Adbolton Hall Limited

Adbolton Hall

Inspection report

Adbolton Lane
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Nottingham
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Tel: 01159810055

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28 October 2020

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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

Adbolton Hall Nursing Home is a care home providing personal and nursing care for 29 people aged 65 and over at the time of the inspection. The service can support up to 53 people across two floors and, at the time of the inspection, the first floor was under refurbishment.

People's experience of using this service and what we found
Areas of the building required refurbishment to ensure they could be cleaned effectively. Not all staff wore personal protective equipment (PPE) correctly. People's medicines were managed safely and staff we spoke with knew how to appropriately raise concerns when necessary.

The service did not have a registered manager in place. However, the manager had recently applied to the CQC to become registered. The provider did not always act upon issues highlighted through the service's quality assurance system, this included not taking timely action when faults had been reported. People and relatives, we spoke with, felt supported by the manager.

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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 27 February 2019). The service remains rated requires improvement. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of the full report.

Why we inspected
We received concerns in relation to staffing and risk. As a result, we undertook a focused inspection on 28 October 2020 to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions, not looked at on this

occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Adbolton Hall on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Adbolton Hall

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Adbolton Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to understand the COVID-19 infection control precautions the provider had in place, and to ensure the inspectors understood the current status of any potential infection risks.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service about their experience of the care provided. We spoke with eight members of staff including the manager, care co-ordinator, clinical lead, care workers, housekeeper, maintenance staff and the cook. We reviewed a range of records. This included medication records. We looked at two staff files in relation to recruitment and staff supervisions.

After the inspection

After the inspection we reviewed three people's care plans and risk assessments. We received feedback, by email and telephone, from four relatives of people receiving a service, and three staff members. We reviewed a variety of records relating to the management of the service, including the provider's policies and procedures. We looked at training data and quality assurance records. We continued to seek clarification from the provider to validate evidence found.

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

Preventing and controlling infection

● At our last inspection we identified areas which required cleaning and maintenance. Although those previously identified issues had been addressed, on this inspection we found other areas that still required improvement.

● Some areas of the care home were not clean. For example, one bedroom had dirt residue on a wall and contained equipment which was not clean. This created an increased risk of the spread of infections. We raised this with the manager who arranged for the necessary cleaning to be carried out immediately.
● Staff did not always wear personal protective equipment (PPE) correctly. Although staff were supplied with PPE, and trained how to use it, we observed some staff not wearing it line with current Government guidance. For example, we observed some housekeeping and care staff not wearing face masks or gloves correctly. This increased the risk that health infections could be spread within the care home.
● Staff rest areas posed an increased infection control risk. The staff rest areas were visibly dirty, and staff were not following social distancing guidance when using them. This was brought to the attention of the manager, who took action to mitigate further risk.
● Visitors were protected from catching and spreading infections. All visitors were subject to screening for possible COVID-19 symptoms. Visitors were required to maintain good hand hygiene and wear PPE supplied by the provider.

Assessing risk, safety monitoring and management

● People were not always protected from environmental risks. Environmental risks had not always been identified or assessed, and action was not always taken to mitigate those risks. For example, exposed heating pipes were found in a communal lounge which created a hazard as people could be burned if they fell against them. We raised this with the manager and action to cover the heating pipes was taken immediately.
● People could not always be swiftly evacuated from the building in emergencies. For example, the rough gravel surface, immediately outside some fire exits, would not enable the quick evacuation of people who had mobility support needs. The provider had previously highlighted this on their own fire risk assessment, but action had not been taken to reduce the risk.
● People's individual needs were regularly reviewed, and measures put into place to reduce their individual risk. Referrals were made to specialist healthcare professionals when needed. For example, a timely referral was made to a dietician when a person was at risk of weight loss.
● Peoples individual care records accurately reflected their needs and were person centred. Staff had access to care plans and one staff member told us, "Everything is electronic now, which is good as the information

is always up to date."

Staffing and recruitment

● Staff were not always safely recruited. Some staff files contained confusing information about whether reliable references had been obtained. Some files contained references from employers not listed on people's previous work history, gaps in staff employment history records were not always addressed. Having the necessary pre-employment checks in place is an essential part of ensuring suitable people are employed as staff in care homes.

● Agency staff were employed in the service safely. The manager ensured agency staff worked exclusively at the service to mitigate potential cross infection risks posed by COVID-19.

● People were supported by suitably trained staff to meet their assessed needs. The service had a structured training programme in place.

● We observed there were enough staff deployed to meet people's needs, this was in line with the provider's assessment of the level of staff support people needed. We observed people did not have to wait for long periods to receive support when they required it.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the service. Relatives we spoke to told us their family members were cared for safely by staff. One relative told us, "The staff can't do enough, I know [my family member] is here and safe because of how they look after them."

