Mr Jayendra J and Mrs Lata J Patel

Abbotsfield Residential 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 effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out this unannounced inspection on 13 February 2015. We last inspected this service in May 2013. At that inspection we found the provider was meeting all of the regulations that we assessed.

Abbotsfield Residential Care Home provides accommodation and personal care for up to 30 older people and people living with dementia. The home is a large period property, set in its own grounds, which has been adapted for its present use. Accommodation is provided on the ground and first floor of the building.

There is a main stair lift and two smaller chair lifts linking the accommodation on the ground and upper floors. There were 21 people living in the home at the time of our inspection.

There was a registered manager employed at the home. 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.

Summary of findings

Although people told us that they felt safe living in this home, we found that people were at risk because appropriate systems were not in place to deal with foreseeable emergencies. At our inspection we found that care staff did not have information about how to move individuals to safety in the event of a fire. We also found that equipment was not available to assist a person to be moved safely if they fell in a room on the first floor of the home.

We found that action was not always taken to ensure people's privacy and dignity were protected. We saw that one person had experienced support that did not maintain their dignity and we also observed that a staff member entered a toilet while a person was using it. People were not asked in a discreet way if they wanted to take their medication.

People were at risk of receiving unsafe or inappropriate care because some care plans did not have accurate and up to date information for staff about how to support people. We also found that people could not always be confident that they would receive the medicines they needed in a timely way.

Although the registered manager had systems to assess the quality of the service we found that these were not effective. We found that improvements were required to the emergency procedures in the home, care planning, recording of risks and to the deployment of staff. We also found that care was not always delivered in a way that protected people's privacy and maintained their dignity. These issues had not been identified by the processes used to monitor the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to protecting people from risk in the event of foreseeable emergencies, people's privacy and dignity not being protected, care not being planned and delivered to ensure people received the support they needed and not monitoring the quality of service well enough. These corresponded to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Most people told us that they enjoyed the meals provided in the home. However, although people received enough to eat and drink, they were not always given choices of the food or drink they received.

Although we saw that care staff had the skills and knowledge to provide the support people needed, we found some training needed to be updated and was overdue.

People told us that there were enough staff to provide the support they needed. Staff had been trained in how to identify and report abuse and understood their responsibilities around protecting people.

Safe systems were used when new staff were employed to ensure that they were suitable to work in a care service.

People were supported to see their doctor and other health care service as they needed. This helped to maintain their good health.

People told us that the staff in the home were kind and treated them with respect. The staff spent time talking with people. We saw many positive interactions and saw that people enjoyed spending time with the care staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were at risk because appropriate systems were not in place to deal with foreseeable emergencies.

There were enough staff to provide the support people needed.

Safe systems were used when new staff were employed to ensure they were suitable to work in the home.

Requires Improvement

Is the service effective?
The service was not effective.

Although people received enough to eat and drink they were not always given choices of the food or drink they received.

Care staff had the skills and knowledge to provide the support people required. However some training needed to be repeated and was overdue.

The registered manager was knowledgeable about meeting the requirements of the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards, (DoLS). People's rights were respected because care was only provided with their agreement and consent.

Requires Improvement

Is the service caring?
The service was not caring.

Although people told us that they were well cared for, we saw that support was not always provided in a way that protected people's privacy and dignity.

People were asked for their views about their care and were included in decisions about their lives in the home.

People were supported to maintain their independence.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were at risk of receiving unsafe or inappropriate care because some care records held inaccurate information.

People could not be confident that they would receive their medicines in a timely way because there were not always staff in the home who were trained and able to administer medication.

Visitors were made welcome in the home. People were able to see their friends and families as they wished.

Requires Improvement

Summary of findings

The provider had a procedure to receive and respond to complaints. People knew how they could complain about the service if they needed to.

Is the service well-led?

Requires Improvement

The service was not well-led.

Although the registered manager had systems to monitor the safety and quality of the service we found that these were not effective. The processes for assessing the service had not ensured that people were protected from foreseeable risks or from receiving unsafe or inappropriate care.

The registered manager had identified some issues with the quality of service and was taking action to address these.

