Mr & Mrs G Watson

Abbotsfield Hall Nursing Home

Inspection report

Abbotsfield
Tavistock
Devon
PL19 8EZ

Tel: 01822613973

Date of inspection visit:
28 September 2020
08 October 2020
15 October 2020

Date of publication:
03 March 2021

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
Abbotsfield Hall Nursing Home (hereafter referred to as Abbotsfield) is a nursing home providing personal and nursing care to 22 people aged 65 and over at the time of the inspection. The service is registered to support up to 28 people and supports older people, some of whom have nursing needs and some of whom are living with a dementia. The service is located in Tavistock in Devon and is a building over three floors set in its own grounds. The service has a lift, chair lifts, a separate dining room and two communal lounges.

People's experience of using this service and what we found
Prior to this inspection we received information of concern regarding the safe care and treatment of people and we decided to inspect. The local safeguarding authority placed the service in to the whole home safeguarding process as there were significant safeguarding concerns. Investigations in to safeguarding allegations were ongoing during our inspection. Due to the quality concerns raised, the local authority provided support to the service from Devon's quality in care homes team. The provider also voluntarily suspended further placements in to the service as a way to mitigate further risk.

People told us they felt safe. However, we found several allegations of abuse had not been actioned appropriately, reported to the local safeguarding authority or notified to us. Although staff had completed safeguarding training, there was a failure on the part of the provider and registered manager to put systems in place. This meant some people experienced improper care and treatment.

Improvements were needed to the way medicines were managed. Some risks people faced in relation to their needs were not assessed. For several people, records relating to risk, incidents and care planning were out of date, had not been completed or had key information missing. Some risks that had been identified did not have clear instruction for staff on how to support people with that risk. This placed people at risk of not having safe care and treatment.

Systems and processes were not robust to check care delivery was safe, of high quality and consistent. Records to show care delivery were often poorly filled out. There was a lack of accountability from service leadership for the failure to complete audits in key areas such as infection control and care planning.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service needed to be reviewed. Systems and processes to protect people and their rights were not always robust.

We saw some evidence to suggest there were not enough staff on shift or they were not deployed effectively during the shift to ensure people's needs were met. Staff were not always recruited safely, and some information was missing from recruitment files that was important in checking whether potential staff were suitable to work with people who might be vulnerable.

Staff told us they felt supported. However, we found formal supervisions were not taking place and interactions with staff where support was offered were often not recorded. Feedback we received about staff was that they were kind and caring and "did their best."

Feedback from professionals was that some positive health outcomes were being achieved for people living in the service and care staff were willing to learn. People and relatives gave positive feedback about staff and the care their loved one was receiving.

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 good (published 27 September 2018).

Why we inspected
We received information in relation to the management of safeguarding concerns and the culture of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We 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 COVID-19 and other infection outbreaks effectively.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this 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 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 breaches in relation to safeguarding, safe care and treatment, staffing, recruitment, good governance and making notifications to us.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 act 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Abbotsfield Hall Nursing 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 team consisted of one inspector, one assistant inspector and one medicines inspector who visited the service. One further inspector supported the inspection remotely.

Service and service type
Abbotsfield Hall Nursing 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 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 on the first day. The second and third days were announced.

What we did before 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. During the site visit we spoke with the two providers, the registered manager, administration manager and a nurse. We spoke with other staff in passing but contacted fifteen staff for feedback after the site visit. We received feedback from five of these staff. 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 reviewed a range of records. This included five people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, and audits were reviewed.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found. We requested several documents to be emailed to the inspection team as some of the inspection was conducted remotely. Not all of these documents arrived. We requested feedback from 13 professionals who have worked with the service and received it from five. We contacted 15 relatives and received feedback from six.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from avoidable harm or abuse. There was no system for reporting safeguarding concerns externally to the safeguarding authority or CQC. Staff had reported the behaviours of some staff were not caring or safe. The registered manager and provider were aware of these allegations and failed to take appropriate action. This was in contravention of the service's safeguarding policy and the duty of the service, registered manager and provider to keep people safe. This meant people suffered avoidable psychological and physical abuse and neglect.
- We had concerns during the inspection that some people were being exposed to improper treatment. This included food that was not moistened, and a person that was not monitored when they were at high risk of falling. The inspection team intervened several times during the inspection by alerting the registered manager to these risks and asking them to take appropriate action. We made three safeguarding referrals to the local authority during the inspection.
- Staff had completed mandatory training around safeguarding adults and told us they knew how to report concerns to the registered manager. However, these concerns were not always reported to the registered manager or the local safeguarding authority by staff when they were made aware of them.

