Karelink Limited

Abbeymere Care Centre

Inspection report

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Tel: 01384395195

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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**

Summary of findings

Overall summary

The inspection took place on 06 December 2016 and was unannounced. At our last inspection on 02 December 2015, the provider was rated as Requires Improvement due to concerns around the management of medication and a lack of effective quality assurance systems.

Abbeymere Care Centre is registered to provide accommodation and personal care to a maximum of 18 older people. At the time of the inspection there were 16 people living at the home.

There was a manager registered with us. However we were informed that this manager had left their role in 2015 and a new manager was yet to register with us. A manager had been recruited and was intending to apply to register as manager. 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.

There were not always sufficient numbers of staff available to support people. People were supported by staff who knew how to report concerns and manage risks to keep people safe. Staff had been recruited safely. There were errors found in the recording of medications that meant the provider could not evidence that medication had been given in a safe way.

People were supported to make their own decisions in line with Mental Capacity Act 2005 however; staff did not always understand Deprivation of Liberty Safeguards and how to support people in line with these. People had choices at mealtimes and had access to healthcare services where required. Staff received training and support to enable them to support people effectively.

People felt that staff were kind and caring. Staff ensured choices were given and that people were supported to maintain their independence where possible. People told us they were treated with dignity and we saw examples of this. However, We saw one instance where people had not been treated with dignity.

There was a lack of activities available for people. People had their care needs assessed and reviewed. Staff knew people's preferences with regards to their care. People were provided with information on how they could complain if they wished.

Some notifications that the provider is required to send to us, had not been sent. Staff told us they felt supported by the manager.

There was no evidence to show that audits completed were used to identify and act on areas for improvement and that people were asked for their views on the service. This is a breach of Regulation 17 of 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 the report.

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.

People were supported by staff who knew how to report concerns and manage risks to keep people safe.

There were not always sufficient numbers of staff available to support people.

There were errors in the recording of medication.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to make decisions but staff were not always aware of who had a Deprivation of Liberty Safeguard in place and how to support people in line with these.

Staff had access to training and supervision to enable them to support people effectively.

People had their dietary needs met and were supported to access healthcare services where required.

Is the service caring?

Requires Improvement

The service was not always caring.

People had not always been treated with dignity.

People felt that staff were kind and caring in their approach although staff availability meant that care was often task focussed.

People were supported to make choices and maintain independence where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their care needs assessed and reviewed to ensure their needs could be met.

There was a lack of activities available for people.

Complaints made had been investigated and outcomes shared with people.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance audits had not identified areas for improvement and feedback had not been acted upon.

Notifications that the provider is required to send to us, had not always been sent.

Staff felt supported by the manager and provider and people felt the home was well led.

Abbeymere Care Centre

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 06 December 2016 and was unannounced. The inspection was carried out by one inspector.

We reviewed the information we held about by home including notifications sent to us by the provider. Notifications are forms that the provider is required by law to send us about incidents that occur at the home. We also spoke with the local authority commissioning team to obtain their views about the home. We used the information gathered to plan areas to focus on during the inspection.

We spoke with five people living at the home. As some people were unable to tell us their views of the service, we used a 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 spoke with two relatives, three members of care staff, the manager and the provider.

We looked at four people's care records and nine medication records. We also looked at records kept in relation to staff recruitment and training, accidents and incidents, complaints and quality assurance audits completed.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt there were enough staff to meet their needs and that if they required support, this was given in a timely way. One person told us, "I think there is enough staff". Another person said, "I have got a buzzer and if I need anything, I have only got to buzz". Staff we spoke with however felt that there were not always enough staff available. One member of staff told us, "No, there isn't enough staff, especially at the minute". The staff member went on to explain that due to current staff vacancies and the new manager working shifts rather than being supernumerary to the rota, the care staff were responsible for supporting people, preparing all meals, completing manager's tasks when the manager was not on shift and on occasions also completing all domestic tasks. Another staff member confirmed this and said, "On a quiet day, then there is enough staff but If the senior is busy, you can sometimes feel rushed".

