Abbeville RCH Limited

Abbeville Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 April and was unannounced. Our previous inspection carried out on 9 and 16 November 2016 found four breaches of regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. This inspection found that improvements had been made in most areas. Some further improvements were still required and the provider was in breach of one regulation.

Abbeville Lodge provides accommodation and care for up to 20 older people, some of whom may be living with dementia. At the time of this inspection 14 people were living in the home.

There was no registered manager in post. However, an experienced staff member was managing the home and they told us that they would be applying to register as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people were not supported to regularly engage in meaningful social interaction. This had not been satisfactorily remedied in over a year with concerns found in two previous inspections during this period.

However, other considerable improvements had been made since our November 2016 inspection. Consequently, the provider was no longer in breach of regulations relating to safety, staff training, safeguarding and the governance of the service.

Risks specific to individual's wellbeing were identified and reduced as far as was possible. A few environmental issues needed addressing, namely an unstable corridor floor and the temperature of the home. The high temperature was also a risk to the stability and effectiveness of people's medicines. However, people received their medicines as prescribed.

There were enough staff to meet people's physical needs and robust recruitment procedures were in place. People felt safe living in the service and were cared for by staff that treated them with kindness and respect. Staff were well trained and felt supported to undertake their roles.

There was a limited understanding in relation to the Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards and how to record this. The provider was aware of this and further training had been arranged. However, people's consent was obtained on a day to day basis.

People were offered choices about what to eat and drink and they enjoyed the food. Where they needed support and encouragement with meals, this was provided.

A management consultant had assisted the service and the provider in making considerable improvements in the home, including the monitoring of the quality of service that people received. Some of the improvements made were very recent.

The service had made considerable improvements since our November 2016 inspection. However, we remain concerned about the ability of the provider to make further progress and sustain improvements made.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were systems in place to manage risk for the safety of people living in and working in the home. However, a few environmental issues required attention.

Staff knew how to recognise and respond to concerns of abuse.

People's medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent was obtained on a day to day basis. However, there was limited understanding and practical application of the Mental Capacity Act 2005 in relation to the assessment process. This meant that the service was not meeting the requirements of the Mental Capacity Act.

People were supported by staff that had received the necessary training and had the knowledge and skills to meet their needs effectively.

Staff provided suitable support to people who required assistance to eat and drink.

Is the service caring?

Good

The service was caring.

Staff were friendly and respectful to people and knew the people they cared for well.

People's privacy, dignity and right to confidentiality were upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider had not made improvements to ensure that people

received opportunities to engage in meaningful activities.

People knew how to make a complaint and were confident that any concerns raised would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A new auditing system had been introduced that was yet to bed in, but a good framework was in place. However, this had been done very recently so we were unable to judge the sustainability of the improvements made.

People living in the home, their relatives and staff were supportive of the new manager.

Abbeville Lodge

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 checked 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 11 April 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines.

Prior to this inspection we liaised with the local authority and reviewed information held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During this inspection we spoke with six people living in the home and relatives of two people. We also spoke with two staff members, the manager, the provider and their management consultant.

We made general observations of the care and support people received at the service. We looked at the medication records of all fourteen people living in the home and care records for five people. We viewed records relating to staff recruitment as well as training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection in November 2016 identified a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This previous inspection had identified concerns in relation to staff not following guidance from health professionals given to help keep people safe, risk assessments, cleanliness and infection control and security of cleaning chemicals.

This April 2017 inspection found that apart from a missing bed rails risk assessment that was required for one person, risk assessments were in place where required. Staff were aware of risks specific to individuals such as falls or the risks of not eating enough. They told us about what actions they took to minimise the risks to people's welfare. This information replicated the documented personalised guidance for staff on how to keep people safe. This guidance was comprehensive and would have enabled a staff member not familiar with people to be able to support them safely. We observed that staff were following guidance provided by health professionals.

We looked around the home and found it to be generally safe. The cleanliness of the service had improved and cleaning chemicals that could be hazardous to people's health were stored safely. Way finding signage had been put up. One relative told us that they had noticed that one person who sometimes was not sure where the bathroom was located was now able to identify it with ease. However, the floor in one part of the main corridor was soft underfoot. This area had previously undergone repairs following a water leak. The unstable floor could present a risk of people falling.