Staff in the home were confident that they could raise any concerns with the registered manager and that these would be listened to and action taken.

Abbotsfield Residential Care Home

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.

This inspection took place on 13 February 2015 and was unannounced. The inspection was carried out by two Adult Social Care inspectors. During our inspection we spoke with 11 people who lived in the home, five care staff, two ancillary staff, the deputy manager and the registered manager. We observed care and support in communal areas, spoke to people in private and looked at the care records for five people. 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 also looked at records that related to how the home was managed.

Before the inspection we reviewed the information we held about the service. We also contacted the local authority commissioning, social work and safeguarding teams for their views of the service.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us that they felt safe in this home. One person said "All the staff here are lovely, you can see that the minute you walk in, I've never had a moment's worry for myself or for anyone else". However we found that people were at risk because appropriate systems were not in place to deal with foreseeable emergencies.

The local authority had shared concerns with us about the availability of equipment to lift people who needed support to move. There was one hoist in the home, which could be used to lift people out of their seat or from the floor if they had fallen. We saw that the hoist was on the ground floor of the home. The home did not have a lift for staff to use to move the hoist to the rooms on the first floor. We were told that this was a mobile hoist which could be taken to pieces and carried up the stairs by the staff. When we visited the home we saw that the procedure for moving the hoist from the ground to first floor was displayed on a notice board at the bottom of the stairs. However, when we asked a staff member to demonstrate how they would take the hoist apart to carry it upstairs, they were not able to so. Despite following the procedure displayed in the home they found the various parts of the hoist would not come apart. This meant that if a person fell on the first floor of the home equipment would not have been available to assist them off the floor safely.

The registered manager showed us a purchase record for a second hoist that had been ordered but had not been delivered. While we were in the home the registered manager also lubricated the mobile hoist joints to ensure it could be taken apart and carried to the first floor if that was required.

Staff in the home told us that they had received training in the action to take in the event of a fire. We found that people did not have personal evacuation plans giving information for staff about how to assist them if they needed to move to safety if there was a fire. We asked one member of staff how they would assist an individual to move safely away from a fire. The staff member was not able to tell us how they would support the person to move to a safe place.

People were placed at risk because robust procedures were not in place to ensure they were safe in the event of an emergency.

We found that the registered person had not ensured action had been taken to mitigate the risk to people in the event of a foreseeable emergency. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals' safety and welfare had been assessed and there was some information for staff about how to manage identified hazards. However we saw that some records were not clear. We found that hazards were identified in one person's care plan but were was not clearly identified in their risk assessments. When we spoke with staff in the home they were aware of how to ensure the individual's safety. The staff told us that they had been informed about the risks to the individual. They said that they were informed if there were any changes to the level of risk or to the actions they needed to take to ensure the person's safety. Although some of the risk assessments were not fully completed, we found that the care staff knew the actions to take to protect the person.

People told us that there were enough staff employed in the home to provide the support they required. During our inspection we saw that the care staff were patient and unhurried when supporting people.

The staff we spoke with told us that that they had completed training in identifying abuse and how to report this. All the staff we spoke with told us that people were safe living in this home and said they would not tolerate any form of abuse or mistreatment. One staff member told us, "None of the staff here would put up with anything except the best care for our residents, we'd all speak up if we thought anyone had harmed one of our residents, we couldn't stand for that".

People who lived in the home told us that they had never seen or heard anything which caused them concern about their safety or the safety or welfare of other people. One person said, "I've never had a concern, I'd tell [the registered manager] if I had, but I haven't".

During our observations we saw that people who could not easily express their views were comfortable and relaxed around the staff who were supporting them.

We looked at how medicines were stored and handled in the home. We saw that medication was stored securely to prevent it from being misused. All staff who handled

Requires Improvement

Is the service safe?

medication had been trained to do this safely. Records of medication administered to people had been completed properly to help to prevent any errors. People were protected because medicines were managed safely.