The service failed to protect people from abuse and improper treatment. Safeguarding systems and processes were not effective and people experienced care and treatment that was degrading and neglectful in some cases. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Risk information was inconsistent across records. For example, the registered manager told us of a choking risk that was not recorded in a person's care plan or risk assessment and was not being monitored.
- There were not always risk management plans or risk monitoring processes in place for risks that people faced. For example, one person had been identified as having heightened and distressed behaviours that resulted in them sometimes being physically aggressive with staff. The registered manager told us any incidents of aggression should be recorded and a behaviour chart should be in place. We found there was not a tool for monitoring or recording this person's heightened behaviours, or a plan in place to manage the risk to staff and others. There was no analysing or identifying trends in their behaviour. This meant staff did not have an overview of this person's behaviour to inform whether they needed to refer to an external professional or not.
- We found that some people were experiencing falls. However, opportunities to identify risk through robust processes and analysis had been missed. Accident form details were transferred on to a log but not assessed for learning. The registered manager said, "I usually note down any trends or if any further action is needed

on the form at the bottom, but I have not done this for a while." This had not been completed for any month in 2020.
● Personal Emergency Evacuation Plans (PEEPs) were in place for each person living in the service. However, fire drills had not been completed since 2019. In the event of an emergency people and staff had not practised evacuating the premises. This placed the service at risk of being unprepared for evacuation.
● Risk assessments relating to the covid pandemic were not person centred or tailored specifically to the needs of staff or people living in the service. There were blanket assessments the service had prepared which failed to detail individual risks people faced.
● Most medicines were stored securely. However, medicines needing cold storage in a refrigerator, were not always regularly monitored. Temperatures had not been recorded for a period of ten days in September 2020. The registered manager told us the refrigerator had been replaced during this period. However, it means it was not possible to be sure the medicines had been stored at the correct temperature and were safe and effective to use.
● Thickening powders were being stored in an unlocked cupboard. The registered manager told us the lock on the cupboard was broken and would be fixed. On day one of the inspection we saw thickening powders had been left out in a public area. This is not safe practice as they can be harmful.
● Where medicines were given covertly, a mental capacity assessment and best interest decision had been taken. However, if pharmacy advice had been taken on how best to give these medicines, or other medicines being crushed or mixed with food to help administration, this had not always been recorded. The covert medicines plan did not include all the medicines it was important for the person to take. The registered manager informed us during the inspection that a review with the GP had been arranged for the following day.
● Where medicines were prescribed 'when required' there were no protocols or person-centred guidance for staff on when it would be appropriate to give doses of these medicines. For two people prescribed a sedative medicine when required, there was information in their care plan about how to help with anxiety or agitation but no mention of the medicines that had been prescribed. This meant it was not always possible to be sure the medicines were being used in the way intended by the prescriber.
● Regular medicines audits were completed. However, the areas for improvement mentioned above had not been picked up by these audits.

Risks regarding safe care and treatment were not always assessed or mitigated. Medicines were not always managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People could be supported to look after their own medicines. Policies and a risk assessment process was in place to make sure this was safe for them.
● There were suitable arrangements for medicines requiring extra security and recording.
● Medicines were administered by nurses and the manager told us refresher training was being arranged for them. There was no formal process of assessing and recording competencies to check they were administering medicines safely.
● There was a system in place for recording the application of creams and external preparations. Directions and body maps were available to guide staff how to use these preparations. We checked four people's charts and saw staff had recorded when these products were applied. However, for one person, we saw there were no records to show preparations had been applied as prescribed. This was put in place during the inspection.

