Adbolton Hall Limited

Adbolton Hall

Inspection report

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16 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8, 13 and 16 February 2018. The first day of our inspection visit was unannounced. Adbolton Hall was last inspected in January 2017 and was rated as Requires Improvement. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have enough staff to meet people's needs, and the provider did not have an effective system to monitor the quality of people's care. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Safe, Effective, Caring, Responsive and Well Led to at least good. On this inspection, we found that improvements had not been made to ensure the provider delivered nursing and personal care that met legislative requirements.

Adbolton Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Adbolton Hall provides personal and nursing care for up to 53 people over two floors. At the time of our inspection, there were 24 people living there. Adbolton Hall provides personal and nursing care to people living with a range of health conditions, including physical disabilities and people living with dementia.

People were at risk of harm because risks associated with their health conditions were not consistently reviewed. There was a risk that information available to staff about people's nursing and personal care needs did not reflect their current needs. People were not kept safe from the risks associated with infections. Risks associated with the environment were not reduced and mitigated. People were not kept safe from risks arising from their health conditions. Action was not always taken to monitor and respond to changes in people's health needs. People were at risk because the provider could not assure themselves staff were consistently monitoring people's health conditions and making timely referrals to health professionals.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA), and people were at risk of not having their rights respected in this regard. People were at risk of receiving restrictive care when this was not proportionate or in their best interests. There were no effective safeguards in place to ensure restrictive care was minimal and reasonable. Consent to care was not always sought in accordance with legislation and guidance, and people were at risk of care that was overly restrictive. People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

Staffing levels were not sufficient to ensure people received the care and support they were assessed as needing, at the times they needed. People were at risk of harm because staff did not always have training to help them to understand how to effectively support people's health and care needs.

People were supported to have sufficient to eat and drink, but mealtime experiences were not always enjoyable for people. People's needs were not fully met by the adaptation, design or decoration of Adbolton

Hall. People and their relatives were not supported to participate in designing or reviewing their care. The provider had not considered people's different communication needs in order to ensure people could participate in daily life in the service. For people who found verbal communication difficult, there was no evidence the provider had considered other ways of promoting effective communication. People's needs and choices were not always identified and delivered in line with current legislation and evidence-based guidance. People did not always have care provided in a dignified or private way.

The service was not managed well. There were failures to meet the fundamental standards in relation to safe care practices, insufficient staffing levels and staff training, planning and delivery of people's care, in line with relevant legislation. Quality assurance processes to ensure people's safe care were not effective. The provider had not used feedback from external organisations to drive effective changes in the quality of care.

The service did not have a registered manager at the time of our inspection visit. Adbolton Hall had not had a registered manager since 3 January 2017. 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. The provider had appointed a manager in November 2017, and they were available throughout the inspection.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to these concerns found during inspection is added to reports after any representations and appeals have been concluded.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

The service did not have enough staff to meet people's needs. Risk assessments were not regularly reviewed to ensure staff had up to date information about how to keep people safe. People were not consistently kept safe from the risks associated with infection.

Is the service effective?

Requires Improvement

The service was not effective.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA). People were supported by staff who did not always have appropriate training to meet their needs. People were not consistently supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have care provided in a dignified or private way. The provider had not considered people's different communication needs in order to ensure people could express their needs and wishes effectively. People's confidentiality was respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care was not personalised to meet their individual needs. People were not supported to participate in designing or reviewing their care. People and relatives knew how to raise concerns or make complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had systems to monitor and review all aspects of

the service, but these did not consistently result in improvements in the quality of care. The service did not have a registered manager. The provider had not always notified CQC of significant events as they are legally required to do.

Adbolton Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident was subject to a coroner's inquest. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks.

We had also received information from local commissioners in relation to concerns about the management of risk of infection prevention and control. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. This inspection examined those risks.

This inspection took place on 8, 13 and 16 February 2018. The first day of our inspection visit was unannounced. The inspection visit was carried out by one inspector, a specialist advisor with experience in providing nursing for older people and people with dementia, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second and third day of our inspection was carried out by one inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about specific events which the service is required to send us by law. We also spoke with Healthwatch Nottinghamshire, who are an independent organisation that represents people using health and social care services.

