Abbeyfield Society (The)

Jim Gillespie House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 15 December 2015 and was unannounced.

The home provides accommodation and personal care for up to 26 older people. Twenty-four people were living at the home at the time of our inspection. 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 The inspection took place on 15 December 2015 and was unannounced.

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Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies. The registered manager assessed risks to people's health and welfare and people's care plans included the actions and equipment needed to minimise the risks.

There were enough suitably skilled and experienced staff on duty to meet people's care and social needs. The registered manager checked staff's suitability to provide care during the recruitment process.

The registered manager regularly checked that the premises and equipment were suitable and properly maintained to minimise risks to people's safety .People's medicines were managed, stored and administered safely.

People's needs were met effectively because staff received appropriate training and support. Staff read the care plans and new staff shadowed experienced staff until they knew people well and understood their needs and abilities. Staff were supported and encouraged to reflect on their practice and to develop their skills and knowledge.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people with complex needs, their families and other health professionals were involved in making decisions in their best interests.

Risks to people's nutrition were minimised because staff knew about people's individual dietary requirements. People were offered a choice of foods and were supported to eat and drink according to their

needs.

People were cared for by kind and compassionate staff who knew them well. Staff knew about people's individual preferences for care and their likes and dislikes. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health and when their health needs changed.

Staff were attentive to people's feelings and behaviours and understood how to reassure them. People were supported to spend time with other people who lived at the home and to maintain relationships with those people were important to them.

People and their representatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed.

People and relatives told us care staff were kind and respected their privacy and dignity. They were confident any concerns would be listened to and action taken to resolve any issues.

People and relatives were encouraged to share their opinions to enable the provider to make improvements in the quality of the service. Staff were guided and supported in their practice by a management team they respected.

The provider's quality monitoring system included regular reviews of people's care plans and checks on equipment, medicines management and staff's practice. The provider's visions and values were understood and shared by the managers and staff. The focus of the service was to ensure people enjoyed the best possible outcomes as identified in the Commission's essential standards.

The provider's plans to improve the quality of the service included more personalised library and medicines services and the use of time saving electronic equipment for staff.

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. Staff understood their responsibilities to report any concerns about people's safety and to minimise risks to people's health and wellbeing. The provider assessed risks within the home and took action to ensure people lived in a safe and comfortable environment. The registered manager checked staff were suitable to deliver care and there were enough staff to support people safely. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People's needs were met by staff who had relevant training and skills. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People were supported to maintain a nutritionally balanced diet that met their dietary needs. People were supported to maintain good health and to access other healthcare services when they needed them.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence by supporting them to lead their lives in the way they wanted.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning and reviewing how they were cared for and supported. Staff knew people's preferences, likes and dislikes. Staff supported and encouraged people to remain active and to make decisions about their community. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Good

The service was well led. People were encouraged to share their opinions about the quality of the service. The management and staff team shared the provider's values to provide an effective,

good quality service that delivered the best possible outcomes for people. Improvement plans were aimed at delivering a more personalised service.

Jim Gillespie 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 15 December 2015 and was unannounced. The inspection was undertaken by one inspector.

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 improvements they plan to make.

We also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with eight people who lived at the home and two relatives. We spoke with three care staff, the cook and the registered manager. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

We reviewed two people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe at the home. One person told us, "There is always someone around." A relative told us, "[Name] feels safe and secure."

A member of staff told us, "The whistleblowing policy is effective. It is for the residents." There was a poster in the hallway which said, "Whistleblowing – Speak out!" to remind staff any concerns would be taken seriously and acted on. Staff received training in safeguarding and understood their responsibilities to keep people safe and protect them from harm. A member of care staff told us, "I would be concerned if people were withdrawn, if there was a change in their personality, or they acted differently around a particular member of staff." Care staff told us they knew the actions they should take if they had any concerns. One member of care staff told us, "I would report any concerns I had to the deputy manager. It is my job to protect them." People, relatives and staff told us they had never seen or heard anything to concern them. The manager had not needed to make any referrals to the local safeguarding team.

In the two care plans we looked at we saw the registered manager had assessed people's individual risks and written a plan to minimise their identified risks. For example, for one person who was identified as at risk of poor skin, their care plan included the use of a pressure relieving mattress and cushion. Staff were instructed to check and record the condition of their skin and to apply cream if red patches were observed. Records showed that staff marked on a body map when red patches were identified and when the application of creams had subsequently healed the skin.