Our observations showed that staff were busy with various tasks throughout the day, and that this had an impact on the time they were able to spend with people. We saw that there were no members of staff within communal areas for extended periods of time and that where staff did support people within these areas, whilst they took time to speak with people and check they were ok, staff were task focussed and only able to spend time with people to support with a care need before moving on. This meant that people did not have time to interact with staff in a meaningful way. We spoke with the provider about our observations. The provider explained that a dependency tool was used and that their current dependency level meant that they should have three care staff, a manager, one domestic and one cook on shift at any time. However we saw that this was not the case and there were only three members of care staff available throughout the day and that these staff had also taken on a manager and cook role to manage the workload and meet people's needs. We asked to see the provider's dependency tool but they were unable to provide this. The provider informed us that a number of staff had recently left and so there were vacancies to be filled. We were told that while recruitment was ongoing, cover was provided by staff working overtime or agency staff. The provider told us that the shortfall in staffing levels on the day of our visit was due an agency staff cancelling their shift at the last minute. However, we saw that on the staff rota, there was only three staff allocated per shift which matched the staffing levels we saw on the day.

People told us that they were supported with their medication and that this was given on time. Staff we spoke with confirmed they had received training in how to give medication and we saw them support people with this in a safe way. We saw that staff responsible for giving medication informed the person that it was time for them to take their tablets, supported them to get these out of the pot where required and then stayed with the person while they took these. The manager told us that they had recently introduced competency checks where staff would undergo a theory and practical assessment around medication to ensure that they remained competent in giving medication safely. Records we viewed showed that some staff had begun to complete these assessments.

We looked at medication records and saw that some people had medication on an 'as and when required' basis. Where people had these medications, there was not always guidance available for staff informing them on when these medications should be given. This meant there was a risk that people would not receive their medication in a consistent way. However, we spoke with staff who gave medication and they

displayed a good understanding of when people would require these medications. From the records viewed, we saw that the availability of some medications did not match what had been recorded as available on the Medication Administration Record (MAR). This meant that the provider could not evidence that medication had been given as prescribed. We saw that in some instances this was due to errors in recording on the MAR. We spoke with the manager about this who advised that audit systems had recently been introduced to identify issues around medication. We saw that these medication auditing processes had commenced in the previous month and would look at the completion of records and checking that the correct amount of medications were available.

People told us they felt safe at the home. One person told us, "I do feel safe, yes". A relative we spoke with said, "[person's name] is definitely safe".

Staff we spoke with knew the procedure they should follow if they had a concern that someone may be at risk of harm. One member of staff told us, "I would report a concern to the manager or directors". Staff told us and records we looked at confirmed that staff had received training in how to safeguard people from abuse. We saw that where concerns had been raised, these had been referred to the relevant authorities appropriately by the provider.

Staff understood how to manage risks to keep people safe. Where people required support with their mobility, we saw that staff provided this support in a safe way. For example, when supporting a person to transfer from chair to chair, we saw staff discuss with the person how they could do this safely and then supported them with this. Staff provided encouragement to the person throughout to ensure they continued to transfer safely. For people who were identified as being at risk of developing pressure sores, staff could explain the action they take to reduce this risk. One member of staff told us, "We turn [person's name] every four hours. [to reduce the risk]. It can be two hours; it depends on how the person's skin is". Records we looked at showed that risk assessments had been completed to identify risks posed and how staff should support people to manage these. The risk assessments looked at areas including nutrition, mobility and risk of pressure areas. Accidents and incidents that occurred at the home were documented and we could see that action had been taken to keep people safe and reduce the risk of the incident reoccurring.

