Care Quality Commission

Key inspection report

Care homes for older people

Name:	Amesbury Abbey Nursing Home
Address:	Amesbury Abbey Nursing Home Amesbury Salisbury Wilts SP4 7EX

The quality rating for this care home is:	two star good service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	Date:							
Susie Stratton	1	3	0	8	2	0	0	9

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.
This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

Document Purpose	Inspection report
Author	Care Quality Commission
Audience	General public
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Internet address	www.cqc.org.uk

Information about the care home

Name of care home:	Amesbury Abbey Nursing Home
Address:	Amesbury Abbey Nursing Home Amesbury Salisbury Wilts SP4 7EX
Telephone number:	01980622957
Fax number:	01980623767
Email address:	david@amesburyabbey.com
Provider web address:	

Name of registered provider(s):	Mrs Evelyn Mary Cornelius-Reid
Type of registration:	care home
Number of places registered:	50

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
old age, not falling within any other category	0	50
physical disability	2	0
terminally ill	3	0
Additional conditions:		
No more than 2 physically disabled residents at any one time		
No more than 3 persons in receipt of terminal care at any one time		
No more than 50 service users over 65 years of age at any one time.		

Date of last inspection	2	4	0	2	2	0	0	9

Brief description of the care home
Amesbury Abbey provides care with nursing for up to fifty older people. However, as a number of rooms registered as doubles are often occupied as singles, this reduces occupancy levels to a more usual figure of around forty. Most of the rooms are in the form of apartments with their own bedroom and sitting room as well as a bathroom. The property is a listed building, set in extensive grounds. Accommodation is provided over three floors, with passenger lifts in between. The small town of Amesbury is close by. Ample parking space is available on site and a bus stop is situated at the end of

Brief description of the care home

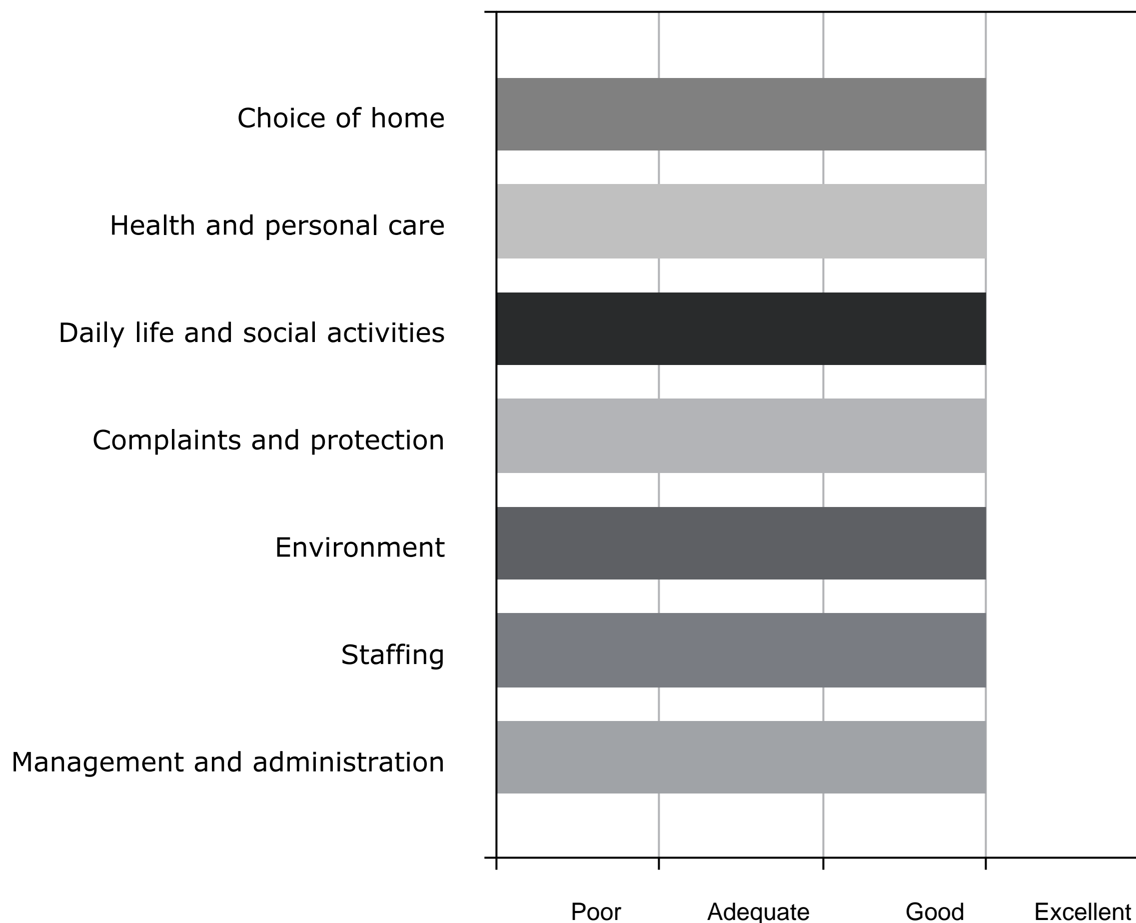
one of the drives. The home is close to the A303. The closest main line railway is in the city of Salisbury, about 20 minutes away. Amesbury Abbey is part of a group of four care homes. The Registered Owner is Mrs M Cornelius-Reid. The registered manager is Mrs Esther Thomas, she is supported by a deputy and a team of nursing and care staff. Mr David Cornelius-Reid, site manager, manages the maintenance, housekeeping and administrative staff of the home, as well as acting as Mrs Cornelius-Reid's deputy. Also situated within the grounds are Amesbury Abbey Mews they are not part of the registered accommodation. A deposit is required for all apartments, deposits range from 15,000 pounds to 25,000 pounds depending on the apartment. The fee range is then from 3,070pounds to 4,200pounds per callender month. The site manager reported that they are also open to negotiations on an individual basis. Items not included in the fees are pressure releiving equipment, hairdressing, chiropody, visitor's meals, newspapers and sundries. A copy of the service user's guide is provided in each resident's apartment and is also available in the main entrance hall.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	two star good service

