Mr & Mrs G Watson

Abbotsfield Hall Nursing Home

Inspection report

Abbotsfield
Tavistock
Devon
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Tel: 01822613973

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Abbotsfield Hall Nursing Home (hereafter referred to as Abbotsfield) is a nursing home providing personal and nursing care to 16 people aged 65 and over. The service is registered to support up to 28 people, some of whom are living with a dementia.

People's experience of using this service and what we found
People were not always protected from the risk and spread of infection. We were not assured that Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures. This was communicated at inspection and the provider and registered manager was supported to take immediate and appropriate action to address the concerns.

Personal protective equipment (PPE) was readily available. However, staff were not always wearing PPE safely and in line with current guidance. We observed staff not always wearing the correct fluid resistant masks, wearing it in the correct way or wearing a face covering at all.

Risks in relation to skin care were assessed, and measures were taken to mitigate these. For example, pressure relieving equipment was in place, staff checked people's skin for skin damage and people were helped to change position regularly to protect vulnerable skin.

Whilst we did not identify any specific concerns in relation to people's skin care, records were not always thoroughly completed to show that action that had been taken to mitigate and manage the risk. The provider, registered manager and clinical lead were aware of the concerns regarding record keeping and were working with the local authority to make the necessary changes.

People were supported to eat and drink enough to maintain their health and reduce the risk of dehydration and malnutrition. Staff were aware of people's dietary risks and needs and were following the eating and drinking support plans that had been put in place. Where people were at risk of losing weight, staff monitored people's weight monthly and action was taken if people had lost weight. People told us they were happy with the food at the service, had enough to eat and drink and received the support they needed to eat their meals.

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

Rating at last inspection
The last rating for this service was inadequate (published 2 March 2021).

Why we inspected
The inspection was prompted due to concerns we received about risks associated with skin care and nutrition and hydration. A decision was made for us to undertake a targeted inspection examine those risks.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe section of this report.

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

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 have identified a breach in relation to infection prevention and control 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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Abbotsfield Hall Nursing Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a specific concern we had about the management of risks associated with skin care and nutrition and hydration.

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
This inspection was undertaken by two inspectors.

Service and service type
Abbotsfield Hall 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 a manager registered with the Care Quality Commission. 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 looked at information we had received about the service since the last inspection. We reviewed information of concern we received from two people's relatives and attended a multi-professional

safeguarding meeting.
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.

During the inspection-
We spoke with four people who used the service about their experience of the care provided. We spoke with the providers and fourteen members of staff including the registered manager, the head of care, the admin manager, registered nurses, care workers and support staff. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to infection prevention and control and the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Prior to this inspection we reviewed information relating to concerns about two people's care. The information we received raised potential concerns about the general management of risks associated with skin care, nutrition and hydration and record keeping. This inspection did not look at the care of the individuals that we received concerns about, as this is being addressed by Devon County Council under the safeguarding adults process. We also reviewed infection prevention and control arrangements at the service. We will assess all of the key question at the next comprehensive inspection of the service.

Preventing and controlling infection
At the previous inspection which took place in October 2020, we recommended the provider/registered manager seek support from their local infection prevention and control team. At this inspection the services clinical lead confirmed advice had been obtained and records showed a partial virtual tour of the service had been carried out in February 2021 and advice had been provided.
At this inspection, we found people, staff and visitors were not always protected from the risk and spread of infection.

- We were not assured that the provider was preventing service users, staff and visitors from catching and spreading infections. For example, throughout the inspection we observed three staff members were not wearing the appropriate fluid repellent surgical masks known as Type IIR as set out in Public Health England's, 'How to work safely in care homes guidance'. When asked neither the registered manager or clinical lead were able to tell us what protection these alternative face covering provided nor had they taken any action to assess and or mitigate any of the risks associated with not wearing an approved face mask.
- We were not assured that the provider was using PPE effectively and safely. For example, during the inspection we observed three staff members wearing their face masks incorrectly, either below their nose and/or their chin. One staff member was observed not wearing any kind of face covering at all.
- We were not fully assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The arrangements in place to mitigate risks associated with transmission and/or cross contamination within the service was not sufficiently robust to control and prevent the spread of infection. For example, throughout the inspection we observed a staff member wearing cotton gloves. When asked the clinical lead told us this was because the person was unable to wear normal gloves due to skin irritation. We did not observe this staff member changing their gloves between tasks, when entering people's bedrooms or communal areas, such as the laundry, or following interactions with people living at the service.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure that risks relating to infection control were being effectively managed and this placed people at increased risk of

harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We shared our concerns with the local authority.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Assessing risk, safety monitoring and management
At the last inspection in October 2020 sufficient information and guidance about how to manage people's risk was not always in place and documents recording how and when assessed risks were being mitigated were not being completed consistently. Following that inspection we issued a notice of decision to impose conditions on the providers registration.

At this inspection in March 2021 we found this still to be the case. Whilst records did not always contain sufficient detail, we found staff knew about people's individual risks and how to provide their support to keep them safe.

● Risks in relation to skin care were assessed, and measures were taken to mitigate these. For example, pressure relieving equipment such as, airwave mattresses and cushions, were in place for people with vulnerable skin.
● Staff told us they regularly checked people's skin whilst supporting them with their personal hygiene and when they helped people visit the toilet. Staff told us they applied prescribed creams, including barrier creams, to protect people's skin and reported any changes they saw to the registered nurses.
● Where people were unable to change their position whilst in bed, staff told us they regularly moved people from side to side and off loaded their feet to make sure their pressure areas did not become damaged.
● We saw staff worked closely with the GP and tissue viability nurses to support people with wound care management. Where concerns were identified, body maps and photographs had been used to document changes and shared with health professionals.
● Whilst we did not identify any specific concerns in relation to people's skin care, records were not always thoroughly completed to show that action that had been taken to mitigate and manage the risk. For example, one person's care plan stated it was important that staff encourage the person to change their position hourly whilst sat in their chair. However, records did not demonstrate this was happening.
● We discussed what we found with the provider, registered manager and clinical lead who were aware of the concerns regarding record keeping and were working with the local authority to make the necessary changes identified at this and the last inspection.
● People were supported to eat and drink enough to maintain their health and reduce the risk of dehydration and malnutrition.
● People were provided with a suitable diet that met their assessed needs. Information was available in people's care plans and in the kitchen about people's dietary requirements and their likes and dislikes.
● Staff were aware of people's dietary risks and needs and were following the eating and drinking support plans that had been put in place. For example, one person's records said they preferred to have a soft diet and sometimes needed help at times from staff to eat their meals. We saw during the inspection they had an appropriate soft meal and staff regularly checked with the person to ask them if they needed help.
● Where people were at risk of losing weight, staff monitored people's weight monthly and action was taken

such as, discussing concerns with their GP and monitoring people's food and fluid intake, if people had lost weight.

● During the inspection we looked at weight records for sixteen people living in the service. One person's records indicated a 4.1kg weight loss between Jan 2021 and Feb 2021. We spoke with the registered nurse on duty, who believed the discrepancy in January's weight was caused by a fault with the weighing scales. Despite this, staff had contacted the person's GP and were observing the person's intake. Following the inspection this person was weighed again and their weight had returned to their previously stable weight.

● We spoke with the person and they were very complimentary about the quality of the food provided by the service, felt they had a good appetite and did not raise any concerns about the quality or amount of food provided. The person looked healthy and not undernourished.

● People told us they were happy with the food at the service, had enough to eat and drink and received the support they needed to eat their meals.