The registered manager used safe systems when new staff were employed. All new staff had to provide proof of their identity and have a Disclosure and Barring Service check to show that they had no criminal convictions which made them unsuitable to work in a care service. New staff had to provide evidence of their previous employment and good character before they were offered employment in the home. This meant people could be confident that the staff who worked in the home had been checked to make sure they were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that they usually enjoyed the meals provided in the home. People told us, "There's plenty to eat" and said, "The food is very good".

We saw that a menu was displayed, showing the choice of options available for the midday meal. People told us that if they did not want any of the options given, an alternative meal would be provided. We observed the midday meal being served. We saw that most people were having fried fish with chips and peas. Two people had fish in sauce. While most people told us they had enjoyed the meal, and we saw this during our observations, two people said they had not enjoyed the fish. We saw that the care staff offered one person a different meal but the other person who had not enjoyed the fish was not offered an alternative meal.

Although people told us that they were given choices about their meals we saw that people were not offered a choice of cold drink to have with their midday meal. We saw that everyone was given orange squash with no alternative offered. We also saw that breakfasts were prepared before people woke up in a morning. Although people told us they could choose what they wanted for breakfast, they were not asked what they wanted in the morning but were given a prepared meal. One person told us, "I always have the same thing, I think I could ask for something else, like porridge, but I'm not bothered".

We observed meals being served in two communal areas. In one room we saw that people were provided with salt and vinegar to season their food. In the second room this wasn't provided. We also saw that people in one room were asked if they wanted tea or coffee after their meal. In the second room people were not asked which drink they preferred, we saw that the staff poured the drinks that they believed people would want.

Although people were provided with enough to eat and drink we saw that they were not always offered choices to ensure they enjoyed their meals.

Everyone we spoke with said that the staff in the home knew the support they needed. They told us that the care staff had the skills and knowledge to provide the care they required. People made many positive comments about the staff. One person told us, "You can't fault the staff here, every one of them knows exactly what they are doing, they're all very good at their jobs".

The staff we spoke with told us they had completed a range of training to ensure they were able to provide the support individuals required. However, the staff training records showed that some areas of training needed to be repeated and were overdue. The registered manager showed us that they were addressing this and had arranged for training to be renewed including in safe moving and handling, infection control, dementia awareness and preventing malnutrition and dehydration. From our discussions with staff we found that they had the knowledge and skills to meet people's needs.

The staff told us that they felt well supported by the registered manager and deputy manager. The staff said that the managers worked alongside them in the home giving support and guidance as they required. One staff member said, "[The registered manager] is very "hands on", he works with the residents and is always around if we need to ask advice".

Some people were living with a dementia and could not easily express their wishes about their care or their lives. The registered manager was knowledgeable about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, (DoLS). The registered manager told us that there was no one living at the home who required an application to be made under the Deprivation of Liberty Safeguards. This was because there was no one who was subject to a level of supervision and control that may have amounted to a deprivation of their liberty. Throughout our inspection we saw that people were free to make choices about their care and their lives in the home. We did not see anything that suggested people were being restricted or deprived of their rights or liberty.

Throughout our inspection we saw that people were assumed to be able to make decisions about their daily lives and were supported to do so. We saw that people were asked if they agreed to care being given and the staff only assisted a person with their consent. This helped to protect people's rights.

People told us that the staff in the home supported them to see their doctors as they needed. During our inspection one person had told the care staff that they felt unwell. We saw that the staff gave this person reassurance and arranged for their doctor to call to see them. This showed that the staff took action to ensure people received prompt support to see their doctor.

Requires Improvement

Is the service caring?

Our findings

Everyone who could tell us their views said that people were well cared for in this home. People said the staff were kind and treated them with respect. One person told us, "The staff are very friendly, they have been very good to me in here" and another person said, "The staff are very, very, kind and understanding".

Although people told us that they received a good standard of care in this home we saw that people's privacy and dignity were not always protected.

Before the midday meal was served, we heard a person shouting loudly for assistance. There were no care staff in the area so we had to find a member of care staff and ask them to assist the person. We found that the care staff had assisted this person to go to the toilet and then had left the room to give them privacy. However no staff members had remained close to the person's room to check if they were managing on their own and to assist them when they required support. This meant that, after the person had used the toilet, they had needed to shout in order to gain attention from the staff. Their support was not provided in a way that maintained their dignity.