There were some temperature control issues in the home. Upon our arrival at 9:30am the home was very warm. A bathroom thermometer read 30 degrees Celsius. Two relatives told us that the home was often too warm. Records of temperatures of the room in which medicines were stored sometimes exceeded the upper temperature limit. This meant that some medicines could become unsafe for use. The manager told us that they would remedy the temperature control arrangements in the medicines storage room and throughout the home generally and keep this under review.

We were satisfied that whilst some improvements were required, that the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection in November 2016 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some complaints that had been received should have been raised as safeguarding referrals to the local authority.

During this April 2017 inspection we reviewed records and spoke with the new manager who had been in post for approximately eight weeks. There had been no issues that had arisen that would require a safeguarding referral to be made. We were satisfied that the manager understood their responsibilities and knew what issues might necessitate a referral to the local authority's safeguarding team.

Consequently, the provider was no longer in breach of Regulation 13 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

People told us that they felt safe. One person said, "For the first time in 88 years I feel safe." Staff confirmed that they had received training about safeguarding people. They told us how they would recognise signs of potential abuse and that they would raise these concerns with the manager. Staff were confident that the manager would act appropriately, but they also knew how to report concerns to external agencies themselves and would do this if they felt it was necessary in order to help keep people safe.

A member of CQC medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Records showed that people were receiving their oral medicines as prescribed. There were internal audits in place to enable staff to monitor and account for medicines. However, we noted there were gaps in records for topical medicines prescribed for external application where they did not confirm these medicines had been applied as prescribed.

Staff handling and giving people their medicines had been assessed as competent in medicine-related tasks. Supporting information was available to staff to enable them to give people their medicines safely and consistently. There was personal identification, information about known allergies/medicine sensitivities and details about people's preferences about having their medicines given. There were care plans in place about people's medicines. When people were prescribed medicines on a 'when required' basis, written information was available to show staff how and when to give people these medicines. However, we noted more detailed information was required about some medicines prescribed in this way to ensure they were given consistently and appropriately.

For people lacking mental capacity to make decisions about their own care or treatment and who refused their medicines there were appropriate records in place. These records showed that best interests decisions were made, in consultation with people's GP, in order to give them their medicines crushed in food or drink (covertly). There was information available for staff to refer to about how and which medicines should be given to people in this way to ensure that staff gave the medicines consistently and appropriately.

People told us that there were enough staff to assist them. One person told us, "I feel that there is enough staff. I have a bell I call and they don't take too long." During our inspection we saw that staff were available to support people upon request or when they needed assistance. Staff rotas we reviewed showed that the service was routinely maintaining the staffing levels that were required.

The provider had processes in place to help minimise the risks relating to the recruitment of staff. These included the taking up of references from previous employers, checking staff against records held by the Disclosure and Baring Service (DBS) and checking people's proof of identity. Where anomalies had arisen we saw that the manager had made further enquiries to determine the level of risk present, before deciding whether to employ the applicant. We found that suitable decisions had been made.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in November 2016 identified a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received sufficient training to carry out their roles and responsibilities.

This April 2017 inspection found that improvements had been made. The majority of staff training was up to date. Staff told us about the training they had received and were due to go on. They told us that they received regular supervisions and appraisals of their performance and development needs. They had access to ongoing support from the manager and senior staff to carry out their duties effectively.

Consequently, the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

We reviewed the records of two people whose ability to make their own decisions was in doubt. DoLS applications to the local authority had been made and authorised in respect of both individuals.

Conditions had been imposed on the authorisation that the local authority had granted in respect of one person. One condition was that the use of bedrails be reviewed. The person's night check part of their care plan stated that the person knew why they were in place and understood how to ask for assistance to have them removed. The person's care plan also indicated that they were aware that giving verbal or implied consent was a continuing process which they could withdraw. Records also stated that the person had consented to the sharing of information about them with health professionals and to the use of their photograph.

The DoLS assessment found that the person lacked capacity to understand their care needs because they could not understand information relevant to a decision that needed to be weighed up, retain the information or use the information as part of a decision making process. Consequently, the provider could not be confident that the person was able to consent to matters as indicated in their care records.