Staff recorded accidents and incidents in people's personal daily records and in an accident and incident log, for the registered manager to review and analyse. One person told us, "I fell and rang the bell and they called the paramedic came and took me to hospital." Staff told us they would record an incident, report it to a senior and call the GP or ambulance if needed. A member of care staff told us, "We look for possible causes, a stool or cushion maybe." Records showed staff took appropriate measures to identify the causes and minimise the risks of a re-occurrence.

People told us they had the equipment they needed to minimise risks to their mobility. People told us, "I have a profile bed. It can change position" and "They have got me a stand aid." During our inspection we saw staff were observant and aware of people's individual risks. Care staff ensured people had the equipment they needed, such as walking frames, near at hand to enable them to move independently and safely. Staff told us the equipment people needed was always available and was regularly checked for safety and effectiveness. Care staff told us, "The call bells are checked every Friday" and "The senior checks the airwave mattresses twice a day and they are replaced or repaired on the same day if necessary."

People's care plans included a personal evacuation plan (PEEP) to be followed in the event of an emergency. A member of care staff told us, "I would look at the panel and decide the safe zone. I have seen the PEEPs and we have a slide to get people downstairs." Records showed the provider regularly completed fire risk assessments of the premises and the policy had been recently updated.

The provider assessed risks to the premises and took action to manage the risks. Records showed external professionals were contracted to maintain essential equipment, such as the lift and heating systems, and to regularly check the safety of the water, gas and electrical supplies. Care staff told us the provider's contingency plans, in the event of a problem, were effective. One member of care staff told us, "When the heating broke down the registered manager authorised staff to go out and buy heaters for the day until the engineers could come. It was fixed the next day."

People told us there were enough staff to meet their needs. One person told us, "You only have to ring they come quick." Another person who chose to stay in their room told us there were plenty of staff and they were, "Constantly popping in." They told us, "I've had thirty-three visits to my room this morning, counting the cleaning and meals." The registered manager checked people's needs and abilities and scored each person's level of dependence to determine how many staff were needed to support people safely and according to their needs. We saw there were enough staff to answer call bells promptly and for staff to spend time supporting and engaging with people individually. A member of staff told us, "There are enough staff. We have time to sit and chat with people" and a relative told us they were pleased to have noticed, "The staff are consistent. There is a really low turnover."

The registered manager showed us the records of the checks they made on staff's suitability to work at the home. They requested references from at least two previous employers and checked staff had the right to work and whether they were known to the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. The registered manager assessed new staff's knowledge and experience of working in the care sector to ensure they received an induction that matched their skills and experience.

People's medicines were managed and administered safely. One person told us "They look after my medicines. They keep them for me and re-order when needed. Saves me worrying about it." Medicines were kept in a locked trolley and administered only by staff who were trained in medicines administration. Medicines were delivered by the pharmacy in named, colour coded blister packs with an accompanying medicines administration record (MAR). The MAR included the person's photo, the name of each medicine, the frequency and time of day it should be taken. The two MARs we looked at were signed by staff and up to date which showed medicines were administered as prescribed.

One person told us, "They bring my medicines. They are always the right ones." The registered manager had asked the GP to check and confirm the homely remedies they kept, such as simple cough linctus and indigestion relief, were safe for people to use. People's care plans explained their preferences for how their medicines were administered. One care plan told staff to, "Administer meds on a spoon" and another person's plan said, "Disperse meds into hand and ensure a jug of water is available." This was in accordance with recent guidance from the clinical commissioning group that medicines should be, 'person led'.

The registered manager showed us how they checked that medicines were managed and administered safely and the actions they took when errors were identified. They checked the amount of medicine in stock matched the amount received, less the amount administered. They checked that staff signed to say medicines had been administered as prescribed or had used the correct code to explain why it was not administered. When they identified errors, they had shared their findings at staff team meetings and increased the frequency of their checks until the issues were resolved. Records showed a recent external medicines audit by the pharmacist identified only a minor recording error.

Good

Is the service effective?

Our findings

People told us they received the care and support they needed. One person told us, "They know me. They are very patient. They help me to shower and pat me dry." A relative told us, "The staff seem to know what they are about."