We saw that staff did not always protect people's privacy. We observed that one staff member walked into a toilet without knocking on the door or checking if the toilet was being used. There was someone using the toilet and the staff member had not respected their privacy. We also saw that people were not asked in a discreet way if they wanted to take their medication. We observed medication being given in the communal areas of the home. The member of staff administering the medicines stood at one side of the room and called across the communal area to ask people if they wanted to take their medicines. This did not ensure people's privacy and dignity were maintained.

We found that the registered person had not ensured that people's privacy and dignity were protected. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection we saw that care staff took the time to spend with people. We saw many positive interactions and saw that people enjoyed spending time with the care staff. We saw that all the staff understood they needed to spend time with people in order to provide good care.

We heard staff speaking with people and noticed that they were friendly but respectful. The staff knew the names people wished to be called and used these at all times.

During our inspection we saw that two people felt unwell. The staff spent time with each person, giving them support and checking that they were safe and comfortable. We saw that both individuals looked to the care staff for reassurance and appeared confident that the staff would look after them until they felt better. This showed that people had developed trusting relationships with the staff and in the home and knew they would care for them if they were unwell.

The atmosphere in the home was relaxed and staff were patient when supporting people. All the staff we spoke with told us that this was usual for the home. One staff member told us, "We have time to spend with people, we don't have to rush from one person to the next, [the registered manager] gives us time to be with our residents".

People told us that they were asked for their views about how they wanted their care to be provided. People who could speak with us told us that they were included in decisions about their care. We saw that the staff were able to communicate with each person who lived in the home and gave people choices about their care in a way that they could understand. However, we had observed that people were not always given choices about their meals or drinks.

We saw that the staff supported people to move independently around the home. We observed one person using the stairs with the support of one member of staff. We saw that the staff member was very patient and gave the person encouragement and guidance. This supported the individual to maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

Everyone who could speak with us told us that they made choices about their lives including the time they got up and where they spent their time. One person told us, "I can have a lie in if I want" and another person said, "I like to sit in the lounge, but I can go back to my room if I want.

We found that some aspects of the service were not responsive to people's needs. Some people's care records had not been reviewed when their needs changed. This meant staff did not always have accurate and up to date information about how to support people. We also found that people could not be confident that they would receive the medicines they needed in a timely way.

People were assessed to monitor if they were at risk of malnutrition or of their skin breaking down. The provider used assessment tools that asked a number of questions about the person and their health and that gave a score that showed the level of risk. This was then used to develop a care plan that identified how staff were to support the person to reduce the risk. If the assessments showed that the level of risk to a person had changed, this would require a review of their care plan to ensure that the risk was managed effectively.

We found that two people had experienced unplanned weight loss but the information in their assessment tools had not been changed. This meant inaccurate information had been used to assess the risk to the individuals and to plan their care to manage the risk. Care staff did not have accurate and up to date information about how to support people. This placed people at risk of receiving unsafe or inappropriate care.

The assessment tool around skin care stated that if a person experienced weight loss, this could affect the risk of them developing a pressure area. The records for one person showed that they had lost weight in the two months before we carried out our inspection. The information in the skin care assessment tool had not been changed to reflect this weight loss. This meant that the information in the assessment was not accurate. No change had been made to the person's care plan to ensure they received appropriate support to protect their skin.

The records for another person showed that they had experienced significant unplanned weight loss in the four months before we inspected the home. The information in the assessment tool used to monitor the risk to the person from malnutrition had not been changed to show this weight loss. As the assessment tool had not been changed, no change had been made to the person's care plan. Staff did not have accurate and up to date information about how to protect the person from further unplanned weight loss or from the risk of malnutrition.

Everyone we spoke with told us that the staff in the home knew them and knew the assistance they needed. They told us that they received the support they required at the time they needed this. However, we found that none of the staff who would be on duty during a four hour period on the evening of our inspection had been trained in how to administer people's medication. This meant there would no member of staff present in the home who could give people medicine if they needed it. The registered manager said that the staff on duty would call a senior member of staff, who lived in the local vicinity, and they would come to the home and administer any medication if this was required. This meant that if people were in pain they would have to wait for the staff member to travel to the home and the administration of pain relief would be delayed.

