wanted it. Where people chose to eat their meals in their rooms, their trays were laid with paper doyleys. Some people were assisted to eat their meals by staff and this was done in a sensitive and kind way. Other people were able to eat more independently because they had their food cut up for them or plate guards were used to prevent their food slipping off the plate. People spoke positively about the food on offer. One person said, "Food is lovely, especially of late". Another

person said, "I like getting a good choice of food" and a third person said, "I'm quite satisfied with everything and like the meals". We observed that people were offered a choice of hot or cold drinks throughout the day and jugs of water or juice were available to people in their rooms.

People were supported to maintain good health and had access to a range of healthcare professionals and services. People told us they could see their GP when needed and those appointments could be made for them. Care plans contained details of visits from healthcare professionals, why the visit was needed and any actions that needed to be taken. People received support with their healthcare from GPs, district nurses, dentists and opticians.

We saw people's rooms and these were furnished comfortably. People were able to bring some of their own furniture with them when they moved into the home and rooms were decorated with pictures and photos that were important to people. One person told us, "I'm very lucky with the view in my room. I have no concerns with being here, everyone is very friendly". We asked people whether they could access the back garden easily and one person said, "Yes and I do, as much as possible".

Good

Is the service caring?

Our findings

People were looked after by kind and caring staff and positive relationships had been developed. Everyone we spoke with said they felt well cared for. One person had stated in their care plan, 'I feel that I am cared for because I only have to push a button for some help'. Staff knew residents well and how to communicate positively and effectively in an empathic way. Throughout our inspection, we observed staff engaging with people in a warm and friendly manner. For example, we saw staff knelt down next to people and made eye contact when talking with them. Staff were not rushed, were patient and kind and had time to spend with people. One person told us that a member of staff had supported them to attend their grandson's wedding. People's life histories were recorded in their care plans and this provided staff with a good understanding about people before they moved into their home, their families, likes and dislikes, and what was important to them.

People were supported to express their views and to be involved in making decisions about their care, treatment and support. Care plans showed that people were involved in all aspects of their care and included whether they would like their relatives to be involved in the review of their care plan. For example, one care plan stated that the person would like their son to be involved and provided contact details for the son.

People were treated with dignity and respect and they had the privacy they needed. One person said, "I could recommend this place to anyone. They leave you alone if you want to be left alone or I can always find people to talk to". We observed that staff treated people with dignity and respect and we asked staff how they would do this. One staff member said, "By making sure you allow them to make choices and when giving personal care they're covered up, curtains are drawn and doors are closed". Another staff member said, "You've got to respect everyone really, that's part of the job".

Where people had chosen to do so, their preferences and choices for their end of life care was clearly recorded. These included people's plans for their funerals and how these should be planned.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. A relative told us, "Staff are very caring and not rushed. Mum has put on a lot of weight since being here and she has a lot of food". They added they were also informed if their mother became unwell and added, "I'm very impressed with the activities and what they try and do here to keep the residents busy". A range of daily activities was on offer including, gentle exercises, Bingo, music for health, manicures and facials, arts and crafts. Outings were also organised into the community, for example, in September some people went on a minibus outing and visited a pub in Arundel. There were plans for future minibus outings to visit Shoreham Airport and a garden centre. One person told us, "The bus only takes one wheelchair. I enjoy getting out, but we take it in turns to go out as I need a wheelchair". A member of staff said, "In the summer, we try and encourage people into the garden" and gave an example of an occasion when people had sat in the garden and enjoyed cocktails. The member of staff added, "We'll take people out in the garden for half-an-hour. Sometimes we take people to the shops or down to the beach. One lady always comes out with us to pay the paper bill".