Staffing and recruitment
● People said, "They do struggle to get the girls in sometimes, so we do have to wait", "At night there aren't

enough [staff]", and "I feel safe but there aren't enough staff." One person told us they had to use their continence pad instead of using the commode as staff took so long to respond to their call bell.
● A relative told us, "There could always be more staff. On our visits I have had on occasions had to find a nurse /carer for one of the other in patients when their call was not answered."
● When we asked staff if there were enough of them on shift, they said, "Most of the time" and "don't have time to cut nails and sometimes residents miss out on their shower/bath." Staff fed back they worked hard but were under pressure due to some staff leaving recently, and extra support during meal times would be helpful.
● On the first unannounced day of our inspection we struggled to find care staff when a person was at risk of falling in the main communal lounge. Fifteen minutes went by where no staff entered the lounge. One person had been identified as requiring one to one staffing to help prevent their falls. We asked where one of the four care staff were to support the person and were told two of them were on a break. This left two care staff to support every person in the service.
● The registered manager identified there were 12 people who required the support of two staff to have personal care or mobilise. They explained sometimes the administration staff, kitchen staff or domestic staff who had all completed mandatory care training, were needed to support people as they were short staffed.
● Staff were not having regular supervision to support their learning, development and ensure they understood what safe, quality care looked like. Out of the five staff files we looked at only two contained supervision records, and the latest record showed meetings took place in 2018. The registered manager also confirmed they had never had a supervision meeting since they started working for the provider.
● We asked the registered manager about supervision of staff and they said, "Staff are not having supervision very often at all here. I wanted it every 12 weeks, but it hasn't worked" and, "I offer extra support every now and then, but nothing structured ever really." Staff confirmed they were not having regular recorded supervision.

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

● Recruitment processes were not always robust. References were not always sought effectively to establish good character. Employment history was not always recorded in line with guidance available to providers on our website. The impact of failures in recruitment processes and auditing of these processes, was that staff were employed without full checks to ensure they were safe to work with people who might be vulnerable.

Recruitment processes were not established and operated effectively. This was a breach of regulation 19 (Recruitment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured 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 using PPE effectively and safely.
● 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.
● We were not assured that the provider's infection prevention and control policy was up to date. It was

three months overdue for review. Infection and prevention and control audits had not been completed since July 2020. We have signposted the provider to resources to develop their approach.

We recommend the provider and registered manager seek support from local infection control professionals to ensure their processes are robust.

Learning lessons when things go wrong

- There was a blame culture in the leadership of the service which affected the ability of the service to learn when things went wrong.
- The registered manager told us they had failed to make notifications and report safeguarding concerns but did not take accountability for the wider safe running of the service.
- We did not find or receive evidence or records, after asking for it, to demonstrate where lessons had been learned and how this was communicated to staff.

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 good. At this inspection this key question has now deteriorated to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of insight from the registered manager about how they were not meeting regulatory requirements. For example, the failure to make safeguarding referrals showed a lack of awareness of a duty to report safeguarding concerns so they could be overseen by an external authority as they should be.
- Risks were increased due to the lack of quality checks and documents were often incomplete. Information in care plans was out of date, some risk information was missing, guidance was not in place for staff on how to support people, and patterns in risk behaviour were not being monitored. The registered manager did not have oversight of the risks people faced, they sometimes gave us conflicting information about risks and their management and was not aware of all of the concerns we identified during the inspection.
- Documents recording how and when assessed risks were being mitigated were not being completed consistently. For example, for one person who had a grade three pressure ulcer, their mattress pressure was not being recorded as checked daily as required. Over a period of 57 days only eight checks had been recorded. This may have placed the person at further risk of their skin integrity breaking down.
- Environmental risks were not consistently monitored or recorded. For example, checks for water temperatures, window restrictions, and safety aspects of people's rooms and the communal areas were not consistently recorded. This meant environmental hazards may not have been picked up.
- Quality assurance systems were either not in place or not operated effectively. For example, infection control audits had not taken place since July 2020, this was particularly concerning due to the risks associated with the coronavirus pandemic. Key policies around fundamental standards of care were out of date, and important aspects of safety such as room checks and care plan checks had not been completed, recorded or audited since March 2020. The registered manager said, "I used to do manager's walkaround on a Friday afternoon when I used to check charts, it all stopped in March."
- We asked the registered manager why quality processes were not in place. They said, "Audits of care plans not done since February because the nurse left, then there was covid and I hadn't got anyone to help me to do everything", "Audits, I try and do a lot of audits, but it doesn't always happen." The registered manager had not made the provider aware that quality and risk checks regarding care delivery were not being completed. The provider did not have a system in place for ensuring risk and quality were being managed safely and appropriately.
- We found the service was in a state of reacting to situations and "fighting fires" rather than reflecting on quality and how they could improve care. Lack of staffing in the right places and ineffective governance led to missed opportunities for learning and improvement.
- The providers and the registered manager were not aware of their accountability in the failings in the

