Bupa Care Homes (CFHCare) Limited

Abbotsleigh Mews Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Abbotsleigh Mews Care Home is a care home that accommodates 120 people living with dementia, sensory impairment or a physical disability across four separate houses, each of which has separate adapted facilities. There were 115 people using the service at the time of our inspection.

People's experience of using this service and what we found
Staff were not always deployed effectively. People and their relatives gave us a mixed response about call bell response times. Risks to people were not always managed effectively. Medicines were not always managed safely. The quality assurance system was not robust, as the provider had not always identified some of the issues we found at this inspection or acted upon them in a timely manner.

The provider carried out comprehensive background checks of staff before they started work.
Staff kept the premises clean and safe. The provider had a system to manage accidents and incidents to reduce the likelihood of them happening again.

There were procedures to reduce risk from any visitors to the home spreading infection at the entrance to the premises. Essential care givers (ECG) and other visitors were supported to follow the government's guidance on visiting, hand washing, sanitising, wearing personal protective equipment (PPE), temperature checks, and social distancing whilst on the premises. We observed staff wearing appropriate PPE, and the home was clean throughout.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. There was a clear management structure in place and staff were aware of the roles of the management team.

During this inspection we carried out a separate thematic probe, which asked questions of the provider, people and their relatives, about the quality of oral health care support and access to dentists, for people living in the care home. This was to follow up on the findings and recommendations from our national report on oral healthcare in care homes that was published in 2019 called 'Smiling Matters'. We will publish a follow up report to the 2019 'Smiling Matters' report, with up to date findings and recommendations about oral health, in due course.

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 December 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made in relation to infection prevention and control. However, at this inspection we found the provider remained in breach of regulations in other aspects. The service remains rated requires improvement.

At our last comprehensive inspection on 13 and 16 September 2019, we recommended that the provider always continues to monitor the overall dining experience of people and consider maintaining staffing levels in response to their changing needs. We further recommended the provider continue to monitor and seek advice from a reputable source on best practice to reduce the risk of falls and act accordingly. At this inspection we found issues with falls management persisted.

Why we inspected
We received concerns in relation to the management of risk of choking, falls and safeguarding people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, risk management and quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Abbotsleigh Mews Care Home

Detailed findings

Background to this inspection

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

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 service was inspected by two inspectors, a specialist advisor, and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is in older people. One inspector and a pharmacist specialist returned to the service on the second day, and an Expert by Experience carried out phone calls to people's relatives to complete the inspection.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post. However, the registered manager was on long leave and interim management cover arrangements were in pace.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at all the information we had about the service. This included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also used information the provider sent us in the Provider Information Return. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspection. We also contacted the local authority to gain their views about the home. We used this information to help inform our inspection planning.

During the inspection
During the inspection, we spoke with eight people and 14 relatives to seek their views about the service. We also spoke with 12 members of staff including, the activities coordinator, the manager, the deputy manager, the regional director and a visiting professional. We reviewed a range of records. This included 12 people's care plans, risk assessments and medicines records. We reviewed five staff files in relation to recruitment, induction, training and supervision. We carried out mealtime observations and observations in communal areas. We also reviewed records relating to the management of the service which included policies and procedures, health and safety checks, cleaning schedules, accidents and incidents, surveys, minutes of meetings and various quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last comprehensive inspection on 13 and 16 September 2019, we recommend the provider continue to monitor and seek advice from a reputable source on best practice to reduce the risk of falls and act accordingly.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risk management plans were not robust to mitigate potential risks to people. For example, one person's risk management plan was not detailed in relation to their diet and was inconsistent with the International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines, which are about providing food safely for people with swallowing difficulties.
● There were systems to ensure people's dietary needs were met. However, we found there were no effective reminders or visual prompts in the kitchen for staff, regarding who needed modified food but how many people required in each of the four houses. Therefore, there was a risk that agency or new staff may overlook the risk and provide foods that increase risk of choking.
● Staff were unable to give modified food information upon request. For example, a care worker was unable to explain how they knew what consistency food people needed to eat safely.
● Speech and Language Therapist (SALT) dysphagia (swallowing difficulties) assessment referrals were not made in a timely manner. For example, one person's choking risk assessment identified significant deterioration on 07/05/2022 taking their risk of choking from low (score 5) to a high (score 22). Despite having identified as at high risk of choking, we found a SALT referral was not made.
● Staff were not attentive during and after mealtimes. For example, one person, returned from a hospital admission with eating and drinking guidance following a SALT assessment. SALT guidance stipulated full assistance and supervision required at mealtime and that this person must be upright and alert. During mealtime observation, we found this person's posture was severely hunched forward and they did not receive full assistance and supervision.
● We saw some people fell asleep when eating and did not receive support from staff to maintain level of arousal for safe eating.
● Risk management plans for falls were not robust enough to mitigate potential risks to people. For example, one person was identified as at high risk of falls on 25/01/2022 and reviewed on 27/04/2022. Their care plan was reviewed and updated on 20/03/2022 to reflect this person now had bed rails in place to reduce risk of injury if they were to roll from the bed. However, there were no bedrails in place but a crash

mattress and a medium sling in their bedroom. The nurse on duty told us, "The care plan needs updating, does not have bed rails, but has crash mattress."
● Staff were not attentive in communal areas. We saw one person at several points lurching forward in their chair. We alerted staff to this and as a result staff promptly assisted the person to their room to sleep.