During the inspection visit we spoke with seven people who used the service, and four relatives. We spoke with one nurse and three care staff. We also spoke with the activity coordinator, one maintenance staff, one office staff, the manager, and the provider's nominated individual. We sought the views of four external health and social care staff. We looked at a range of records related to how the service was managed. These included four people's care records and we looked at how medicines were managed for eleven people. We

also looked at two staff recruitment and training files, and the provider's quality auditing system.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

Not all of the people living at the service were able to fully express their views about their care. We used 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 asked the provider to send us information about staff training after the inspection visit, and they did so.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2017, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had been insufficient staff to meet people's needs. The provider had given CQC an action plan stating they would provide staff based on the dependency of people and their needs, and that this would be reviewed weekly.

On this inspection, we found there were still times when there were not enough staff to meet people's needs. One relative said, "Some days there are enough [staff]but sometimes there isn't." Another relative said, "Not on some days, like when they're doing breakfast and they [staff] can't leave the room, and it takes two staff to hoist [my family member]. So [my family member] just has to wait until someone is available."

Staff told us there were times when there were not enough of them to provide care and support in a timely manner. Our observations indicated there were times when staffing levels were not sufficient to meet people's needs and keep them safe. For example, on the first day of our inspection, there was an incident between two people in the main lounge, and both were agitated as a result. The incident led to a third and fourth person becoming distressed. At the same time, two other people were separately trying to stand up and were very unsteady. Staff confirmed both people needed support and supervision to stand. During the incident there were three staff present, and at times two staff left the lounge, leaving one staff there. There were not enough staff available to support people when this was needed.

Feedback from Healthwatch's visit to Adbolton Hall in June 2017 identified issues with staffing levels. For example, the lack of staffing impacted on some areas of care, for example at mealtimes and interaction with residents who chose to sit in their room, meaning that some residents were left waiting for their needs to be met. We found through our observations this was still the case. At lunchtime on the first day of inspection, there were not enough staff available to provide support to everyone who needed it. Three people were being encouraged and supported by their relatives to eat and drink. Five other people needed assistance from staff to eat. Staff confirmed there would not have been enough staff to support everyone safely, if relatives had not been there to assist. People were at risk of not getting support they required when they needed it.

We spoke with the manager about staffing levels. They said they were not currently using a dependency tool to assess the numbers of staff required, and planned to introduce one to assist decisions about staffing levels. They said the provider asked for information about people's needs and dependency levels, then provider made decisions about the number of staff needed based on this. Records of how staffing levels were determined were not available at the home, and there was no evidence to identify whether staff skills and experience was taken into account when planning staff rotas. The manager said they planned to request an increase in staffing levels as they felt there were not enough staff on shift. The provider confirmed with us on 13 February 2018 that they had agreed to increase staffing levels. However, at the time of our inspection, the provider had not ensured there were always enough staff to meet people's needs.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

People were not supported to maintain their skin integrity. Feedback to CQC from health professionals in October 2017 identified concerns about how the provider was assessing risks and taking appropriate action in relation to skin integrity. One person had come to harm as a result. The provider was aware of these concerns. On this inspection visit, we identified areas where staff did not take steps to prevent people from risk of harm. People used pressure relief cushions which were not designated for their personal use, which is good practice. Staff could not always ensure people used their individual cushions to reduce the risk of harm. Another person needed support to change their position to give pressure relief to their skin. They had a grade three pressure ulcer which required daily monitoring and treatment, and needed repositioning every two hours during the day and every three hours at night. Records did not reflect whether the person was being repositioned in accordance with their care plan. For example, there were gaps in recording on 6 and 7 February 2018, and staff could not say why this was. This placed the person at further risk of skin deterioration. The provider could not ensure that action was taken to reduce risks relating to people's skin care.