Our judgement for each outcome:



How we did our inspection:

As part of the inspection, 30 questionnaires were sent out and 13 were returned. Comments made by people in the questionnaires and to us during the inspection process have been included when drawing up the report. As part of this inspection, the home's file was reviewed and information provided since the previous inspection considered. Following the last inspection, the home submitted an improvement plan to us and has kept in regular contact with us, to inform us of their improvement strategy. We also received an Annual Quality Assurance Assessment (AQAA) from the home. This was their own assessment of how they are performing. It also gave us information about what has happened since the last inspection. We looked at the AQAA, the surveys and reviewed all the other information that we have received about the home since the last inspection. This helped us to decide what we should focus on during the visit to the home.

As the home presented a wide range of issues of concern at the previous inspection,

this inspection was performed by three inspectors, one of whom was our pharmacist inspector. These people are referred to as "we" throughout the report, as the report is made on behalf of the Care Quality Commission (CQC). We were also accompanied by an officer from the Health and Safety Executive. The site visit was on Thursday 13th August 2009 between 9:45am and 6:10pm. The visit was unannounced. Mrs Thomas, the registered manager was present for the site visit and she and her deputy and the site manager were available for feedback at the end of the site visit.

During the site visit, we met with eleven residents and observed care for four residents for whom communication was difficult. We toured all of the home and observed care provided at different times of day. We reviewed care provision and documentation in detail for six residents across all parts of the home.

As well as meeting with residents, we met with a registered nurse, three carers, a domestic, a laundress, two waitresses and the hotel service manager. We observed a lunchtime meal. We reviewed systems for storage of medicines and observed a medicines administration rounds. A range of records were reviewed, including staff employment records, complaints records, minutes of staff meetings, quality assurance reviews, the Statement of Purpose and Service Users' Guide.

What the care home does well:

Amesbury Abbey is a large building, which is surrounded by well-kept parklands. One resident described these as "marvellous, beautiful grounds" another that the parklands were "a great resource". Accommodation is in the form of apartments, all rooms are large and much exceed our standards. One person reported "my room is spacious and well equipped". Nearly all have extensive views over the surrounding parklands. Residents are enabled to furnish their own rooms as much as they want to, so all rooms had highly individual appearances, reflecting the person's likes and preferences. Management has a planned approach to making improvements to the home, this includes most recently plans for the kitchen and conservatory areas.

People commented on the home. One person reported that the home did "most things" well, another "they're very good here" and another that the home "encourage and stimulate residents to be as active as possible". People commented on the staff. One person reported "very caring staff", another "the staff are willing, helpful and cheerful" another that the staff "show love and care" and another that staff "have performed above and beyond any reasonable expectation". Staff also made comments about the home. One person reported "the induction packs and training for staff are really good", another "if staff which to attend any particular study sessions our training manager usually manages to book them" and that the home was good at supporting residents in "adapting to meet new challenges".

What has improved since the last inspection?

At the last inspection, 25 requirements were identified. All had been addressed by this inspection, six months later. Additionally 30 good practice recommendations were advised and most had been addressed by this inspection. This indicates that management is prepared to take necessary steps to improve outcomes for residents.

The home has ensured that prospective residents and their supporters now have information about the services provided, so that they can make a decision about if the home can meet their needs.

Major improvements have been made in meeting residents' health and personal care needs. Where a resident has a need or risk, an assessment is always drawn up and a care plan developed to ensure that the person's need is met and risk reduced. Assessments and care plans are regularly reviewed and up-dated if a person's condition changes. Full monitoring systems have been put in place so that staff and management can ensure that people's basic needs are being met.

Improvement have been made in medicines management, with an audit process, to ensure that all systems in relation to administration and documentation of medicines comply with guidelines. All limited life medicines are correctly managed. Developments have been made in ensuring documentation in relation to medicines prescribed on an "as required" basis.

A review of the catering service has taken place and all residents are now offered a choice of meals at lunchtime.

The home has fully revised its systems for management of complaints. Complaints are

fully documented, together with records of investigations, actions taken and feed-back to complainants.

Systems have been put in place to ensure that risks which may be presented by the home environment are reduced, this includes correct use of equipment and improved practice in prevention of spread of infection, including separation of laundry at source. Where residents chose to use certain equipment which could present a risk, an assessment is drawn up. Staff have been provided with a suitable room to change and and relax in.

A full review of staffing levels has taken place, to ensure that there are sufficient staff, with an appropriate skill mix to meet the needs of residents. The home has fully reviewed its system for recruitment of staff and staff files showed that the home are now complying with our guidelines in full. Staff meetings have been developed to improve communication and to hear staff comments on service provision.

Major improvements have been made in ensuring the health and safety of people. This includes checks on equipment such as wheelchairs, hot water systems and safety in hot surface temperatures.

We are very pleased to note the improvements in service provision and that the home can now be assessed as providing good outcomes to people. We are intending to perform a random inspection, within the next year to ensure that current improvements in service provision has been sustained.