We also found that individuals' care records did not hold detailed information for care staff about the choices people had made about their lives such as what time they liked to get up, where they liked to spend their time or the activities they wanted to follow. This meant that, if people were not able to express their wishes, the staff did not have information to refer to in order to ensure people individuals' preferences were respected.

We found that the registered person had not ensured that care had been planned to meet people's needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people we spoke with told us that they enjoyed a range of activities in the home. People told us that the activities provided included; singing to music, playing cards and doing gentle exercises that were designed to be performed sitting in an armchair. However two people told us that there were times that they felt bored in the home and said they would like more quizzes and a broader range

Requires Improvement

Is the service responsive?

of activities. During our inspection we saw that some people took part in an exercise session, some people followed activities of their choice such as reading and one person went for a walk in the garden.

Everyone who could speak with us told us that the staff in the home spent time with them and listened to their views. They said that they were given choices about their care and their lives in the home. One person told us, "The staff here are marvellous. They ask what I want and nothing is ever too much trouble for them."

We saw that the staff knew the people they were caring for well. They knew the friends and relatives who were important to individuals. We saw that the staff spoke with people about their families and observed that people enjoyed engaging in these conversations with the staff.

People told us that their visitors were made welcome in the home. They said there were no restrictions on when or where they received their visitors. One person said, "I like to see my family in my room, but other people see their visitors in the lounge".

The registered provider had a procedure for receiving and handling complaints about the service. We saw that a copy of the complaints procedure was displayed at the entrance of the home. This meant that it was accessible to people who lived there and to their visitors if they wished to look at it. People who could speak with us told us that they knew how they could complain if they needed to. One person told us, "I'd speak to the staff if I had a problem, but I have no complaints" and another person said, "I'd tell the boss man [registered manager], no question, he'd sort any problem".

Requires Improvement

Is the service well-led?

Our findings

We found that the atmosphere in the home was friendly and inclusive. The staff spoke to people in a kind and friendly way. We saw many positive interactions between the staff on duty and people who lived in the home. One person told us, "I like it here, they are all very nice people". Another person told "The girls, [care staff], are like family, we're all just one big, happy family really".

People told us that they were asked for their views about the service and said action was taken in response to their comments. People told us they knew the registered manager of the home and would speak to them, or a member of the care staff, if they wanted any changes to the service they received. However two people told us that they would like a broader range of activities. This had not been identified by the registered manager.

Although the registered manager had systems to assess the quality of the service we found that these were not effective. We found that improvements were required to the emergency procedures in the home, care planning, recording of risks and to the deployment of staff. We also found that care was not always delivered in a way that protected people's privacy and maintained their dignity. These issues had not been identified by the processes used to monitor the quality of the service.

We found that the registered person had not ensured that the systems used to assess the quality of the service had protected people from foreseeable risks or from receiving unsafe or inappropriate care. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the staff we spoke with told us that the registered manager set high standards. They said they knew that they had to provide a high quality of care and said they were given the time they needed to do this. The staff told us that they could raise any concerns with the registered manager and said they were confident that these would be listened to and action taken.

We saw that the registered manager and deputy manager were visible in the home and available for people or their relatives to speak with as they wanted. The deputy manager worked alongside the care staff providing support to them.

Although we had found areas at our inspection where improvements needed to be made to the service, we found that the registered manager had already taken action to address some issues. Training had been booked to ensure staff had up to date knowledge of best practice in supporting people. The registered manager had also ordered a second hoist to ensure equipment was available to support people at the time they needed. We saw that the deputy manager and registered manager had started to check people's care records to identify where these needed improving.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were placed at risk because action had not been taken to mitigate the risk to people in the event of a foreseeable emergency. Regulation 12 (1) and (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not supported in a way that protected their privacy and dignity.Regulation 10 (1) and 2(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care was not planned to meet people's needs. Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The processes for assessing the quality of the service had not ensured that people were protected from foreseeable risks or from receiving unsafe or inappropriate care.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 (1) (a).