Risk assessments were not consistently reviewed and updated to ensure staff had up to date information to keep people safe. Records showed and staff confirmed people's risk assessments and care plans should be reviewed every four to six weeks to ensure they contained up to date information about people's needs. We found this was not consistently done. There was no evidence people or relatives were involved in managing risks associated with their own needs, particularly where these involved restrictive care practices. For example, one person was seen by a dietician in January 2018, and had been prescribed dietary supplements. The person's eating and drinking care plan had not been updated to reflect this. The manager confirmed that prior to their employment in November 2017, care records had not been regularly reviewed. The manager told us people's care plans were still in the process of being updated, as they had identified this as an issue when they started working for the provider. This meant people were at risk because staff did not always have accurate information about their current care needs.

People were not consistently kept safe from the risks associated with infection. The clinical commissioning group (CCG) carried out an unannounced Infection Prevention and Control audit on 6 November 2017. This identified a range of issues, and the CCG gave the provider actions to take to improve infection control. The provider had taken action, but we identified areas where the prevention and control of infection still required improvement. For example, it is good practice for people to have their own slings for hoisting to prevent cross contamination. The manager said only one person did not have their own sling for this. Some slings were labelled with people's names, but others were not. This meant the provider could not ensure that staff were using the correct sling for each person, and there was a risk of cross-contamination.

We saw medications for eye care being administered to people in the dining room at lunchtime. Staff doing this were not wearing gloves, and did not wash their hands before and after each procedure. The manager said the provider's policy was for staff to wash hands before and after applying medication to each person. We reviewed the policy which confirmed this. One hoist which we inspected had the covering of a foam pad which was damaged. People using the hoist often place their hands on this pad whilst being hoisted. The damage to the covering meant the pad could not be cleaned effectively. The provider could not assure themselves that people were always protected from the risk of infection.

People were at risk from aspects of the building environment. For example, access doors to rooms under refurbishment and to the maintenance store were not locked when we checked. We accessed several rooms containing tools and decorating equipment which presented a risk to people. We spoke with staff and the manager about this, and immediate action was taken to secure rooms which contained hazards. We viewed

a bedroom which the manager told us was refurbished and ready to be occupied. There were patches of damp on a wall and part of the wooden window frame was rotten. In the same room, hot water pipes leading to a washbasin were exposed with no cover to prevent people coming into contact with them. People were at risk of burns from exposed hot water piping. We found a cord light switch in an upstairs toilet where the plastic fitting was coming away from the ceiling. Staff were aware of this, but no action had been taken to address this. The provider had not consistently ensured risks associated with the service environment were identified and mitigated. This meant people were not always kept safe from hazards associated with the building environment.

Since the manager started in November 2017, accidents and incidents were reviewed and monitored to identify trends and to prevent reoccurrences. We saw documentation to support this, and saw where action had been taken to minimise the risk of future accidents. However, prior to this, there was no evidence that information from the review of accidents and incidents was used to improve the quality of care. Feedback from health professionals in October 2017 had not resulted in improvements to maintaining people's skin integrity. Following our inspection visit, we received a Coroner's report in relation to a person who had died at the service in August 2017. This raised concerns about how the provider had managed the person's health condition. Evidence from this inspection demonstrated the provider had not improved the processes for monitoring and maintaining people's health conditions. The provider had not learnt lessons when things went wrong to drive improvements.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to minimise the risk of abuse. People felt safe, and people and their relatives felt able to tell staff about any concerns. One relative said, "I think [my family member] is safe here." Staff knew how to identify people at risk or abuse or suspected abuse, and were confident to recognise and report concerns. They also knew how to contact the local authority or CQC with concerns if this was needed. Evidence from records showed the provider had contacted the local authority in relation to safeguarding concerns. The provider had policies on safeguarding people from the risk of abuse, and staff knew how to follow this. Staff received training in safeguarding people from the risk of avoidable harm and this was supported by training records.

People felt staff supported them to manage their medicines safely. Relatives felt their family members received medicines as prescribed. Staff told us and records showed they received training to ensure they managed medicines safely. Staff knew what action to take if they identified a medicines error. There were checks in place to ensure any issues were identified and action taken as a result. Staff followed national guidance for managing health conditions, for example, for people with diabetes. Medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. This meant people received their medicines as prescribed.

Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This helped reassure people and their relatives that staff were of good character and were fit to carry out their work.

There were plans in place for emergency situations. For example, if there was a fire. Staff knew what to do in the event of an emergency, and the provider had a business contingency plan in place. This meant people

would be supported safely if there was an emergency, and would continue to receive the care they needed.

Requires Improvement

Is the service effective?

Our findings

Staff were not always trained in skills needed to provide personal and nursing care to people living at Adbolton Hall. The provider offered training in a range of areas they considered necessary, including safeguarding, medicines, nutrition, and infection prevention and control. However, we found not all staff involved in providing care had undertaken training in areas relating to the needs of people For example, only two staff had undertaken training in care planning, and 18 staff had no training in end of life care. 'Communication' training had only been done by three staff. Ten staff had done training in skin care and pressure sore prevention and only two staff were recorded as having training in continence care. There was inconsistent evidence of staff having their care skills assessed; some staff had been assessed in relation to areas of care, but others had not. This meant people were supported by staff who did not always have appropriate training to meet their needs.

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

People's needs and choices were not always identified and delivered in line with current legislation and evidence-based guidance. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. For example, the NICE guidance on "Pressure ulcers: prevention and management", Clinical guideline (CG179), was not being followed in relation to ensuring people were repositioned in accordance with their assessed needs.

People were not consistently supported to maintain their health. People with health conditions did not consistently have records to show regular monitoring was taking place. Two people were at risk of constipation, and the care plan said staff should monitor this daily. We found staff were not recording as required. The manager said they felt the staff were monitoring but not recording this. There was no way to identify whether people's constipation was being monitored to ensure they were not at risk of harm. This lack of information meant people were at risk of not receiving appropriate medical intervention in a timely manner.

Another person was at risk from poor nutritional intake. Staff were using a monitoring tool every month to help ensure the person maintained their weight. There was a recording gap between September 2017 and January 2018. The same person was seen by a dietician on 9 October 2017, and should have been reviewed four weeks later. There was no evidence that a review had taken place, or that staff had followed this up. Records showed the person had lost weight between 12 October 2017 and December 2017. A fourth person was seen on 1 February 2018 by an external professional who recommended the use of sensory equipment in relation to the person's diagnosis of dementia. The equipment suggested is designed to provide sensory stimulation and reduce anxiety. The person's care records had not been updated to advise staff on how to support the person in this respect. Staff told us the equipment had been provided, but during our inspection we saw no evidence that the person was being supported to use the recommended sensory equipment. People were at risk because the provider could not assure themselves staff were consistently monitoring people's health conditions and making timely referrals to health professionals. Evidence seen during this

inspection demonstrated that the provider could not assure themselves that people's health needs were being met. People were at risk of not having their health needs met.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA), and people were at risk of not having their rights respected in this regard. The 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 be as least restrictive as possible.

People's consent to care was sought for most daily personal care activities. People and their relatives confirmed staff gained permission before offering care. However, where people lacked capacity to consent to aspects of their care, the MCA was not consistently followed. For example, two people had records of assessments of their capacity to consent to aspects of their care. These records did not state what the best interest decisions were, and did not evidence that relatives had been consulted as part of the decision making process. Staff understood the principles of the MCA, including how to support people to make their own decisions. However, the provider could not consistently demonstrate how people and their relatives' views were sought as part of best interest decision making. This meant people were at risk of not having their rights upheld in relation to consent to care.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. No-one was subject to a DoLS authorisation at the time of our inspection. The provider had assessed people as being at risk of being deprived of their liberty and had made applications for a number of people. The manager confirmed they were waiting for assessments to be carried out for those people identified as being at risk of being deprived of their liberty. Evidence in people's care records showed that restrictions in people's care were not being reviewed by the provider to ensure they were less restrictive. This meant people were at risk of not having their rights upheld in relation to restrictive care practices.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination.