Care staff told us their induction programme included reading the policies and procedures, attending training, meeting the people who lived at the home and shadowing experienced staff. A member of care staff told us, "New staff observe for the first few days, or weeks, depending on their experience. I give feedback about their performance" and "You have to get to know people well to be effective." Records showed that the shadowed staff updated a list of tasks and activities that new staff had to learn before they were signed off, such as, learning people's routines, using the specialist bath and support with meals. Staff told us they felt prepared and supported when they started working at the home.

The registered manager told us, "I am working through the Care Certificate to assess the difference between the common induction standards and the new Care Certificate. All our new staff are already qualified, but unqualified new staff will go onto the Care Certificate." The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

Care staff told us they had training that supported them to meet people's needs, such as food hygiene and diabetes management, and they discussed their training needs at regular one-to-one meetings with the senior. Care staff told us they felt well supported and were encouraged to reflect on their practice and to consider their own professional development, for example, to study for nationally recognised qualifications in health and social care. Care staff told us they could talk to the seniors, deputy and manager at any time. Care staff told us, "I have regular one-to-ones. It is very good here" and "Any problems I can tell the manager."

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.

No-one was being deprived of their liberty at the time of our inspection. The registered manager ensured that people or their representatives consented to care and support. In one care plan the person had signed their own needs assessment, but the care plan was marked, "'I would like my [named next of kin] to sign" and it was signed by the named next of kin. Records in a second care plan included a mental capacity assessment that demonstrated the person did not have the capacity to sign. The care plan was marked, "[Name] unable to understand care planning, next of kin to represent" and the care plan was signed by the representative. A member of staff told us, "People are supported by their families. Non-one needs an advocate at the moment." An advocate is an independent person who is appointed to support a person to make and communicate their decisions.

Care staff understood the requirements of the MCA. They understood that the capacity to make decisions depends on the decision being made and that capacity to understand information could fluctuate. We saw staff asked people how they wanted to be cared for and supported before they acted. One member of care staff told us, "I watched the MCA DVD. I always say, 'What would you like to wear? And fetch clothes and show them". Another member of care staff explained, "If people decline care, we keep trying, offering, but if they say no, we might have to think about best interest decisions."

People told us the food was good and they had a choice of meals. One person told us, "The food is very good. They come round and ask what you want. There are always two things on the menu. Or they will get you something else." A relative told us, "The food is excellent. I have eaten here. The food is superb and there is always a choice." The menu was written on a noticeboard in the dining room to remind people of the choice when they came into lunch. The cook told us the menu was agreed in consultation with people and in response to people's likes, dislikes and allergies. There was a folder in the dining room with information about known allergens in a list of commonly used foods and named branded products, which supported people and their relatives to understand how to manage their dietary requirements.

Care plans showed that people's preferences, allergies and specific dietary needs were identified at an initial assessment. The cook told us they followed this up by having a conversation with each person when they moved in to confirm the information was up to date. For people who were not able to state their preferences the cook confirmed with their representative. The cook told us their conversations with people were also useful to assess whether people might eat more if they had better assistance. They told us two people had been supported, and eaten more, with the use of plate guards and spoons, rather than standard cutlery. One person told us, "The meals are good and the staff are very thoughtful. They will bring my meals to my room if I want."

At lunchtime we saw the tables were laid with cloths, napkins, flowers, condiments and jugs of drinks. People were seated in small groups to encourage them to socialise. Staff sat and ate with some people where they could promote conversation, offer assistance and observe whether people ate well. Care staff weighed people regularly and monitored how much people ate and drank if they were at risk of poor nutrition. The food and fluid monitoring charts were kept in the kitchen where the cook could oversee what people were offered and whether they ate well. The charts were detailed enough for staff to calculate the nutritional content and volume of fluid the person consumed in total each day. Records showed people were referred to dietary specialists, such as the speech and language team, to ensure they were supported to maintain an appropriate nutritional intake.

People told us they were supported to maintain their health and they were happy with the arrangements in place. A member of care staff told us, "I check the daily records and if I see if they are not feeling well I can get the GP." People told us, "The GP comes here if I am sick. I see the optician and have my own dentist" and "The (district) nurse checks my skin." Care plans included records of visits and advice from other health

professionals, such as the GPs, dieticians and chiropodists. Staff shared information about people's health during the handover meeting at the beginning of each shift to ensure all staff knew signs to look out for if people's health declined. Care staff told us they felt well informed because they shared information about people's appetites, moods and behaviours at shift handover.