service. This led to a closed culture of blame, where abuse went unreported outside of the service and was not dealt with effectively. A lack of effective governance systems meant people's safety and well-being were not placed at the centre of the service by the leadership team. There were not efforts to improve their governance or auditing practises and we had to explain how these could be improved.

This evidence constitutes a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were repeated failures to notify the CQQ of events which we are required to be notified of by law. For example, multiple allegations of abuse were not notified to us. The provider also did not notify us of an absence of the registered manager for more than 28 days.
● The registered manager said they thought they could manage the situation themselves.
● At the time of writing this report notifications regarding historical allegations and incidents had still not been made, despite the registered manager being signposted to our website several times throughout the inspection process. There was a failure also to send in a notification of the new safeguarding concerns we highlighted during the inspection.

This was a breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009.

● Notifications regarding when a person has passed away have been sent to the commission as required.

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
● The registered manager said people who had been subject to alleged abuse had not been apologised to. We prompted the registered manager to ensure people knew what action had been taken and for an apology to be considered.
● The provider said they did not want to scare people when the manager was absent from work. This information was knowingly kept from people living in the service.

We recommend the provider and registered manager familiarise themselves with the duty of candour and ensure they are upholding their duty of candour.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us they felt supported and were all complimentary of the registered manager. One staff said, "We weren't working all together before but now we are working as a team."
● Relatives gave positive feedback on how they were engaged and the service in general. They said, "All of the staff are unfailingly friendly, attentive and helpful to residents and visitors. The residents are at ease and very well cared for."
● We received feedback from external professionals that staff had provided good wound care to a person whose pressure ulcer was healing. This was a positive health outcome for this person and showed staff were following professional advice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives gave us positive feedback about being kept up to date with changes in the service. One relative said, "During the covid period we have been notified regularly of what changes they are putting in place and what to expect if we visit."

● Prior to March 2020 the service held "residents and relatives' meetings" where people's views were gathered and collated and put on a display board in a communal area. We saw evidence that people's suggestions had been taken on board and implemented.

Continuous learning and improving care; Working in partnership with others

● We discussed with the registered manager ways they could stay up to date with best practise and reflect on care practice in the service. Several times throughout the inspection we signposted them to the CQC website, local authority support, NICE guidance and emphasised the importance of having clinical supervision.

● Professionals we spoke with said staff seemed eager to learn, communication was good, but "The governance requires improvement."

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Registration Regulations 2009 Notifications How the regulation was not being met: Notifications were not being made to the commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA RA Regulations 2014 Recruitment How the regulation was not being met: Robust recruitment processes were not taking place

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risks associated with people's care and treatment were not always assessed or mitigated. Medicines were not always managed safely. Regulation 12

The enforcement action we took:

Conditions have been placed on the provider and manager's registrations with CQC. They need to report to us on a monthly basis how they are meeting the conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding How the regulation was not being met: Safeguarding concerns were not raised with the local safeguarding authority or investigated thoroughly People were subject to degrading abuse that was avoidable

The enforcement action we took:

Conditions have been placed on the provider and manager's registrations with CQC. They need to report to us on a monthly basis how they are meeting the conditions.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Records were incomplete, missing or not contemporaneous Systems and processes to ensure the safe management and mitigation of risks were not robust

The enforcement action we took:

Conditions have been placed on the provider and manager's registrations with CQC. They need to report to us on a monthly basis how they are meeting the conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: There were not adequate numbers of staff deployed to meet the needs of people Staff were not suitably supported for their role, supervisions were not taking place

The enforcement action we took:

Conditions have been placed on the provider and manager's registrations with CQC. They need to report to us on a monthly basis how they are meeting the conditions.