People had a mixed experience of mealtimes. Due to a lack of staff to support people, some people had to wait for some time with their food in front of them before staff were able to assist them. For example, one person was given their hot meal, and it was nine minutes before staff were free to support them to eat. Another person sat at the table for over thirty minutes without food, and with no interaction from staff. This meant some people were not consistently supported to eat in a timely way. Two other people, who needed assistance to eat, were supported by a staff member who sat between them, taking turns for offer each person food. On several occasions, we saw staff supporting people to eat, stop this activity and leave the

table without any explanation to enable people to understand what was happening. A fifth person was clearly communicating they did not wish to be sat at a table, and they did not want the food options offered to them. Staff kept gently guiding them back to their seat and offering more food, despite the person saying, "No." This was not respectful of the person's choices.

People said they liked the food and were offered choices. One person said, "You can have a choice," and their relative confirmed, "They're asked every day. They do it [food choices] bespokely. It's always a well-balanced diet." We saw how people were supported at lunchtime to eat and drink. We noted there was no information about meal options on the menu board, but people and staff confirmed choices were offered for each meal. People were offered regular drinks and snacks throughout the day. People who needed adapted cutlery and equipment to enable them to eat and drink independently were given these. People who were at risk of not having enough food or drinks were assessed and monitored, and advice sought from external health professionals. Guidance about people's individual assessed needs was available to staff, including catering staff. Staff knew who needed additional support to eat or had special diets, for example, fortified diets or appropriately textured food and thickened drinks. However, people's care plans did not always contain information about people's food preferences. There was no evidence that people were involved in planning meals, or that their views were sought about the quality of food, drinks and the dining experience. People were supported to have sufficient to eat and drink, but mealtime experiences were not always enjoyable for people.

Adbolton Hall was inspected on 14 February 2018 in relation to food safety. The local authority responsible for doing this gave a rating of five stars, and said the management of food safety was very good.

People's needs were not fully met by the adaptation, design or decoration of Adbolton Hall. We noted a lack of consistent signs throughout the building to assist people, relatives and visitors to orientate themselves. This meant there was a risk people would not be able to find their own bedrooms without assistance. There were several areas in the building where the floor sloped up or down. There were signs to say the floor was sloped, but these were not clearly sited before the slope. There was a risk that people with health conditions affecting their vision would fall in these areas. No showers were available for people living at the service, despite evidence that staff had raised this as a need in March 2017. Staff meeting minutes from 6 March 2017 noted staff had been asking about having showers or a wet room, "For several years now." This meant people did not have a choice in relation to having baths or showers. Whilst staff told us people had access to the garden, we noted that the design of the ramp and footpath would discourage people and relatives from doing this independently. The manager and provider told us they were in the process of having the building refurbished, and we could see where work was taking place. However, at the time of the inspection, the building did not meet the needs of people living there.

Relatives spoke positively about the skills staff had. One relative said, "They all know what to do. There are a number of staff who have been here consistently and they know [my family member] really well and know how to look after them." All staff had a probationary period before being employed permanently. Staff told us they felt their induction gave them the skills to be able to meet people's needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to. The provider had an induction for new staff which included training and shadowing colleagues. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensures nurses maintain their nursing practice and keep up to date with skills training. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse.

Staff told us and evidence showed they kept daily records of key events relating to people's care. Information about people's care was recorded and staff shared information with colleagues throughout the day and at shift handover. This meant that staff knew what action was needed to ensure people received care they needed. The provider held meetings for staff to discuss information relating to people's care. Staff also had individual meetings with their supervisor to discuss their work performance, training and development.

Requires Improvement

Is the service caring?

Our findings

People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. There was no evidence that the provider had considered people's different communication needs in order to ensure people could participate in daily life in the service. There was a risk people's own communication styles and needs were not understood, and therefore their ability to express themselves would be affected.

Daily records of people's care used language which was not person-centred and demonstrated a task-focused approach. Language used in records sometimes reflected judgements about people's behaviours, which did not demonstrate respect or understanding about people's underlying health conditions. For example, one person's daily care records contained subjective phrases like, "Usual obstructive behaviour," and "[The person was] extremely difficult early in evening." No other factual information was given about what the person was doing, and therefore there was a risk staff would not be able to accurately assess the meanings behind behaviour and non-verbal communication.