Before people were admitted to the home, a pre-admission assessment was completed. This included any allergies people might have, their likes, dislikes, health and physical wellbeing, social and communication preferences. Care plans provided detailed and comprehensive information and guidance to staff on how people wished to be cared for. Information was included as part of people's risk assessments (see the 'Safe' section of this report). Care staff completed daily records for people, how they had spent their day, any visitors or healthcare appointments and what kind of mood they were in. One staff member confirmed they completed the daily records for people which were kept in people's rooms and said, "I'm quite meticulous really". Handover meetings were held three times a day between shifts. These provided an opportunity for staff to communicate with each other on the care people had received that day or night, any changes to their care needs and any concerns. This ensured that people's most current care needs were met effectively. One member of staff told us about the importance of keeping people hydrated and their role as 'Hydration Champion'. This meant that people's fluid intake was recorded and how much reliance on a carer they needed to drink sufficiently through 'Reliance on Carer' charts.

Complaints were managed in line with the provider's policy. This stated that any concerns should be reported to a care team leader initially with a view to resolving any complaint within five working days. A full written response would be sent within 28 days. The registered manager and a representative of the provider were also involved in resolving any complaints. Two complaints were received during 2015. Records showed these were managed appropriately and to the satisfaction of each complainant.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service. On the first day of our inspection, a residents/relatives' meeting was planned and we sat in on this meeting. We observed the registered manager and staff encouraged residents to be involved in planning future activities and places they would like to visit. Everyone was given the opportunity to have their say and reassured that their feedback was valued. Staff used language with people such as, "What were your thoughts?" and, "Do you have any suggestions?" People were communicated with in an effective and inclusive way. People spoke highly of the registered manager and felt their views were listened to and acted upon. Residents' meetings were held every three to four months and records confirmed this.

People and their relatives were also asked for their feedback on the quality of care delivered and on the leisure and social activities on offer. The last questionnaires were sent out in January 2016. In response to the relatives' questionnaire about the quality of care, management and staff and the premises, 16 responses had been received. In answer to the quality of the care provided, 12 relatives said they were very satisfied and three people were satisfied with the quality of care. Where one relative had expressed dissatisfaction, the registered manager had taken action to clarify the areas of concern. The issues were discussed and managed to the satisfaction of the relative who thanked the registered manager for taking the time to explore and address their constructive comments. Overall, the majority of relatives were happy with the care and service provided and comments included that relatives were happy with the, 'Friendly, homely atmosphere', 'Capacity to facilitate any need of my relative' and the, 'Quality and choice of home cooked food'. People were asked for their views about the activities on offer and which activities they liked best and which they liked least. This enabled staff to plan activities that people enjoyed and were of interest to them. For example, out of nine responses, six people stated they were very interested in listening to music and four people enjoyed taking part in physical activities, such as music and movement. As a result, activities were planned that were of interest to the majority. Five people expressed an interest in reading newspapers or books and these were freely available.

In the provider's Statement of Purpose it states, 'We are aware that leadership and effective management of the care home is central to all its operations and residents can expect a management approach which creates an open, positive and inclusive atmosphere'. We observed this to be the case in practice.

Staff told us that the registered manager was accessible and that the home was well managed. One staff member said, "Anything we want to know about, we can go to the manager. There's always someone to ask for help". They added, "It's a nice, very well run home and it's small. There's a nice atmosphere. Sometimes when you're busy, you get a bit tired. Staff are good at covering and filling in. On the whole I think it's very well run". Another staff member explained, "And if you have any concerns, you can talk to them [management team] at any time". A third staff member told us, "I like working here very much. The girls are all good". One person had recorded in their care plan, 'Cornwell House is well led because the staff are always available'. Staff were asked for their feedback about the home in a questionnaire in January 2016. Overall the feedback was positive.

Good quality care was delivered and measured through a system of quality audits. Audits monitored and identified areas for improvement through night-time visits, where the registered manager made unannounced visits to the home to observe night care staff, mealtime observations, medication audits and an analysis of accidents and incidents to identify any emerging trends or patterns. We were shown a copy of the annual development plan for the home which showed the plans for the year ahead and investment in improvements to the premises. A member of staff told us, "I think it's a very 'homely home' and it's a nice environment to work in. If the residents are happy, it shows they're well cared for".