What they could do better:

The home should further improve clarity of information for people of the services provided by the home. Pre-admission assessments need some development to provide a full base-line for staff. A checklist should be developed to ensure that each newly admitted resident's room is fully prepared to meet their needs.

The home needs to develop audit systems for assessments and care plans to ensure that all are completed to the same standard. Information about residents and their needs should all be documented in their notes, rather than using additional systems. Audit of compliance with standards relating to administration of medicines should continue.

The home must fully revise its safeguarding policy to ensure that it complies with national and local guidance, so that staff can be fully informed of actions to take to prevent abuse to vulnerable persons. Some documentation relating to restraint, deprivation of liberties and challenging behaviours needs up-dating. The home should include "low level" complaints in its quality audit of service provision.

The home should develop audit systems for cleaning, to ensure that all areas of the home are cleaned to a satisfactory standard. They should also continue to consider modernisation of facilities, including provision of assisted bathrooms for people with complex disability needs, more sluice rooms and a private office for the manager.

In order to ensure the health and safety of people, waitresses need to be trained in first aid, so that residents in the dining room can be fully protected in the event of an emergency. All staff who may use or fit bed rails need to be fully trained in their safe

use. Some developments are advised in quality audit, including assessment of response times when call bells are used and a confidential staff survey.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.
You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line 0870 240 7535.

Details of our findings

Contents

Choice of home (standards 1 - 6)

Health and personal care (standards 7 - 11)

Daily life and social activities (standards 12 - 15)

Complaints and protection (standards 16 - 18)

Environment (standards 19 - 26)

Staffing (standards 27 - 30)

Management and administration (standards 31 - 38)

Outstanding statutory requirements

Requirements and recommendations from this inspection

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.
People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People will now have the information that they need to help them to decide if the home will suit them and have an assessment of their needs performed prior to admission.

Evidence:

The home reported in their AQAA that since the last inspection, they have devised new documentation to support the admission assessment process. Additionally, they have fully revised their Statement of Purpose and Service Users' guide. The Statement of Purpose now fully complies with our guidelines. It included a summary of the home's latest resident survey. We noted as good practice that this was impartial, including both positive and negative comments. The section on emergency admissions would benefit from additional information to explain that a full assessment of a person's needs would be undertaken before offering a permanent place.

The Statement of Purpose needs to show our correct address. It also needs a better

Evidence:

explanation of the medication policy particularly the section on self-administration, which was not clear. The content of the Service User's Guide matched the Statement of Purpose. We advise that it would be helpful to add information about annual quality surveying, and how people could access the results of surveys. It would also be more accessible if the most practical everyday information was at the front of the guide, not the end.

The Statement of Purpose specifically states that if a person needs a pressure-relieving mattress it will be the individual's responsibility to provide it. Mrs Thomas reported that the home will support people in procuring such equipment when needed unless were a need on admission, when the cost would be factored into the fee. The contract stated that the home would "provide free any medical attention, drugs and treatments available under the NHS, but any others not in the accommodation charge, for which a charge is made by the supplier, shall be payable by the patient". This sentence is complex to understand and should be re-written to make it clearer to prospective residents and their supporters. All of the eight people who responded to this section of the questionnaire reported that they had been given information about the home's terms and conditions.

The home has not had many admissions since the last inspection. One person reported that their family "came over" and were shown round the home on their behalf. Another person reported that they "always knew about it because I had visited a friend here" and that they were pleased to be able to find that they were able to be admitted when they needed long-term care.

We met with one person who had been admitted on the day of the inspection. We reviewed their pre-admission assessment, as well as talking to them. As reported in their AQAA, the home have introduced new pre-admission assessment records. The admission assessment gave a clear and detailed indication of the prospective residents' needs, including nursing and care needs, however the assessment was not completed under all the areas. Mrs Thomas reported that this was because the person did not have needs under these sections. We advised that it would be preferable to state that on the form, so as to provide a full baseline of the person's needs, if they did change after admission, rather than leaving the section of the form blank. The form has a "yes/no" box for the person performing the assessment to complete to state if they can meet the person's needs. this was not completed. The form had not been signed and in accordance with Nursing and Midwifery Council Guidelines, this needs always to take place. Mrs Thomas reported that they had had very few people admitted to the home since the last inspection and so were not yet fully used to completing the documentation.

Evidence:

We met with staff and asked them about how they found about peoples' needs on admission. All of the staff reported to us they they were fully informed verbally at report and also could access the care plans, finding them helpful in informing them of a new resident's needs. The hostesses in the dining room also reported that staff made sure that they knew about newly admitted people and any specific needs that they might have.

When we met with the new resident, they reported that they were comfortable in their room and we observed staff spending time with them to help them to settle in. However attention was needed in a few areas, for example the person's room was not on the ground floor but their window opened wide, they did not have a bath-water thermometer in their en-suite and they were assessed as being at risk of pressure ulceration but relevant pressure-relieving equipment had not been provided prior to admission. We discussed that many homes have a brief check-list, which staff complete prior to admission to ensure that the room is safe and that all relevant equipment is available to meet the new-admission's individual needs as admission.

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.
If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents' medical, nursing and care needs will be met by the home's assessment and care planning systems.

