Care One Limited

Abbey Care Home

Inspection report

28 North Road
Clacton On Sea
Essex
CO15 4DA

Tel: 01255420660
Website: www.careone.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Abbey Care Home is a residential care home providing personal care to people aged from 18 to 65 years and over who may have mental health, learning disability, physical disability or dementia. The service can support up to 20 people in one adapted building, over three floors. The service is centrally located providing easy access to local community facilities and transport. At the time of the inspection there were 12 people accommodated.

People's experience of using this service and what we found
The service was not well-led. There continued to be a failure to recognise and identify significant failings impacting on the quality and safety of service provision and a continued lack of consistency in how well the service was managed and led. Lessons had not been learned to minimise risk and drive improvement. Management and staff roles and responsibilities were not clear or understood. Concerns continued to be raised by whistleblowers, professional visitors and others.

People were not protected from abuse or avoidable harm. Management did not recognise or appropriately respond to abuse; they failed to properly apply safeguarding policies and procedures when circumstances needed it. People were not valued and treated with dignity and respect, especially people living with dementia or mental health needs. The provider failed to ensure there were enough suitably competent and skilled staff deployed to meet people's needs safely and effectively.

There continued to be significant shortfalls with how the provider and registered manager were responding to the COVID-19 pandemic. They were failing to do all that was possible to keep people safe from the transmission of COVID-19 infection. Management and staff were not following Government guidance and best practice infection prevention and control (IPC) guidance. Measures to limit the risk of cross infection continued to be neglected, compromising people's safety and welfare. Areas of the home were still not clean, and the provider was failing to have effective and additional cleaning schedules in place for frequently touched areas and deep cleaning.

Immediately following this inspection, we made safeguarding alerts to the local authority. The local authority safeguarding, and quality improvement teams continue to monitor the service through management support and regular visits to ensure the safety of people living at the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was inadequate (published 11 November 2021) and there were multiple breaches of regulation. We took immediate enforcement action to force improvement. We shared our concerns with the local authority and fire safety authority. In response, the local authority monitored people's care experience and offered to support the provider through the improvement process. The provider completed an action plan after the last inspection to show what they

would do and by when to improve.

Why we inspected: We received information of concern about infection prevention and control measures at this service during an outbreak of COVID-19 and the way people were being treated by some staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. As part of CQC's response to care homes with outbreaks of COVID-19, we are conducting reviews to ensure that the Infection Prevention and Control (IPC) practice is safe and that services are compliant with IPC measures. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This report only covers our findings in relation to the key questions Safe and Well Led. Ratings from previous inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains inadequate. This is based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbey Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to infection prevention and control practices, safeguarding, staffing, managerial oversight and leadership at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. We will monitor and review information received about this service and inspect sooner if we need to.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in 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? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Abbey Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Abbey Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers registered with the Care Quality Commission, one of whom is the sole owner and director of the registered provider. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four members of staff including the director and registered manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We attended safeguarding strategy meetings with other system stakeholders.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. Although some action had been taken, it was not effective and risks to people was still not recognised and acted on. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider and registered managers failed to demonstrate their safeguarding responsibilities and failed to have a robust approach to protect people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no improvement had been made and the provider was still in breach of regulation 13.

- Management did not recognise or appropriately respond to abuse; they failed to properly apply safeguarding policies and procedures when circumstances needed it.
- During our inspection inspectors witnessed a verbal altercation between a staff member and a person living in the home.
- One of the registered managers heard the altercation but did not come out of their office and told inspectors they would make notes and have a supervision with the staff member. They failed to recognise and understand the impact of the staff members behaviour on the person which was rude and dismissive of their needs. They did not take action to support the person or immediately address the staff members behaviour.
- Following the inspection, the inspectors raised a safeguarding alert in relation to the incident. The registered manager did not take any action to address this incident until two days later following intervention by the local authority.