Staff told us that before they started work, they were required to complete checks that would show they were suitable for the position. These checks included obtaining a full employment history, providing two references from previous employers and completing a Disclosure and Barring Service (DBS) check. The DBS would show if a staff member had a criminal record or had been barred from working with adults. Records we looked at confirmed these checks took place.

Requires Improvement

Is the service effective?

Our findings

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and 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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We saw that some people living at the home had a DoLS in place. We saw that applications to deprive people of their liberty had been made appropriately. However, not all staff displayed an understanding of what DoLS were and who had an authorisation in place. Without understanding who had a DoLS authorisation in place, staff would not be able to ensure they were supporting people in line with this. We raised this with the provider who advised that staff had received training in DoLS but would address this again with staff to ensure people are supported effectively.

People told us that staff sought their consent before supporting them and we saw that this was the case. Staff we spoke with could explain how they obtained permission from people and one staff member told us, "I get permission by asking people and they can all tell me yes or no". We saw that staff understood the importance of ensuring they were not unlawfully restricting people. For example, we saw that one person had their breakfast in the lounge with a table in front of them. After their breakfast, a staff member approached the person and asked if she would like the table to be moved to the side of them, rather than in front. When the person asked why, the staff member responded, "Because I don't want to stop you from being able to get up". This demonstrated that staff understood the need to ensure people were able to move freely without restriction.

People and their relatives told us that they felt staff were well trained and knew how to support them effectively. One relative told us, "Staff definitely know what [person's name] needs".

Staff told us that when they started work, they had completed an induction that included attending training and shadowing a more experienced member of staff. One member of staff told us, "The induction was fine. I followed the staff around and watched them work. I wasn't thrown in the deep end". Another member of staff told us, "I made sure I shadowed the other staff until I knew what I was doing.

Staff told us that they had received training to enable them to support people. One member of staff told us, "I do feel that I get all of the training I need. They [the provider] are good like that". Staff also confirmed that they had supervisions to discuss their development and if they felt they required extra training, they could request this, although staff spoken with had not felt they needed to. One member of staff said, "We have supervisions and can ask for more training then if needed". Records we looked at showed that staff had received training. We could see that where gaps in training had been identified, the provider was taking

action to address this and had sourced new training materials to support staff with their development needs.

People told us they were happy with the meals they were provided with. One person told us, "The food is very good. I get to choose what to eat. If I don't like it, I don't eat it". Another person said, "I have just had my breakfast and I can have more if I want". We saw that care staff were responsible for preparing meals for people and that training in food hygiene had been provided. There was information available within the kitchen area informing staff of people's specific dietary needs and staff we spoke with all knew how to access this information if they were responsible for meals. There was no information displayed for people detailing their choices at mealtimes. However, we did see that staff prepared two meal choices and asked people at mealtime which they would like to eat. We saw that mealtimes were informal and people ate in the dining area, the lounge or their bedrooms. People we spoke with confirmed this was their choice of where they wished to eat.

People told us that staff supported them to access healthcare services when needed. One person told us, "They [staff] would have got the doctor out if I needed one. They are very good". Staff we spoke with understood the actions they should take if a person needed urgent medical attention and could explain how they would access emergency health services. Records we looked at showed that people had been supported to access a number of health services including; opticians, speech and language therapy and dentists.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring in their approach. One person told us, "The girls [staff] are all nice". A relative we spoke with said, "The staff are super". We saw that where staff were supporting people with their care, staff displayed warmth and it was clear that staff had developed positive relationships with people. However, the issues around staff availability meant that people were often left without staff interaction for extended periods and staff were not always available for people to spend time with them other than to support with their immediate care needs. Where staff did spend time with people, this was task focussed rather than centred on the person due to the staff being busy.