Evidence:

In the AQAA, the home reported on their "enhanced" and "improved" care plans. They also reported on their developments in ensuring safe systems for the administration of medicines. As the last inspection, we set a range of requirements relating to these areas, including effective systems for assessment of need, development of care plans and documentary monitoring systems to ensure that residents' needs were being met. This inspection showed that the home have fully revised practice in this area and made substantial improvements. People commented to us on this in questionnaires. All people reported that they always or usually received the care and support that they needed. One person reported that the care system "is well run and efficient" and another person reported that the management of their relative's medical condition was "better than its been managed for 30 plus years". We also asked people about how the home met their needs, during the site visit and received favourable answers. One person reported "they're good and do what I ask".

Evidence:

We met with a range of residents who had varying needs. We noted that all frail residents who were cared for all or most of their time in bed looked comfortable and had clean fingernails, eyes, night clothes and bed linen. We met with one resident who had become frailer recently, they reported on how supportive the staff were and that they did appreciate being able to continue to have their own personal items around them. One person reported "I go to the big bath - I was bathed by one of the senior carers yesterday. If they don't clean you there, they are there and very thorough every day."

All personal care was provided behind closed doors. When we were with a resident, we observed that a carer knocked on the residents' door and asked if they could come in. They then asked the person how they were and if they needed anything before they left the room. We also noted in the minutes of a staff meeting that staff had been reminded to only speak English in front of residents.

We reviewed documentation relating to provision of nursing and care and noted a marked improvement from the last inspection. All residents now had full individual assessments of their needs, these were regularly reviewed and up-dated if their condition changed. Among other areas, all residents were assessed for manual handling risk, risk of pressure ulceration and dietary risk. Were a person had additional risks relating to their condition further assessments were drawn up. For example one person was assessed as being at risk of choking as they had a swallowing difficulty. They had a detailed and clear assessment of the risk for them. This assessment was regularly reviewed.

If a person was assessed as having a need or a risk, a care plan was put in place to direct staff on how the person's need was to be met and risk reduced. For example one person's records showed that they had complex care needs relating to management of their bowels. They had a very clear care plans, which detailed interventions to take to make the person comfortable. The care plan was written in clear, measurable language. Another person we met with had limited vision. They informed us that they liked to remain as independent as possible in their personal care and in order to be able to do this, they needed their toiletries to not be moved from where they had been put in their en-suite. We observed that this was fully detailed in their care plan. Some of the residents had additional care needs relating to dementia. We observed that such residents had clear plans relating to how their dementia care needs were to be met. These were written in non-judgemental language and were very individualised.

Evidence:

The improvements in care assessment and planning were not just a paper exercise. We discussed meeting peoples' needs with a range of staff. One carer we spoke with knew about the resident with limited vision in detail, were able to report on how they supported the person in being independent with their personal care and how the person needed their bathroom to be set out as they wanted to, to facilitate this. We discussed a resident who had additional needs relating to dementia and the member of staff showed a detailed understanding of the residents' condition and how they were to be cared for in the light of this. They emphasised the importance of working with the resident to support them.

We asked carers how they knew about residents changing needs, for example if they had been off duty for a few days. They reported that communications were good. One carer reported that they were informed about how residents were "as soon as I come in" and that after that, for more detail, they read the care plans. Another person reported that they were "informed by word of mouth or just read the care plans" and another "the care plans are very good here". A registered nurse reported that they always told carers about needs at report and they found that the care plans helped them to find out more details about a resident, especially if their needs had changed. Mrs Thomas reported that they had drawn up the new assessments and care plans with the carers, as they knew the resident's individual needs in detail.

As with any major changes in practice, there are a few areas which still need development. Mainly these related to consistency in approach. For example, most people who were assessed as being at high risk of pressure ulceration had full care plans relating to how the risk to them was to be reduced. However for one person who had a clear care plan about how risk was to be reduced whilst they were in bed, they did not have a care plan to direct staff on how risk was to be reduced when they were sitting in a chair, although the person was sitting out when we visited. Most residents had clear care plans relating to application of topical creams, however one resident had a visible sore area, which they reported their doctor had seen and prescribed a preparation for but they did not have a care plan relating to this. One resident had changed needs relating to risks associated with bathing themselves but their documentation had not been revised when their condition changed.

The home still use a day book, in which they document such matters as how much fluid a person has been able to take in during the 24 hour period. This means that some observations may be written in the day book but not the residents' own notes and relevant matters such as how much fluid a person is able to take in is not documented in their own record. This means that relevant information may not be included in evaluations of care plans.

Evidence:

Now that the manager has drawn up full assessments and care plans, we recommend that responsibilities for drawing up of care plans be delegated to staff who know residents individually, such as named nurses or key workers. This would mean that the manager would then be in a position to audit care plans regularly and identify areas for development or where individual staff needed additional support.

People reported that the home called in their doctors when needed. Staff reported on the good working links with local health care services, particularly the hospice. Where a resident had a wound there were clear records of assessment of the wound and regular evaluations of the response by the wound to treatments.

Our Pharmacist Inspector looked at all the areas of medication handling in the home. Medicines were stored securely and appropriately, however at the time of the inspection some confidential records were not kept safely, these were secured during the inspection and staff were made aware of the need to continue this practice. All the medication administration records that we saw had been completed correctly and doses had been signed for or coded as appropriate. An extensive list of homely medicines had been agreed with the GPs, but individual prescriptions had been obtained for any medicines that they thought people may need on an "as required" basis. Senior nurses had set up an audit process so that they could check the medicines that were in use and a procedure to guide staff on various aspects of medication handling had been compiled. No medicines that were out of date or not in use were seen.