Systems were not operated effectively to protect people from abuse or improper treatment. This placed people at risk of harm. This was a continued breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection; Assessing risk, safety monitoring and management

At our last inspection we identified significant shortfalls in how the provider and management team were responding to the COVID-19 pandemic. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the Commission taking enforcement action to force improvement this inspection found very little improvement had been made and the provider was still in breach of regulation 12.

● Infection prevention and control (IPC) was still not managed safely. The provider did not follow or meet national guidance in relation to COVID-19 IPC management. This was despite support being offered and provided by external professionals and our previous report.
● Although there was an infection control policy this was not followed by management and staff. Management did not have a contingency plan in place for a COVID-19 outbreak; staff did not know how to immediately instigate full infection control measures to enable them to care for people with symptoms safely and minimise the spread of infection.
●There were no clear agreements for delegation of duties and responsibilities and senior staff in the absence of management did not know what was expected of them. There were no robust systems for the testing and monitoring for Covid-19
● Measures were not in place to safely admit visiting professionals into the service. Neither the inspectors nor another visiting professional were asked for proof of COVID-19 vaccination or to show the NHS COVID-19 pass when they entered the premises.
● There was no effective system in place for the safe management of people self-isolating. People positive with COVID-19 were seen to move freely through the service without a risk assessment to ensure others were not at risk. For example, to support a person who smoked to safely exit the building. The leadership had not zoned areas, routes around the home or exits to minimise risks to others.
● Staff were not using or disposing of personal protective equipment (PPE) safely to safeguard people from the spread of infection. Staff entered and exited isolating rooms in either inappropriate PPE or failed to remove items of PPE before continuing through communal areas, creating a risk of cross-infection.
● There continued to be poor systems for PPE disposal which were unsafe and placed people at risk of cross infection. Aprons, gloves and masks were being disposed of throughout the service in open bins and black general waste bags. A facility for the disposal of clinical waste (which includes used PPE) was outside in a general use dustbin not appropriate for clinical waste.
● The service is located next to a public car park. There was a pile of disposed black general waste bags outside the service spilling out used masks, gloves and continence pads into a public area. A specialist bin for clinical waste was full; many clinical waste bags over spilled beside it. The provider did not have a regular arrangement for the collection of clinical waste, and this was not addressed until after our inspection.
● The environment did not support good infection control and areas of the home continued to be unclean and unhygienic.
● Despite a COVID-19 outbreak there were no enhanced or more frequent cleaning schedules in place to include high touch areas.

We found no evidence that people had been harmed however, the provider failed to have robust systems in place to ensure infection outbreaks could be effectively prevented or managed to protect people as far as possible from the risk of harm from the spread of infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment; Using medicines safely

At our last inspection the provider failed to have enough numbers of staff with the right skills and competencies to provide the right level of care and meet people's needs safely and effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection found very little improvement had been made and the provider was still in breach of regulation 18.

● The provider still did not have a contingency plan in place to help manage unforeseen staff absences such

as long-term absences and resignations. There were no contingency arrangements in place to ensure adequate staffing during a COVID-19 infection outbreak which placed additional pressures on the small staff team.

● We were informed a senior staff member was told to return to work with a positive COVID-19 test, this was confirmed, because there was nobody else trained to administer the medicines.

● We observed administration of medicines to be unsafe. There were not enough staff and the senior administering medicines was continually interrupted to answer the door and the telephone, and to assist visiting healthcare professionals.

● There continued to be no night staff trained and competent to administer medications. Medication was given at 20:00 hours by day staff before they completed their shift. There were no risk assessments in place which demonstrated this practice considered the impact of this on the effect of medicines and time between doses. There were on call management arrangements, but these were not robust because they had not considered sickness or leave.