People told us they were treated with dignity and given privacy. One person told us, "The staff always knock my door before coming in [my bedroom]. They are very polite". Staff told us how they ensured people's dignity was promoted and gave examples that included; covering people up during personal care to ensure they are not exposed and allowing people privacy when using the toilet. The staff member told us, "I will ask if they want me to come in or wait outside while they were on the toilet". However, due to the lack of staff in communal areas, there posed a risk that if people required support with their personal care, staff would not be available to support them with this need in a timely way. We also saw one instance where people's dignity had not been promoted. We saw staff walk into a bathroom without knocking the door first. Once opened, it was clear that someone was using the bathroom and so their dignity had not been respected. The staff member apologised immediately to the person and closed the door. We raised this with the manager and provider who assured us that this would be addressed with staff.

People told us they were supported to make choices. We saw that some people had stayed in their room instead of accessing the communal areas. One person who had chosen to remain in their bedroom told us, "The staff do ask if I want to go downstairs. I have got a choice". Staff we spoke with told us how they ensured people were involved in their care and could make choices. One member of staff said, "I ensure people have choice by asking them what they would like". The staff member went on to give examples including, asking people where they would like to sit and what they would like to eat. We saw that people were provided with choices. For example, one person was asked if they would like to have rollers put into their hair. When the person responded yes, staff ensured that someone was available to support them to do this. We saw people being given other choices including; whether they would like to go outside for a cigarette, what they would like to drink and whether they wished to watch television or listen to Christmas music.

Staff told us that where possible, they encouraged people to remain independent. One member of staff explained, "We encourage people to wash themselves if they are able". Another staff member said, "If people are able to do things for themselves, then we let them". We saw that people were supported to be independent. For example, we saw that people were encouraged to eat their meals independently and that staff allowed people to try this before offering support. We saw one person being given their meal and when they felt they needed support, they called for staff and staff then sat with the person and supported them to eat.

People had been supported to maintain relationships with their family and friends. We saw a number of relatives visit throughout the day and records showed that some people often went out with family. People told us there were no restrictions on their family visiting and one person said, "My family visit and can come at any time". A relative said, "If I call, they take the phone to [person's name] so we can talk".

No one currently living at the home required the use of an advocate. We spoke with the manager who understood where advocacy services may be required and how they could access these. This meant that systems were in place to ensure that if a person may require advocacy support, the manager would be able to support with this need.

Requires Improvement

Is the service responsive?

Our findings

People told us that there were not always activities available for them. One person told us, "One day we played bingo [but] there aren't things on every day. I don't go out as they haven't got the staff half the time". Another person said, "I don't think there are a lot of activities". Our observations confirmed what people had told us. We saw that as staff were busy supporting people with their care needs, there were no staff available to support people to take part in activities that were of interest to them. This meant that people spent long periods of time sat in communal areas with little interaction or activities to keep them stimulated. We saw that staff did plan to support people with activities; however they did not always have time to complete these. We spoke with the manager and provider about the activities available for people. The manager informed us that they had recently made contact with an external organisation that would be visiting the home on a weekly basis and completing activities with people.

We saw that before moving into the home, an assessment was completed to ensure that the provider was able to meet the person's needs. The assessments looked at the person's care needs, life history and preferences with regards to their care. Records we looked at showed that these assessments took place. We saw that care records were reviewed to ensure that the information held about people's needs were accurate. However, we could not see evidence that people and their relatives had been consistently involved in the assessment or reviews of their care. We spoke with a relative who told us that they had been kept informed about any changes and were happy with this. The relative said, "If there was a problem, they would call me or my sister but [person's name] is always happy".

We spoke with staff and found that they knew people well and how they wished to be supported. For example, staff could explain what topics of conversation one person liked to have to help them relax. One staff member explained, "[person's name] enjoys a musical and talking about their family". One relative confirmed this and said, "Staff definitely know what [person's name] needs". The information staff gave reflected the information held in the person's care records. Care records we looked at held personalised information about people including, their religious wishes, likes and dislikes with regards to meals and family / life history.