We looked at care plans for medication. One person had a very clear care plan to guide staff in the use of their medicines that were prescribed "as required", particular attention had been paid to the correct selection of medication where two or more medicines were prescribed for the same indication. However, as noted in care planning above, this was not always the case. Another person who was prescribed a similar range of medicines did not have a suitable care plan in place. Controlled drugs storage and records were suitable and accurate and any medicines no longer in use had been disposed of appropriately. At the time of the inspection the lancets that were in use for taking blood samples were not those advised by recent Medicines and Health care products Regulatory Agency guidance, since the inspection the home has shown us that these have now been changed. The arrangements for recording the variable doses of anticoagulant were altered during the inspection to come into line with current good practice guidelines.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents will be able to live the daily life they prefer, with mealtimes being seen as a key area in a person's life in the home.

Evidence:

In their AQAA, the home reported that "The quality assurance questionnaire issued internally by the home enables the users to exercise control over their own lives. The home operates in such a way as to allow users flexibility in their daily routines. There are no restrictions on visiting hours within the home, residents are actively encouraged to maintain links with the outside community. Meals are taken in a congenial setting with waitress service, choice of menu available".

At the last inspection, which was only six months ago, outcome areas relating to activities were assessed as being good. There was no indication in the home's AQAA or in questionnaires from people that this had changed since the last inspection. One person commented in their questionnaire on how one of the home's strengths was to "encourage and stimulate residents to be as active as possible".

People reported that visitors are able to come when they wished. One resident reported to us that they appreciated that they could "even have people to stay". One

Evidence:

relative reported that they appreciated how the home "allow [my relative] to keep their own timetable even if this means watching snooker (when on) to the wee small hours and staying in bed till noon". Another person reported that it was "absolutely up to us here how you do your day".

It was reported that as part of the reviewed care planning process that an "interest sheet" for each resident had been developed, to show things a person previously liked doing and would like now to do. As a result of this exercise, it was reported that a person's liking for chess had been found and they were now said to be playing regularly with another resident, where they had previously shunned the offer of activities within the home. In discussion with one carer, they reported that a particular male resident preferred to be given a bath by mature female carers rather than a male or younger female carer. This was not documented in their records. A person had very detailed records relating to their family supports and how they preferred to spend their days. For this person, their records it did not document details of what their carer informed us about their preferred television programmes. It was discussed with the manager that once responsibilities for drawing up care plans was delegated to more junior staff, that it would be easier to ensure that such key "known" matters would be documented in residents' records.

We met with the hotel services manager, who also manages the catering service and they reported that the priority since the previous inspection had been to introduce a choice of main meal at lunch every day. They showed us a four week rolling menu. They reported that the fish alternatives to Sunday roasts had been more popular than anticipated. On the day of the inspection, the alternatives were both chicken dishes, one being curry. The manager reported that feedback about the menu from residents was positive and in this instance, people had not wanted to forego chicken just because they did not want curry. People were asked at supper time what was their choice for the next day's lunch. The catering manager reported that there had not been management agreement about offering choice at the point of service, out of concerns about possible wastage. However, the current system had advantages, for example, people could make a choice to ask for a third alternative the day beforehand. We were also told that people were invited to confirm their choice of lunch option during the morning, so they felt more involved in knowing what they were to have.

As would be anticipated in a larger home, there was a variable response from residents about the meals. These varied from "the lunch meal is always the same with no efforts made to improve it", or the food "is very good except for the lunch meal" to "food very good", "the food is infinitely better than my last home" and that one of the

Evidence:

areas that the home does well is "the meals". People commented on choice. One person reported "there's always a choice of two", another "I believe there is a choice, I always eat what's on the menu because its very good". People commented on the presentation of the meals. One person reported that the "presentation varies" however another person reported that the meals were "beautifully presented".

People could eat in the dining room, where there was a waitress service or in their own room, as they preferred. One person reported that they appreciated this, saying "where I eat, they're very flexible, they bring it up or they take me down." We met with two hostesses, who reported on how important the appearance of the meal was to residents. We observed that they individually plated meals from a hot trolley, using a large or small plate, depending on a resident's appetite. The hostesses reported on the good communication with the nurses and carers, who told them of relevant changes in residents' conditions and if they were to expect them in the dining room or not. We also observed that where resident needed supports with eating, that carers sat with the resident, supporting them and assisting them to eat, using teaspoons where residents were not able to open their mouth wide.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People’s legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents and their supporters will have their complaints listened to and be safeguarded from abuse. This will be further improved when supporting policies and procedures have been up-dated and improved.

Evidence:

In their AQAA, the home reported "as a result of our last key inspection we have reviewed and updated our complaints procedure, we now have one file containing all complaints and concerns, included in this file is documented evidence of a response and outcome".

People reported to us in questionnaires that they knew how to raise concerns and complaints, both formally and informally. We also discussed this with residents during the inspection. One person reported "I could talk to Esther [Mrs Thomas] - she used to be awfully good", another "if I'm not happy I talk to [the receptionist] or Esther", another "there is always someone I can talk to if I need to, they're very good on the whole", another "I speak out and usually it gets sorted [the deputy manager] is the great authority over the nurses, she's very good" and another "I tell the head of night staff - she's a very sensible person".

The complaints policy states it is the responsibility of all staff "to support and respond appropriately to individuals and key people making comments or complaints. These should be passed via the senior nurse on duty to the matron, no matter how trivial".

Evidence:

The complaints, whistle-blowing and quality audit policies were all kept together. An annual review of complaints and compliments should be tied in with the annual stakeholder survey. We also suggested adding a question to the resident survey - if you have made any complaint, were you satisfied with the response?