● There continued to be insufficient staff deployed to cover effective cleaning across the service. There was one staff member identified on the rota to carry out three hours of cleaning a day from Monday to Friday. At the inspection we saw this person was doing other tasks. This included using allocated cleaning hours to cover for the cook and to move a person in a hoist. Despite a COVID-19 outbreak there had been no formal review of cleaning and what actions would be needed to minimise risks. The leadership team had failed to recognise the risks and were reliant on staff covering multiple roles.

● The provider could not evidence all staff had received relevant practical moving and handling training and were competent to move people safely. Two people required assistance from staff to move with a hoist.

● The rota did not always accurately reflect or demonstrate the staff who had worked or who were scheduled to work had the right mix of skills and experience. This included being clear where new staff were being inducted or shadowing another member of staff. This system meant the provider could not evidence staffing on each shift was minimising risks for people and keeping them safe as possible.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lessons learned

● There was not a culture of learning. Our concerns were repetitive of previous issues; lessons had not been learned and used to improve the service and limit risks to people

● Whilst some action had been taken to improve fire and window safety this was a reactive response to enforcement action.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found very little improvement had been made and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care.

● Some improvements to the environment had been made or were planned for such as new carpeting. However, the culture continued to reflect care which was task orientated and not centred on the person. Risk was not managed in a way which protected people or fully reflected they had their wishes and/or needs met. There was little or no exploration into this which meant opportunities were missed to identify how people's quality of life could be improved.
● The provider was unable to demonstrate they had effective leadership and oversight. There were two registered managers (one being the sole director of the registered providers company). We asked for their job descriptions, but these have not been received. There was no clarification of their roles and responsibilities.
● The leadership team had not identified the ongoing risks to people due to poor infection control practice. When a COVID-19 outbreak occurred this meant staff were ill prepared and action to minimise risks and manage the situation failed.
● Although the provider had submitted an action plan and response to our previous inspection, the plan demonstrated it was not robust or workable. It had not improved the quality and safety of the service and had not identified and addressed shortfalls.
● The provider had failed to engage proactively with professionals and commissioners who offered support to improve and sustain good practice prior to and since the previous inspection in August 2021. This included training opportunities for staff.
● Enhanced IPC training from the local NHS clinical commissioning group (CCG) and practical moving and handling training from the local authority quality improvement team had been declined by the provider which meant people continued to be at risk from poor practice.
● The provider did not inform the appropriate authorities about having a COVID-19 outbreak which spread very quickly throughout the home. We learnt of the outbreak from a whistle blower who had significant concerns about the management of the outbreak. The provider had not kept themselves informed of local arrangements during the COVID-19 pandemic and told a meeting held by partner stakeholders they were not aware of the reporting arrangements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The culture was not open and transparent. Staff were not informed of or engaged in an improvement plan and were not aware of their role within any improvement processes. We received information from staff telling us they were blamed by management for the failure of the service.
● Management were not visible within the home. The office was away from the hub of the service and located upstairs with the bedrooms. Oversight was managed via 14 CCTV cameras and the registered managers mobile phone. The provider failed to comply with legal requirements around the use of CCTV in a care home setting and had not fully ensured people were consulted or whether it was in their best interests. The registered managers and provider told us CCTV was used to monitor falls or incidents between people using the service. However, there was no record or analysis of these events or link to how they were reduced by the use of CCTV.
● Staff did not have access to the office and relevant documents required for the day to day running of the home when the management were not at the home.
● We continued to receive information indicating a split staff team and a bullying closed culture. We were informed about the bullying behaviour by a staff member prior to our inspection. This was witnessed during the inspection, however registered managers and provider failed to recognise this and take appropriate action.
● There was no plan about how the service kept up to date with developments in dementia care and other mental health conditions to ensure the care provided was appropriate and in accordance with best practice. There continued to be a lack of recognition and understanding of the wider aspects of living with dementia and related needs such as changes in appetite, hunger and risk of malnutrition. In general people living in the home had complex needs which had not been continuously explored or reviewed to ensure they could experience a meaningful and safe life as far as possible.

This is a continued breach regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014