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. One person told us, "The staff are very good. I am comfortable. I am well looked after." Another person said, "They are a friendly lot. I can have a laugh and a joke with them."

The registered manager told us staff were told about the provider's standards of care and were expected to behave in the "Abbeyfield Way", to ensure all residents were treated with compassion, kindness and respect. The provider ensured staff understood how to demonstrate the behaviours through a series of training sessions that included dignity and respect, confidentiality, autonomy and choice. A member of staff told us this meant, "Asking quietly, not shouting across the room" and "You keep information to yourself, unless it is concerning information."

Staff spoke discretely when offering to support people with personal care and they checked that people wanted to speak with us before we were invited into their rooms to speak privately with them. Staff kept people's personal information and records in the office where only staff could access them.

People's care plans included a personal profile, which included their culture, religion and important family relationships. Care staff told us this helped them to understand the person and to get to know them as an individual. Care staff told us, "The care plans make sense and include people's preferences for clothes, food and cultural preferences, family and friends" and "We get to know people by watching how they respond to care and what they do."

We saw people were relaxed with each other and in staff's company. Staff recognised people's diverse needs and supported them accordingly. For example, staff knew which people liked to attend religious services and ensured they were supported to do so. Staff knew which people liked to go out, which people liked to spend time at home alone and which people liked to socialise with others in the home. People told us staff supported them to lead their lives in the way they preferred. A member of care staff explained their role as, "You are a carer and friend."

People and relatives told us they were involved in planning their care, which meant they received the care and support they wanted. A member of care staff told us they were able to adapt the method of communication for people if they could not communicate well verbally. They told us, "We have a board for [Name] and write things down and when [Name] lived here we used to use flash cards and they used to point."

The registered manager promoted people's independence and involvement by arranging regular meetings for them to discuss how the home was run. People told us they were given a service user guide, so they knew what services were available at the home, and were invited to house meetings every other month. Records showed people discussed staff changes, planned repairs and building work, the meals, activities and planned changes to the library service and new staff. People were reminded they could speak to the manager or the deputy at any time if they had any concerns.

Good

Is the service responsive?

Our findings

People told us staff responded to their needs appropriately. One person told us their needs were met because they had the equipment they needed, company when they felt sociable, their health had improved and nothing was, "Too much trouble" for staff.

Care planning was centred on the individual and their personal needs and abilities. A relative told us, "I was involved in the care plan and it is reviewed with us every month. I know about changes and sign it." Care staff told us they got to know and understand people well because they read the care plans, talked with people and their families and observed people's response to care. Care plans included a social care plan, which explained how people liked to spend their time. One plan we looked at was marked, "No hobbies or interests to pursue. Will attend communion, likes to chat with staff and others. Likes to sit in own room with TV."

We saw a list of activities and events that people were invited to attend. The registered manager told us the age and profile of people who chose to live in a care home had changed in recent years. They told us, "We need to re-invent activities as people are less active. People choose to stay in their rooms more, less people want to eat in the dining room. Only one person wanted to make and decorate a gingerbread house for Christmas." A relative told us, "There is a list of activities on the table, as per feedback from relatives. There is a lot of live entertainment – bingo, exercises, communion, reminiscing. They fill people's days as much as possible, but don't force anything."

One person told us, "I like to stay in my room, unless there is bingo on. It passes the time and is more sociable. They have musicians and singers too." Another person told us, "I enjoy the dancers and singers." People told us they were looking forward to the Christmas party because it was nice to have a reason to dress up and they had bought tickets for a prize raffle. A member of care staff told us, "The party is for the people, their friends and families and staff and their families." Everyone told us they were looking forward to celebrating as one big family.

A relative told us the ethos of family was clear all the year round, not just at traditional holidays. The relative told us their relation spoke well of staff because they were genuine in their desire to involve people in the local community. They told us, "Staff here spent their day off taking two people to the pub for lunch."

The provider's complaints policy was effective and easy for people to use. People told us they had no complaints, but if they did they would report them to the staff or manager. A relative told us when they had made a complaint on behalf of their relation the manager had taken prompt action to resolve it. They were satisfied with the response and the outcome because it minimised the risks of a further complaint about the same subject.