The second person's care records also showed that they had consented to the sharing of information about them and the use of their photograph. However, a health professional had determined that the person lacked capacity in relation to an issue covered by the DoLS application. Consequently, we were again concerned that the provider could not be confident that the person was able to consent to matters as indicated in their care records.

There were no records of appropriate mental capacity assessments carried out by the service or best interests decisions taken on people's behalf. There was limited information recorded about people's ability to comprehend, remember, weigh up or communicate their decisions where there were doubts about their mental capacity.

During the day of our inspection we saw that staff sought people's consent before providing care or support. People were assisted to make their own decisions when necessary, for example by staff them offering choices.

Whilst staff had received training in mental capacity, further training was due to assist staff to improve their understanding in this area. This had been arranged.

People told us that they enjoyed the food and that they received choices. One person said, "You really get spoiled sometimes. They often ask if we want seconds." We observed a tea trolley with a choice of snacks including crisps, yoghurts and hot cross buns as well as hot and cold drinks. We saw that people who chose to stay in their rooms had drinks available. If people's drinks had gone cold we saw that replacements were offered. People's dietary requirements were familiar to both care and catering staff. This helped ensure that people received the food they needed and preferred. Where people needed the support of staff with their meals this was provided. A relative told us how their family member's appetite had recently decreased. The manager had ensured that staff spent time with the person encouraging them to eat.

People's healthcare needs were well managed. Their records demonstrated that staff sought advice and support for people from a wide range of health professionals. Outcomes from appointments with or visits from health professionals were recorded and people's care plans were updated and amended as necessary.

Good

Is the service caring?

Our findings

People were positive about the staff that supported them. One person said, "They are really very good." Another person told us, "We always talk; we can have a good laugh." A third person said, "The staff here are very good." We were told that staff were friendly and cheerful and this helped to create a good atmosphere in the home. One person said, "The relationship I have with staff here is unbelievable, they are beautiful!" A relative told us, "You can't fault the staff here. They are so patient."

We saw and heard staff speaking with people in a caring, respectful and relaxed manner. Staff used people's preferred names when speaking with them. We heard general conversations about everyday matters and heard staff discussing things with people that were important to them or of interest to them, such as their family and friends. This demonstrated that staff knew the people they were caring for which helped to foster good relationships in the home.

We observed staff kneeling to be at eye level with people when appropriate. We saw that physical contact was used to gently reassure and comfort people if they became distressed.

Staff understood the importance of treating people with dignity and respect during their interactions and told us about the ways they did this. For example, they would close people's bedrooms doors when personal care was being carried out or private conversations were taking place.

We saw that whilst there were no formalised arrangements in place to discuss people's care with them, people told us that their views were sought and acted upon. Their care records contained details about what was important to people about the way they were supported and what they liked and did not like. One person told us, "It is just part of our normal chats with staff and that is fine for me."

During our inspection we spoke with relatives of two people living at the home. They told us that they felt involved with their family member's care and support and were able to discuss matters with staff on an ongoing basis. They told us that they felt welcomed at any time and had good relationships with the staff.

Staff told us that they encouraged people to do what they could so that they could retain their independence for as long as possible. We observed one staff member suggesting an alternative and easier way for one person to do something they were struggling with. The person said, "That's a good idea. I'll give that a go." The staff member remained nearby, ready to assist if necessary, but they were not required. Once the person had achieved their aim both they and the staff member were smiling. The person said, "Easy really." They both laughed.

The importance of treating people's private and sensitive information confidentially was understood. People's records were stored in a locked office or on computer systems that were password protected and restricted to ensure they were only viewed by appropriately authorised people.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection in November 2016 found that some people felt there was enough for them to do in the home, whilst others did not. This April 2017 inspection found the same mix of opinions. Some people living in the home, mainly those who were more physically and/or cognitively able, were able to occupy themselves. Some of these people tended to go out on a regular basis and did not require the support of staff to do so. Others were able to pursue their interests in the home.

There was little time allocated to supporting people with their social interests. A craft session had been held a week before our inspection. One person told us that they had made Easter bonnets. However, people were unable to tell us about any other activities that had taken place.

Two people told us that they didn't get opportunities to go out of the home. One person told us that they felt lonely. The DoLS authorisations for two people stated that the service should consider opportunities for accompanied trips out. However, this had not happened. Staff told us that this was due to cost constraints. One relative told us that their family member had little interaction from staff other than when tasks were being carried out. A knitting club had commenced at one point, which their relative had enjoyed participating in, but this was not happening now.