The provider had not ensured there were sufficient numbers of staff available to take the time to spend more meaningful time with each person, or to involve them and their relatives in reviewing and making decisions about care.

People did not always have care provided in a dignified or private way. For example, we saw people being supported to change medicine patches and have eye medicines whilst sitting with others at lunch. We also saw a person having their medicine given via PEG. This is a percutaneous endoscopic gastrostomy, a procedure in which a flexible tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus. The people receiving medicine via PEG or changing medicine patches have the right to have this done in private, as they may need to expose part of their bodies. We saw these activities were done whilst other people and relatives were present, and this was not respectful of people's privacy and dignity.

People and relatives spoke warmly about the staff who supported them. One person commented about a particular staff member, "She's very good. Really nice – treats everyone the same." A relative said, "[Staff member] is absolutely lovely. They are [my family member's] favourite, and they're very good with [my family member]." During our inspection, we saw staff supported people in a caring way. Staff spoke respectfully with people, and there was a lot of good humoured interaction with people. Staff knew people well, calling them by their preferred names, and were knowledgeable about people's preferences. They ensured people were comfortable and, where possible, took time to explain what was happening around them in a patient and reassuring manner. Where they were able to do so, staff spent time with people who appeared anxious or agitated, and we saw this had positive effects.

Staff respected people's right to confidentiality, but were also clear when it was appropriate to share information about risk or concerns. We saw staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care discreetly or in private. Records relating to people's

care were not always stored securely. For example, we found filing cabinets containing records relating to care were not locked. These were accessible to people, relatives and visitors. We raised this with staff who took action immediately to ensure information about people's care was secure. People's confidentiality was respected.

People were supported to spend private time with their friends and family if they wished. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right to private and family lives were respected.

Requires Improvement

Is the service responsive?

Our findings

People's care was not personalised to meet their individual needs. People were not supported to participate in designing or reviewing their care. Two people confirmed they had not had any input into writing or reviewing their plans of care. The provider had not ensured information about people's care was given to them in an accessible way, for example, if people needed information about their care in large print, or an easy-read format. It was unclear how relatives participated in reviewing people's care. One relative said, "I didn't help with the care plan. I don't have any rights with [family member's] care." Records we reviewed did not always contain information about people's views and preferences for how their care was provided. There was a risk people's needs based on their protected equality characteristics or their values and beliefs were not recognised and met.

Staff told us, and we saw people were supported to express their views and wishes about their daily lives, but this was not evidenced in care records. For people who were less able to communicate verbally, there was no evidence how staff sought their views, wishes and aspirations. For people who found verbal communication difficult, there was no evidence the provider had considered other ways of promoting effective communication. This meant people's views about their care were not heard and acted on, and the provider did not ensure people's autonomy and independence was enhanced.

Records of reviews of people's care were focused on how staff felt care had been, and did not include the views of people or their relatives. The manager confirmed that people and relatives were not routinely involved in reviews of care, and said the service planned to change this in future. However, at the time of our inspection, the provider could not demonstrate how people were involved in making decisions about their care. People's views, wishes and aspirations were not identified. This meant there was a risk people were not supported to have care in ways that were meaningful to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had mixed views about being supported to enjoy activities and hobbies. One person said, "We play games and things like that." Another person said they preferred to spend time in their room, saying, "I like the peace and quiet." However, they commented that staff did not often spend individual time with them other than in relation to specific care tasks. One relative said, "They [people] could do with more. [Family member] sleeps and eats; doesn't do a lot." Another relative said, "They do a lot of activities on weekdays, but there are no activities at weekends."

The provider employed staff to coordinate and facilitate activities at Adbolton Hall, and relatives were positive about this. We saw that each person had an assessment with staff in relation to their hobbies and interests, and what support they would need to take part in activities. The assessments identified both group and individual activities, and where appropriate, recorded information from relatives about people's past interests. From speaking with staff and watching activities, we identified that staff who were involved in providing personal care to people did not generally support people in relation to activities. This was

because there were not enough staff available to do this, and staff were focussed on ensuring people's basic care needs were met first. This meant there was a risk people were not able to take part in group activities if they needed additional support from staff.