We found no evidence that people had been harmed. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last comprehensive inspection on 13 and 16 September 2019, we recommend the provider always continues to monitor the overall dining experience of people in Calvin House (one of the four houses) and consider maintaining staffing levels in response to their changing needs.

Not enough improvement had been made at this inspection and the provider was in breach of regulation 18.

● Staff were not always deployed effectively. We received a mixed response from people about call bell response times. For example, one person told us, "It's a fact that I have waited up to 20 minutes and that's not nice." Another person said, "I do get a bit annoyed when I get uncomfortable in bed because they've taken a long time to come and turn me, may be three to four hours. I got bit angry once and the carer said; 'There are 93 others here; you're not the only one." However, a third person commented, "I feel secure, they check on me every hour. If I've been moved to the lounge, someone will keep checking on me."
● We received mixed feedback from relatives of people. Some relatives told us their family members were not always promptly supported when they needed help. A relative commented, "I have more than once arrived and heard my husband calling down the corridor for a nurse. How long has he been waiting? I know [name] doesn't constantly shout out. It's only when [name] needs help and it would help him even if they [staff] popped in and said they would be back. The reason for all this is because [name] can't get their buzzer. Due to health conditions can only see and reach on the right side and sometimes carers are not leaving it on that side." Another relative said, "My Mum gets concerned when staff are late in giving her eye drops. Being late seems to be a regular thing. There seems to be a shortage of staff during mealtimes. My mother is concerned about the number of staff at night-time, there are very few around." However, a third relative said, "There are enough staff around."
● Call bells were not always responded to in a timely manner. We looked at the weekly call bell analysis record for the period from 01/10/2021 to 05/05/2022 and found there were 274 incidents of call time responses that were over and above from eight minutes and up to 134 minutes delayed. The reasons for delayed response were recorded by the deputy manager for each of the delayed response were as follows; Attending other residents/staff with residents, only two staff working/only two staff both with residents, only three staff on, only two staff on and one agency, understaffed, agency staff working, staff handover time and mealtime.
● Delayed call bell response times were not analysed to understand the patterns and trends and to put in place remedial measures. The regional support manager told us, "We have call bell analysis done weekly, and if the response time is over eight minutes reasons are recorded and these reasons are reviewed by the regional director or the regional support manager and if people had to wait over 15 minutes; staff training, supervision and disciplinary was considered. No such incident has happened in the last four weeks." However, we found for the period 01/04/2022 to 05/05/2022 there were 49 incidents of call bells that were responded to after eight minutes; of which, nine of them were responded to after over 15 minutes. When asked, the regional support manager told us, they have not reviewed the call bells response time as yet.

● The staff dependency assessment process was not robust. The regional support manager told us, there was a staff dependency tool and we were given a copy of this by the deputy manager. Most people were identified as requiring three care hours a day. It was not clear how these care hours had been arrived at.
● We brought these concerns to the attention of the regional director, regional support manager (current manager). They told us they would review the staff dependency tool and revisit staff deployment and arrange suitable numbers of qualified staff for day and night shifts.

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

● Robust recruitment procedures were in place. Staff recruitment records included completed application forms, applicant's full employment history, employment references, Disclosure and Baring Service (DBS) checks, health declarations and proof of identification. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Using medicines safely
● Medicines were not always managed safely. One person had not received their prescribed medicine for over three weeks. The medicine was dispensed by the pharmacist on 06/05/2022 but not yet administered by the time we visited on 23/05/2022. We highlighted this to staff and were informed that they had a problem arranging for a district nurse to visit for the administration of the medicine. We further noted that an initial referral was made to the district nurse to take a swab on 29/04/2022 which also took some time to organise.
● Medicines including controlled drugs were stored safely and securely.
● Protocols were in place for medicines prescribed on when required basis to enable staff to give these medicines consistently.
● We saw evidence that people who administers medicines had appropriate training. Registered nurses who administer medicines also underwent training as part of their professional revalidation.

Preventing and controlling infection
At our last targeted inspection on 13 November 2020, we found there were serious infection risks people were exposed to and this had an impact on their safety and wellbeing. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to serious infection risks to people.

● The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 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..