The complaints policy directs usage of a complaints form. This had been recently devised. Two complaints were on record between March and June 2009 which had been recorded by way of notes in a complaints book. In each case actions had been taken to prevent recurrence, in one instance the home had agreed a repair to a broken item at the home's expense. Investigations were timely. Investigations into a third complaint, of which we were aware beforehand, had been recorded effectively by means of the complaint form, and it had not been upheld. All telephone calls, emails and correspondence were logged in order, which demonstrated the matters alleged were taken seriously and responded to in an appropriate way.

Some matters of complaint had been dealt with effectively through care planning, but did not figure in complaints records. These "low level" complaints need to be logged so they are considered as part of annual review. Such recording can also be a valuable resource in showing the history of any later complaint received.

The Vulnerable Adults policy was insufficient and did not fit with local inter-agency safeguarding procedures. The policy must make clear that any allegation must be referred to safeguarding procedures for agreement on how it will be investigated and should explain that a member of staff alleged to have been abusive may be suspended for the protection of all parties, including themselves.

An out of date guidance document about restraint needed to be removed and could usefully be replaced by a policy on implementation of Deprivation of Liberties (DOLS) guidance. A guidance document on "dealing with aggressive behaviour" needed updating, by making reference to the safeguarding policy and should include guidance to staff on how and where to report incidents. A folder entitled "challenges" had no guidance about what purpose it was intended for or who would review it, yet it contained sensitive and potentially subjective information about residents.

Evidence was seen that all staff were issued with "No Secrets" and care staff received a copy of the General Social Care Council (GSCC) code of practice for social care workers. Mental Capacity Act training was said to have been delivered to all staff. We discussed different scenarios with staff, which could indicate that a person may be at risk of abuse. All staff we spoke with were area of their responsibilities for reporting such matters.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents will be cared for in an environment which largely meets their needs.

Evidence:

In their AQAA, the home reported "we provide our clients with a pleasant environment which is clean, odour free and generally well maintained". They also reported on developments and how "working closely with our new business consultant, many new policies and procedures have been drawn up relating to the homes environment. A complete audit of the work required to reinvigorate the home has now been drawn up. Levels of priority have been indicated and from this, we have already started a planned programme".

During the inspection, we observed that maintenance plans had been introduced for each area of the home as part of the overall management review. Scaffolding was erected in the main entrance area. This was because the gallery windows were being replaced. A date had been set to have the kitchen floor fully replaced. Improvements were planned for the conservatory area, so that it could be put back into use. The home have provided staff with an attractive sitting and changing area. The previous staff room is now being used as a wheelchair and buggy store. Staff meeting minutes showed staff had raised issues about security downstairs and this had led to new locking procedures and fitting of more window restrictors.

Evidence:

Amesbury Abbey provides accommodation over three floors of a large building. All of the rooms exceed our standards for room sizes and many are in the form or apartments, with residents having a sitting room, as well as a bedroom and en-suite. The home has two disabled shower rooms and a Parker bath. To use these facilities, residents have to be able to bend at the middle, which with some medical conditions, is not possible. It is recommended that the home provide at least one assisted bathing facility for people with complex disability needs. The Parker bathroom does not have a lock or an occupied/unoccupied sign on the door. During the morning a resident was using the toilet in the bathroom and we nearly walked in and disturbed them as we did not know they were in there, so appropriate equipment to ensure privacy, whilst ensuring the resident's safety is needed.

The home has a drawing room, which is very attractive in appearance but as it is large, is not intimate. There is also a dining room and some residents like to sit in the entrance hall, which is seated. The drawing room is also used for other purposes, for example we were in there for most of the inspection. As such it will therefore not always be available to residents. Mrs Thomas has an office, but it also functions as the nurses station, so she does not have a private area where she can meet with relatives or support staff. Due to the atmosphere in the drawing room, it would also be difficult to provide such supports in there. We advise that the manager be provided with a private office and/or a private meeting room be provided, so that people can be effectively supported.

People commented to us on the environment. One person reported in their questionnaire about how good the home were at "keeping rooms neat and tidy" and another person on the "comfortable" environment. One person who reported that staff took them out into the gardens in a wheelchair and described the Abbey as "a beautiful place", another person reported "I'm thankful for my balcony".

We observed that the home had a range of hoists to support residents who had manual handling needs. We met with a carer who was in charge of organising the hoist slings and slide sheets for residents. They had a clear system for ensuring that such equipment was discretely named and used only for that resident and were regularly laundered. The home has a supply of variable height beds for people with complex needs. However they do not have any profiling beds and it is advised that the home invest in such beds so that the use of bed rails can be further reduced. As stated in Choice above, people are expected to supply their own pressure relieving mattresses, although the home does have a float of four such mattresses if this is difficult for the resident and their supporters. It is recommended that the home review this situation.

Evidence:

All of the people commented in their questionnaires that the home was always or usually fresh and clean. We observed that as good practice that as much as possible cleaners cleaned residents rooms when they were not in them, for example in the dining room for lunch. We noted that most areas were clean and well maintained, however there were a few occasions where this was not the case, generally where roles overlapped or where communication had not taken place. For example, one resident's dripping tap to their hand wash basin had been repaired but a large lime-scale deposit had not not been removed, the inner door and parts of the walls of the sluice room were grubby, one resident had a fan in their room which was very dusty and some of the lifts had visible dust and debris in the dirt-trap in the door.