The registered manager handled written and verbal complaints with the same respect and attention. The complaints log detailed the nature of the complaint, details of the manager's investigation and the outcome, and the action taken to resolve the complaint. Records showed complaints were resolved within

28 days and most were resolved in less than five days. Complainants were clearly satisfied with the outcome and one person had written to say, "Thanks for taking the time to listen."

Good

Is the service well-led?

Our findings

People told us they were happy living at the home. One person told us, "I am happy here. I have a cooked breakfast, I get the newspaper and have my own TV. I have my books and crosswords." A relative told us, "I would recommend it. They listen. There are no difficult discussions."

The provider's quality assurance system included an annual survey of people who lived at the home. The survey was conducted by an external professional to ensure an unbiased response was obtained. The provider had recently updated the format of their survey to reflect the key lines of enquiry that the Commission examines during an inspection. People were asked questions related to whether they felt the service was safe, effective, caring, responsive and well led. The most recent survey sent in the summer of 2015 had been sent out to 26 people and 15 people had responded. The results had not yet been collated and shared, but from the individual responses we saw, people were satisfied. There were no particular issues that required improvement.

The registered manager understood the responsibilities of their registration and notified us of the important events as required by the Regulations. People and relatives told us the registered manager was approachable and they felt fully informed about events and issues at the home. One relative told us, "I am invited to meetings and come if I can. They keep me up to date." People and relatives were given information to make them feel familiar with the service and demonstrated the open culture of the service. In the hallway the information available included a copy of the Commission's previous inspection report, posters about whistleblowing, dignity champions, planned activities and invitations to attend events, such meetings and a party.

The registered manager led by example and encouraged staff to work as a team. They held one-to-one and team meetings with staff. Records showed they discussed policies and procedures, feedback from people, staff's practice and the results of their recent quality assurance checks. Staff were reminded how to deliver care safely and effectively. Staff were reminded, for example, of the importance of checking people's mattresses were inflated according to people's weight, and that food and fluid charts were completed appropriately for people who were at risk of poor nutrition.

Staff were encouraged to demonstrate the ethos of the service through their actions. At recent team meetings staff were encouraged to share the same mind set, because, "We are all here for the same reason 'to look after residents'." Staff were reminded to, "Listen and respond to feedback" and to "Make time for activities." Staff who were not able to attend meetings signed to say they had read the minutes.

The provider checked the registered manager's competence against an agreed set of criteria. The assessment included, for example, their leadership and governance skills, how they supported people, staff, and volunteers, and how well they maintained the environment. Records showed the registered manager had been certified as competent in 2015. Staff told us they were happy working at the home and they appreciated the registered manager's management style and purpose. Care staff told us, "They are a great bunch of carers and a good manager. It's a good home" and "It's a very good management team." One

member of care staff told us, "[Name] is the most approachable manager ever. I can tell her any problems."

The registered manager conducted regular quality assurance checks and audits and took action when issues were identified. For example, they checked people's care plans were regularly reviewed and up to date, that fridge, freezer and food temperatures were monitored, checked medicines were managed and administered safely and checked call bell response times. A member of care staff told us, "We work as a team. If there is a gap in a MAR, the next staff on duty should check with previous shift staff to check if it was actually missed or declined and phone the GP, if it is not a recording error."

Additional quality assurance checks were made regularly by the provider's business manager and occasionally by a volunteer, which ensured the checks were unbiased. The quality assurance checks followed the format of the Commission's essential standards and asked if the service was safe, effective, caring, responsive and well led. For the two issues identified between August and October 2015, the manager took action to improve before the subsequent, monthly quality assurance visit. The manager had ensured staff who conducted fire drills knew how to switch off the alarm after the drill and ensured that prescribed pressure relieving equipment was fully described in people's care plans.

The registered manager told us about some of their plans to improve the service, which included changes to the library service, to make it more personalised to investigate the possibility of extending the wifi capability from the dining room to the furthest bedrooms. They also planned to trial an electronic recording system for night staff which would use bar codes on the back of bedroom doors to record the care and support they delivered at night, which would be less time consuming than handwritten records, giving more time to deliver care.

The registered manager told us they were happy with their pharmacist's decision to change the format for supplying medicines, because it would ensure staff were better aware of the amount, type and purpose of each medicine that was prescribed. The provider planned to make changes to the layout of the building to provide three additional bedrooms and a larger laundry room. People told us they knew about the planned changes and how they would affect them as they were discussed at recent home meetings.