People and their relatives told us they knew who they should go to if they wished to make a complaint. One relative told us, "I know how to but there has never been a problem so I don't need to complain". We saw that information was displayed informing people of how they could complain. Records we looked at showed that where a complaint had been made, this had been investigated and the person who had made the complaint had been informed of the outcome.

Requires Improvement

Is the service well-led?

Our findings

There was a manager registered with us, however we were made aware that this manager had left in 2015 and a new manager had not yet registered with us. A manager had been recruited in October 2016 and was going to be applying to register but this application had not been received yet. The manager was unavailable during the morning of the inspection but was present for the afternoon.

At our last inspection in December 2015, the provider was rated as Requires Improvement due to their quality assurance systems being ineffective at identifying areas for improvement. At this inspection, we saw that these issues remained. The provider showed us the audits they completed to monitor the quality of the service. These audits collected information on what had been happening at the home including; the number of falls and the number of hospital admissions. However, there was no information available on what was done with this information once it had been collected or what action was taken where areas for improvement were found. We spoke with the provider and the manager about this who informed us that action plans were completed but could not find these. Following the inspection, the provider sent an action plan they had completed following a specific incident at the home. However, this action plan did not evidence how the information collected monthly had been used to make improvements at the service. This meant that the provider was unable to evidence that their auditing systems were used to identify and act on areas for improvement. The audits that had been completed had failed to identify the issues found at this inspection, including errors in medication and concerns around staffing levels and activities.

The provider informed us that people were asked to feedback on their experience of the service via questionnaires. However, they were unable to provide any information about this; including completed questionnaires or an analysis of the feedback given. We spoke with staff who told us that they were not aware of any questionnaires being sent to people. Following the inspection, the provider sent us an example of one completed questionnaire dated December 2016 and the response was positive. However, we were unable to see that the feedback given was shared with people. This meant the provider was unable to evidence that they had sought people's views and then acted on feedback given to make improvements to the service where required.

The provider had not ensured that staffing levels were sufficient to meet people's needs. We observed a lack of staff available to spend time with people due to staff having to cover other roles, including the preparation of meals, domestic tasks, and the role of manager when she was not at work. The provider had not adhered to their dependency tool or reassessed their staffing levels where vacancies became available to ensure there were enough staff to meet people's needs. This meant that people had experienced a lack of activities and interaction with staff and were also left unattended for extended periods.

The provider had failed to ensure that systems were in place to monitor the quality of the service and could not evidence that they had sought and acted upon the views of people who used to service.

This is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not met their legal obligation to inform us of incidents that occurred at the service. We saw that four Deprivation of Liberty Safeguards applications had been made and authorised. However, we had not been notified of these. We spoke with the provider about this who informed us they would look into why these notifications had not been sent.

People spoke positively about the new manager and felt the home was well led. One person told us, "The mood here is lovely". A relative we spoke with said, "I feel that [person's name] is getting the best care. As far as I am concerned, I am happy with everything". We saw that when the manager was at the home, she was visible in communal areas and people knew who she was. The manager had a friendly relationship with people and people were happy in her company.

Staff told us they felt supported in their role. One member of staff told us, "I do feel supported. I can 100 per cent raise an issue and it is acted on". All staff we spoke with told us they had chance to speak with the manager and the provider in team meetings or at daily handover. One staff member explained, "We have a discussion on any concerns or if we need to raise anything. If we do raise things, they do get acted on". Staff confirmed that a manager or the provider was always available outside of office hours should they require any support.

Staff we spoke with all understood how to raise concerns or whistle blow if they needed too. One member of staff told us, "I know how to whistle blow. I would go to Care Quality Commission if I wasn't satisfied [that my concern had been addressed]". We saw that the provider had informed us of safeguarding concerns at the home and had acted to keep people safe.

At our last inspection in December 2015, the provider was rated as Requires Improvement. We saw that the provider had displayed the outcome of their most recent inspection in the reception area of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems were in place to monitor the quality of the service and could not evidence that they had sought and acted upon the views of people who used the service.