We met with the hotel services manager, who reported that housekeepers work to daily and weekly cleaning schedules. We reviewed some of these, which were quite considerable. The home was looking at the possibility of creating a senior housekeeper role, who could have delegated responsibility for staff supervision and monitoring of standards. This would be a positive step, if staff numbers on the floor were not compromised, as the current systems were not systematic. The home would benefit from a regular audit of areas that present high risks to infection control, and where domestic, care and maintenance staff responsibilities overlap, by a person trained to identify emergent problems and with the experience to correct them.

We met with the laundress and reviewed the laundry. We observed that the laundry was clean and well organised. The laundress understood their responsibilities in the prevention of spread of infection. They reported that all laundry was consistently separated at source and that staff always used red bags for infected or potentially infected laundry.

We observed that staff used protective clothing, including disposable gloves and aprons. Glove dispensers are available in some areas of the home, however it is recommended that glove dispensers be provided in all areas of the home where personal care is carried out, including en-suites, to ensure ease of access and thereby reduce risks to cross infection. The home only has one sluice room. This is on the ground floor. As many of the residents many need to use commodes, in order to ensure that sanitary items can be effectively cleansed, the home should consider installing a sluice room with a washer disinfect on every floor of the home.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Peoples needs will be met by staff who have been safely recruited and who are trained in their roles.

Evidence:

In their AQAA, the home reported that they "provide a good skill mix of staff on duty". Since the last inspection, Mrs Thomas has performed a full review of staffing levels. Of the eight people who responded to this section of the questionnaire, five people reported there were always, two usually and one sometimes staff available when they needed them. Of the five staff who responded to this section of the questionnaire, one person reported there were always and four usually enough staff to meet the individual needs of residents. This represents an improved response from the previous inspection. One person commented in their questionnaire that the home needed to "provide more staff", however another person commented about staffing "this had recently been slightly better".

During the inspection, we asked people about staffing, particularly about response times to call bells. One person reported "on the whole they're very good and they come fairly swiftly", another "on the whole they come, they're not rushing all the time", however another person did report "they're always busy I think, they're short staffed, ringing bells doesn't help".

Evidence:

We talked to staff about staffing levels. One carer reported that if they needed help they could get assistance from other floors. For example, they reported one of the people they were on duty with was busy admitting the new resident, so when they needed help, they were able to ask someone to come from one of the other floors to help them. As carers do not remain in the dining room at meal times, we asked the waitresses how they got help if they needed it. They replied that they rang the bell and that staff came quickly to assist if needed and if they rang the emergency bell staff always came very promptly.

It was reported that staffing had been at a lower level because of lower resident numbers. There has been no recent need to recruit apart from current need for a registered nurse on alternate Saturday nights, but new recruitment is now anticipated as there is a drive to increase resident numbers.

Mrs Thomas demonstrated the new staff recruitment record system introduced since the previous inspection. Each record now commences with a standard summary form, which gives an immediate overview of any item missing from the record. They have been acquiring references for existing staff for whom there were none. In a very few instances, there is a reference from the home itself, where the member of staff has been known for many years. All staff now have current criminal records bureau (CRB) clearance obtained by the home, including garden and maintenance staff, who previously did not. It is intended that each staff file will be put in an order to match the summary form. Three files checked at random all contained the information that had been recorded on the form. There were photos of all staff. There was a separate check sheet in respect of the few references and one CRB still awaited, these all concerned non-care staff who have worked a long time at the home.

The summary form will act as a ready reference for the progress of any new applicant. This will ensure no person is employed until two references and protection of vulnerable adults clearance has been received and CRB application made. The application form has a place for people specifically to explain breaks in their employment record, and this is checked at interview. The structure of interview questions was seen to verify this. Mrs Thomas and the deputy manager jointly interview all nursing and care applicants, the hotel services manager interviews kitchen and housekeeping staff on their own. For care staff, the recruitment policy commits to supervised working only, until receipt of CRB disclosure. The first three days of employment are a three day induction, which includes practical information and an introduction to theory. This leads into a full recorded induction over three months, with a designated mentor. Kitchen and housekeeping staff also have a supervised induction period.

Evidence:

All domestic staff have or are working towards NVQ level 2 in hospitality or customer care and one is to go on to level 3. The hotel services manager showed good records of training completed and planned and of supervision and appraisal of domestic staff. There was evidence of close liaison with the training organiser.

Training and supervision records were kept deliberately separate from HR records to protect information on a need to know basis. At the previous inspection, training records were clear and provided full evidence of compliance with guidelines, therefore they were not assessed at this inspection.

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.
People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Residents will be supported by the improved management systems in the home to ensure their health, welfare and safety, a few areas only remain to be addressed.

Evidence:

In their AQAA, the home reported on the "stable management team who have been at the home for many years" and the "improved admin since last inspection". Following the last inspection, the company took on a business manager, whose priority area was efficiency savings. This person accessed the home as needed, including at least one unannounced night visit. Following developments in the service, this person has gradually reduced input from full time to a few days per week and will complete their role soon. This person worked with the home management on streamlining and targeting processes. The catering manager was supported in rationalising business management of the kitchen to bring about savings, with no impact on quality of service for residents. Mrs Thomas has been supported in fully revising the home's approach to assessment of resident needs and care planning.

Evidence:

Staff meetings have been two-monthly since February 2009 and there was a date set for an August meeting. Minutes showed good attendance across all roles. The February meeting was seen as a key one to engage the staff group in change. Minutes for that meeting were circulated with pay slips, since then minutes have been posted at agreed strategic places around the home. As well as working with staff to effect change, staff meetings have also been used to listen to staff. For example, staff meeting minutes confirmed the issue of cover for the Mews flats was raised in February 2009 and was reported on at each meeting, as well as being subject of a special meeting in March. Action has been taken by the home and the Mews will have their own on-call member of staff purely to take a "good neighbour" role, who will call on external agencies as necessary without reference to the home. All support to the Mews from the Abbey will therefore cease.