People and relatives knew how to raise concerns or make a complaint. Information about this was available in the home. Complaints were managed in accordance with the provider's policy.

Inadequate

Is the service well-led?

Our findings

During this inspection we identified shortfalls across all of the key questions we ask about services. This included failures in safe care practices, insufficient staffing levels and concerns about staff training, planning and delivery of people's care.

Feedback from external organisations had not been acted on to improve the quality of care for people living at Adbolton Hall. For example, health professionals undertook a visit on 9 October 2017 in response to concerns raised about skin care. A number of recommendations were made to improve care, but we found action was not always being taken to reduce risks relating to people's skin care. The local authority's quality monitoring visit on 11 August 2017 had identified a range of areas where care needed to improve. For example, ensuring people and relatives were fully involved in the care planning process and reviewing of plans of care, and ensuring care plans were fully person centred. An external infection prevention and control audit was carried out on 6 November 2017 which identified action the provider needed to take to manage the risk of preventable infections. Feedback from Healthwatch had identified continued concerns about staffing levels, which had been identified at CQC's previous in section in January 2017. Despite feedback given to the provider from a range of external organisations in relation to the quality of care, the provider had not taken sufficient action to ensure people's care was safe.

Staff understood their roles and responsibilities, but the provider was unable to demonstrate staff were trained to provide care that was in accordance with the provider's policies. The provider could not assure themselves staff had training, skills and support needed to provide personal and nursing care to people safely and effectively.

Records relating to people's health and social care needs were not kept up to date and were not always stored securely. Audits carried out by the provider had failed to identify records were not accurate or contemporaneous, and no action had been taken to rectify this.

There were systems in place to monitor and review the quality of the service. The manager carried out checks of the quality and safety of people's care. However, these did not consistently identify issues where action needed to be taken. For example, an audit on 22 January 2018 stated the sharps bin (for the disposal of used needles for nursing procedures) was stored safely away from the public. On 8 February 2018, we saw a sharps bin which had a broken lid. The contents were accessible, and the bin was stored in an area accessible to people and visitors. A bedroom which we were told was ready for a person to move into was not of a suitable standard in relation to safety. The systems and processes in place to ensure care met legislative requirements were not effective.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager at the time of our inspection visit. 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. Adbolton Hall had not had a registered manager in post since 3 January 2017.

This was a breach of Section 33 of the Health and Social Care Act 2008.

The provider had not always notified CQC of significant events as they are legally required to do. For example, the manager told us there had been an outbreak of infection which had affected people at the service. We were also aware of an allegation that a person had been placed at risk of harm because they had been given a drink of unsafe consistency for them. We confirmed with the manager that we had not received a notification for these events. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care. We spoke with the manager about this, and received assurance that notifications would be made in future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and relatives felt the service was improving, and spoke positively about staff and the manager. One relative said, "Since the audit last year it's got a lot better; the decoration, the upkeep, the cleanliness." Another relative commented, "The new staff (manager and deputy manager) are really trying. It's a lot to get back and put right, but they are trying. Now the staff work together as a good team; it's much better." Staff spoke positively about their work and the support they received from the manager and from each other. The manager told us they had worked with the staff team to address a number of issues as a priority, including improving the management of infection prevention and control. We saw evidence that improvements had been made in the redecoration of parts of the service, and improving the standard and safety of equipment.

The provider was displaying their ratings from the previous inspection, both in the service and on their website, as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt able to raise concerns about the quality of care, but felt that, in the past, action would not always have been taken. Staff felt improvements were being made at Adbolton Hall in relation to concerns raised about the quality of care. For example, staff told us there were now additional staff available to ensure essential cleaning and domestic activities were carried out.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified CQC of significant events as they are legally required to do.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to consent to aspects of their care, the MCA was not consistently followed. The provider could not consistently demonstrate how people and their relatives' views were sought as part of best interest decision making. This meant people were at risk of not having their rights upheld in relation to consent to care. Restrictions in people's care were not being reviewed to ensure they were less restrictive. People were at risk of not having their rights upheld in relation to restrictive care practices.