● People were protected from the risk of abuse. Staff received training in safeguarding and knew who to report concerns, both to the provider and externally. This helped to ensure people were protected from the risk of abuse or neglect.

● People were protected from the risk of abuse by the providers policies and procedures. The manager understood their role and responsibilities in keeping people safe. Safeguarding incidents were reported to appropriate authorities and acted upon to reduce further incidents.

Using medicines safely

● Medicines were managed safely. People received their medicines as prescribed.

● Staff received the necessary training to administer prescribed medicines safely. Staff had their competency to administer medicines assessed Medicines were recorded, administered, stored and disposed of in line with current best practice guidance and legislation.

● The provider's system for managing medicines ensured people were given the right dose at the right time. Medicines records had information about allergies and how people preferred to be given their medicines.

● People received their necessary medicine in a timely manner. One person told us, "I pull my [alarm]cord if I am in pain and they come straight away". This meant staff assessed people's pain quickly and administered the person's appropriate prescribed medication without delay.

Learning lessons when things go wrong

● Complaints were logged and investigated by the manager. Safeguarding incidents were dealt with appropriately and reported to the local safeguarding team.

● Lessons were learned from incidents. The service identified learning from individual incidents and had implemented new processes to mitigate risk. For example, improvements in the management of pressure areas following an incident.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

- There was no registered manager in place. The service had not had a registered manager since November 2019. The current manager had been in post for over 12 months and had only recently applied to the CQC to become registered.
- Quality improvements were not always carried out in a timely manner. The provider's internal quality audits identified issues which required improvement. For example, some of the carpets were found to be stained and dirty, however the provider had not taken timely action to address this. Staff told us, "The provider can be a bit slow with some things." The failure of the provider to act swiftly when they have identified potential hazards leaves people at increased risk of harm.
- The provider did not always act on feedback received from staff about safety issues. For example, a person's wardrobe needed repairing in order for it to be cleaned effectively. Staff told us this had been fed back to the provider, but action had not been taken to rectify the issue. We also found that a window was broken and needed repairing to allow for proper ventilation and effective cleaning. Staff told us that this had been reported to the provider but action had not been taken. The provider failed to act on concerns raised by staff leaving people at an increased risk of harm.
- The care people received from staff was monitored by the manager. Care monitoring systems were in place to identify where care needed to improve, this was fed back to staff during team meetings. For example, we found the manager had observed some poor moving and handling techniques, this was addressed in a team meeting and further staff training arranged.
- The manager understood regulatory requirements. The manager was aware of their responsibility to notify CQC of certain incidents. Our records evidenced that we received notifications appropriately.

Continuous learning and improving care; Working in partnership with others

- Opportunities to improve the service had been missed. The provider commissioned an external organisation to carry out a quality audit of the service and an improvement action plan was in place. However, the provider had not taken timely action to reduce risk. For example, some external exit door alarms were defective. Issues highlighting alarms on doors had been identified to the provider in the external quality audit carried out July 2020, but the provider had not taken the necessary action to rectify the matter.
- Incidents and complaints were reviewed appropriately. Regular reviews were carried out by the manager

and a senior manager and necessary actions were taken. For example, we found information had been shared with staff, and appropriate external professionals, when it had been identified that a person was at increased risk of falls. That helped to reduce the likelihood of further falls.

● When people's needs changed, staff ensured appropriate referrals were made to external professionals if required. Staff worked with other health and social care professionals to ensure people received the care and support they needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and the families were involved in care planning. One relative told us, "We have always been involved in care planning and my [family member] has always been treated very well with supportive caring staff."

● People were supported to maintain relationships with their relatives and friends. The manager had communicated with families throughout the COVID-19 pandemic and supported people to maintain contact with loved ones through video calls and window visits.

● People using the service were encouraged to speak up about the care they receive. Resident's meetings were held, and these had been adapted taking into consideration COVID-19 guidance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People's health outcomes improved as a result of the care they received. The manager promoted person centred care and we found improvements had been made because of this. One relative told us, "My [family member] was having lots of falls but the carers have worked so hard that these have really reduced."

● People were supported by staff who knew them well, and by a manager who acted when needed. One staff member told us, "People are treated with respect, privacy and dignity, I feel confident to report any issues and the manager listens."

● People were supported by staff who were committed to providing good care for people. The manager recognised the impact the staff had on people, and told us, "I am proud of my team, we have really worked hard and we all have one common goal, to improve the care for people we care for."

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 manager understood their responsibility to be open and honest with people and acted appropriately when things went wrong. One relative told us, "When [family member] had a fall, the manager phoned me straight away and made sure she was ok."