Resident surveys were carried out in April and July 2009. The latter was used as a quick check that people recognised improvements, but only six residents responded in July, it was said people verbalised that they did not want such frequent questionnaires. Both surveys showed evidence of analysis and action planning as a result. Surveys will now be annual. It would be useful to also have a staff confidential survey at the same time. There had been a decision to implement a staff suggestion box, with rewards for best ideas.

Mrs Thomas also regularly performs a clinical audit of outcomes for residents, this includes such matters as incidence of pressure ulceration, infections, falls, accidents and incidents. Compliance with procedures in relation to administration of medicines are regularly audited. Now that an effective care planning system is in place, we discussed systems for audit of care plans and assessments. We did observe that some staff use liquid paper some times in records and that this is ill-advised in what can be a legal document. Given that some residents felt that there was a slow response to when call bells were used, it would be advisable for response times to call bells be included in quality audits and a "mystery shopper" approach was discussed as an effective method.

At the previous inspection, six months ago, there were safe systems for the management of residents' moneys which complied with our guidelines. So this area was not reviewed at this inspection.

During the inspection, we were accompanied by an officer from the Health and Safety Executive. They looked at all aspects relating to health and safety, including maintenance systems. They expressed themselves as satisfied with the improvements which had been made in the home at the time they visited.

Evidence:

We did observe that two residents were cared for in bed with non-integral bed rails. Neither of these rails were safe in that there were significant gaps between the head of the bed rail and the rail. Additionally, the rails were loose in their fixings. Safety rails can present a risk of injury to people and therefore their use should be avoided as much as possible. Discussions with staff, including the maintenance man indicated that they had not been trained in the safe use of bed rails and this is needed so that they are aware of their responsibilities. The officer from the Health and Safety Executive was able to advise on some training materials in this area.

On discussion with waitresses, as noted in Staffing above, they are not supported by care staff at mealtimes. A review of accident records and discussion with the waitresses indicated that at times residents have had an accident or experienced a sudden change in their medical condition, when in the dining room. As on such occasions, the waitresses will need to take action before assistance from qualified persons is available. All waitresses therefore need to be trained in first aid, to ensure the safety or residents in an emergency.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements: These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.				
No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.				
No.	Standard	Regulation	Requirement	Timescale for action
1	18	13	The home's safeguarding policy must be fully revised and up-dated, to ensure that it conforms to national and local guidelines on safeguarding adults. People need to be protected by a policy which makes it clear that any allegation must be referred via safeguarding procedures for agreement on how it will be investigated, to ensure that vulnerable people are safeguarded.	30/10/2009
2	38	13	All staff who have responsibilities for use and management of bed rails need to be fully trained in their use. Bed rails can present a risk of injury to residents therefore staff who use or fit such equipment need to be fully trained.	30/10/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
3	38	13	All waitresses must be trained in first aid. As care and nursing staff are not available in the dining room, waitresses will be the first people who need to take action until qualified assistance is able to attend. Therefore they need to be fully trained in actions to take to ensure the health and welfare of residents.	30/10/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	1	The Service Users' Guide should be made more approachable by having practcal every day information placed at the front of the Guide and include the results of surveys.
2	1	The home should further revise their Statement of Purpose to clarify the sections of emergency admissions, self-medication and include our correct address.
3	2	The contract should be revised in certain areas, to ensure that the principals of plain English are adhered to.
4	3	The home should develop a checklist, so that staff can ensure that a newly admitted person's room is fully checked, including safety features and that all relevant equipment is provided prior to admission.
5	3	Sections on the pre-admission documentation should not be blank, the "Yes/No" section on whether the home can meet the person's needs should always be completed and the assessment should always be signed by the person completing the assessment.

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
6	7	Roles for drawing up assessments and care plans should be delegated, this will ensure that all known information can be made available to all who need to know it. This should also include ensuring that all relevant information is documented in the residents' notes, not the day book.
7	7	The home should further develop their audit system to ensure that all parts of care plans are consistently completed to the same standard.
8	9	The registered manager should make sure that the home is following the current good practice guidelines in the safe handling of medicines that are produced by healthcare regulators and professional bodies.
9	16	"Low level" complaints and concerns should also be documented, so as to inform the annual stakeholder survey.
10	16	The annual review of concerns, complaints and compliments should be tied in with the annual stakeholder survey with the residents' questionnaire being revised further.
11	18	Out of date documents relating to safeguarding should be removed and up-dated and guidance relating to challenges should be developed.
12	19	The home should modernise some its facilities by providing a private office for the manager, a small more intimate sitting room for residents, a sluice room on each floor of the home and an assisted bathroom for residents who have complex disability needs.
13	22	The home should consider investing in profiling beds and more pressure relieving equipment
14	26	Glove dispensers should be provided in all areas, such as en-suites, where personal care is performed.
15	26	All communal bathrooms should be provided with a lock which can be opened from the outside and/or an occupied/unoccupied label.
16	26	The home should set up a written audit for the quality of cleaning in the home
17	33	Response times to call bells should be included in home's quality audit.

Recommendations These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.		
No	Refer to Standard	Good Practice Recommendations
18	33	The home should introduce a confidential staff survey.
19	37	Liquid paper should never be used in nursing and care documentation.

Helpline:

Telephone: 03000 616161

Email: enquiries@cqc.org.uk

Web: www.cqc.org.uk

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