Visiting in care homes
The provider had visiting arrangements in place that was in line with the government guidance and the manager ensured all visitors followed it. The provider screened all visitors to the home for symptoms of acute respiratory infection before they could enter the home. Visitors were supported to follow the government's guidance on hand washing, sanitising, wearing personal protective equipment (PPE), temperature checks, social distancing, and were not allowed to go into any other areas that is not designated for their visiting whilst on the premises. The essential care givers (ECG) were able to meet people in their bedroom and the other visitors in designated pods.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. People and their relatives told us people were safe and that staff treated people well. One person told us, "Overall I feel safe; there is nothing I worry about." "They [staff] hoist my [loved one] perfectly reasonably." Another relative commented, "Yes, my [Loved one] is safe here."
● The provider had policy and procedures in place to protect people from the risk of abuse. Staff had completed safeguarding training and understood the different types of abuse and the signs to look out for. They were clear about their responsibilities to report any concerns to their line manager.
● Safeguarding concerns had been raised, the provider worked effectively with local authorities and health and social care professionals, to address concerns and they notified the CQC of these as they were required.

Learning lessons when things go wrong
● There were systems and processes in place to manage and follow up on accidents and incidents.
● Staff knew how to report accidents, incidents and concerns and records showed they had taken appropriate actions in response when required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Requires Improvement

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last targeted inspection on 13 November 2020 we found systems were either not in place or robust enough to ensure people were protected from the risk of catching and spreading infection. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17, in relation to infection prevention control, which is reported under the safe domain. However, not enough improvement had been made at this inspection in relation to various other aspects of quality assurance and governance and the provider was in continuous breach of regulation 17.

- The provider did not have an effective oversight of the service. The quality assurance system and processes had failed to identify and correct issues we found at the inspection.
- Monthly medicines audits were routinely carried out, although this did not pick out the issues, we raised about medicines administration delay.
- Eating and drinking risk management plans were not always robust. Speech and language therapist (SALT) dysphagia assessment referrals were not followed up in a timely manner to mitigate risk of choking.
- Falls risk management plans were not always effective.
- The leadership team was unable to provide information on how the staffing levels were calculated or reviewed.
- Monthly operational assurance audit dated 26/04/2022 looked at weekly call bell analysis and recorded as "Pass" without any analysis of trends and patterns about how to mitigate delayed call bells response time.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found some good practice with quality assurance. The provider undertook regular audits. These audits covered areas such as infection prevention and control, night care, nutrition, wellbeing, health and safety, and staff recruitment checks.

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

● People gave a mixed response about how the service was run and the support they received. One person told us, "Over the past four years the place has changed. The carers have lost their spark. They used to sing and dance with us, but that has stopped. The weekends are dull with little to do and I'm stuck inside. Why can't they let us out in the gardens more? It's only the 'activity girl' who takes us out one at a time. All we want is a simple walk around." Another person said, "I complain about the food with little improvement. By the time it gets to my room it's cold, I send it back and I know it's been put in a microwave. I had a tummy upset and I'm sure it's because a meal was warmed up again." However, a third person commented, "I have no complaints. I've made friends here and I am so comfortable."

● Relatives of people who used the service gave a mixed feedback about how the service was managed. One relative told us, "My only complaint is that [my loved one] is not getting showered enough. They [staff] strip wash him, but my [loved one] only had one shower in the last two weeks." Another relative said, "I feel the management should work on improving the attitude of agency staff who come here. They just don't have the compassion of regular staff." A third relative commented, "The place seems to run well and they[staff] are friendly."

● The provider sought people's views using satisfaction surveys and residents and relatives' meetings. Although the 2021 satisfaction survey responses received were below the considered percentage for a statistical analysis, staff had acted to make improvements where people had made suggestions, for example, in relation to indoor and outdoor activities.

● The manager held regular meetings with staff where they shared learning and good practice, so they understood what was expected of them at all levels.

● Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health and social care professionals, and any changes or developments within the service.

● Staff also discussed the changes to people's needs during the daily shift handover meeting to ensure continuity of care.

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 service had a registered manager in post; however, they were on an extended leave. The provider had made interim arrangements to manage the home, and the current manager demonstrated knowledge of people's needs and the needs of the staffing team.

● There was a duty of candour policy and the manager understood their roles and responsibilities. Staff were encouraged to report all accidents, incidents or near misses and to be open and honest if something went wrong.

Continuous learning and improving care

● The senior management and the current manager demonstrated a willingness to provide good quality care to people. They continued making improvements following feedback from people, and health and social care professionals. For example, around infection prevention and control and falls management.

Working in partnership with others

● The senior management team and the manager were committed to working in partnership with other agencies and services to promote the service and to achieve positive outcomes for people.

● They continued working closely with local authority commissioners and healthcare professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always appropriately assessed and managed safely.

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 The quality assessment system and processes in place were not always effective.

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 Staff were not always deployed sufficiently to meet people's needs.