The manager told us that a staff member would be working extra hours with a view to supporting people socially. Initially, they would be seeking people's views about what they would like to do. There were plans in place to improve the social provision in the home. However, this was now the third inspection in a row where we had found insufficient social support for people.

Consequently, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the service was generally responsive to their physical needs and that they received the support that they needed and in the way that they wanted. One person told us how staff supported them several times a day with a specific exercise to help them treat the symptoms of a health condition. A relative told us that a white board had recently been provided to help their family member communicate with people more easily. Previously they had been using pen and paper, but had found that the whiteboard worked better for them. A second relative told us about improvements in the way that staff were supporting their family member with some compulsive behaviours, which had, on occasions, presented risks to their welfare. The relative told us, "It's much better managed now."

An unused room had been converted into a hair dressing salon since our last inspection. This looked welcoming and was nicely decorated. The manager had arranged for a hairdresser to come to the home on a regular basis. Both relatives we spoke with told us how their family members had enjoyed and benefitted from this new amenity.

People's records contained assessments of their individual needs and included the views of the person and

their preferences. Records showed people's life histories and what was of importance to them, for example their religion or hobbies. Risk assessments and care plans were updated on a regular basis or more frequently if necessary when people's care needs changed. We found a few issues with the completeness of people's care records where insufficient guidance was available for staff. For example, there were no details to show what the acceptable blood glucose range was for a person living with diabetes. The manager told us that they would address these points.

People told us that they knew how to raise and concern and that the manager was responsive if they raised any issues. They said that they would be comfortable to raise any matters with them or other staff members and had confidence that they would be appropriately addressed.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in November 2016 found a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance arrangements in the service were poor.

This April 2017 inspection found that improvements had been made. The registered manager in post at the time of our November 2016 inspection was no longer employed. A senior and experienced staff member who had overseen a domicilary care agency owned and operated separately from the provider's three Abbeville homes was now managing this service. This person had also received considerable training and was able to directly train staff themselves. They told us that they would apply to CQC to register as the manager.

A new auditing system was in use that placed a greater emphasis on observations of the standard of care that people received. The manager carried out daily floor walks which helped to identify practical issues and gave a better scope for ongoing monitoring. For example, this inspection had identified high temperatures in the home. The manager had added a temperature check to their daily floor walk check. People's views were sought at meetings and through a quality assurance survey as well as informally during the day to day running of the service.

We saw that a wide variety of audits were in place that were carried out by the manager. These were part of a new auditing system that had been recently introduced following the appointment of a management consultant. These included health and safety checks, medicines audits, falls audits, infection control checks as well as an unannounced check during a night shift to see how the service operated at night. Timescales for improvement actions were built in to the audits. However, there was no care plan audit carried out by the manager. This was due to be arranged and implemented.

The provider had recently increased their engagement and oversight of the home and had just completed their first audit of the service. As well as environmental and management checks a sample of two people's care records were reviewed. We had case tracked one of the two people whose records had been sampled. The provider's audit had not identified the anomalies we had found on this person's care records including consent issues and incorrect calibration of the nutritional screening tool that had resulted in an incorrect nutritional risk score. However, this was the first audit the provider had carried out and a good structure for their quarterly check was in place.

We were pleased to see that progress was beginning to be made in the governance arrangements of the service. This progress needs to continue and be sustained in order for us to have confidence in the provider. However, we were satisfied that they were no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home were supportive of the manager. One person said, "She's okay, she has made improvements." Another person said, "I get on well with the manager." One of the relatives told us that they

been concerned about their family member's personal care, but said that since the new manager arrived this had not been an issue. They had also noticed that their family member's room was being kept cleaner.

A second relative told us that the manager had made positive changes. They told us they were pleased to see the provider was showing an interest in home and despite visiting a family member in the home for several years had not known who they were until recently. However, they were disappointed in the level of investment in the environment.

Staff were positive about the changes made and told us that their views were sought and their suggestions welcomed. One staff member told us, "[The new manager] is the first manager who says thank you. I feel valued here." A second staff member said, "We're a little family. I love it here."