Abbotsford Care Home Limited

Abbotsford Nursing Home - Manchester

Inspection report

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19 December 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Abbotsford Nursing Home took place on 7, 14 and 19 December 2017 and was unannounced. The home was last inspected in December 2016 and was found to require improvement at that time, with breaches of regulations in relation to person centred care, receiving and acting on complaints and good governance.

This inspection was brought forward due to some information we received, alleging people were being abused. Whilst we found no evidence to substantiate evidence of intentional physical or psychological abuse, we found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care and good governance. Additionally we found breaches of the regulations in relation to dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, nutrition and hydration needs, staffing and fit and proper persons being employed.

Abbotsford 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.

Abbotsford Nursing Home is a four-storey detached building, set in its own grounds, with ramped access to the building. The home provides accommodation and care to a cultural mix of people including, Caribbean, Chinese and Pakistani or British descent. The home is registered to provide accommodation for up to 44 people who require nursing or personal care. On the first day of our inspection, there were 36 people living at the home, 16 of whom required nursing care. On the last day of our inspection, one person had sadly died and two people had been admitted to hospital.

The home had a manager in post. They had not yet registered with the Care Quality Commission, although they had begun the process of their application during our inspection. 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 was a safeguarding and whistleblowing policy in place and the manager and staff were able to outline the actions they would take if they had any concerns anyone was at risk of abuse or harm. However, people's care needs were not always met and this placed people at risk of harm.

Risks to people had not always been identified and, where they were identified, we found measures to reduce risks were not always followed. Systems were in place for safe management of medicines. However, staff did not always follow appropriate procedures and some recording of medicines required improvement.

Good analysis of accidents and incidents took place, to enable trends or themes to be identified.

People were not always provided with safe care and treatment, in line with their plans of care and appropriate actions were not taken in an emergency situation. This placed people at risk of harm.

Although some regular checks were made to ensure the safety of the building and equipment, we identified some areas which posed a risk, such as those in relation to hazardous substances or combustible materials.

Despite a dependency tool being used to help determine staff numbers, it was not evident sufficient numbers of staff were deployed to meet people's needs because the dependency tool was not effective nor updated when needs changed. Safe recruitment practices were not followed.

People were not always protected by the prevention and control of infection procedures. We found some areas of the home were not kept clean or hygienic to ensure people were protected from acquired infections.

Staff received induction into their roles and regular training. However we identified moving and handling training had been ineffective. We found clinical supervision was lacking.

People were not supported to have maximum choice and control of their lives and records did not demonstrate people were supported in the least restrictive ways possible. The principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not followed.

Nutritional and hydration needs were not effectively met, with some people losing weight and appropriate action not being taken. A tool used to determine the risk of malnutrition was not being used correctly and therefore some risks were not identified.

People received additional support from health care professionals, in order to have their care and treatment needs met where this was appropriate. However, actions following this were not always effective.

Although some staff treated people with kindness and compassion, other staff did not. Some staff spoke over people to each other. Some staff failed to recognise when people's dignity was being compromised. The language used in some care plans was not indicative of a caring environment.

Care plans were updated regularly but people or their relatives were not always involved in this. Person centred care was not embedded practice and care provision was seen to be task orientated. Some people's care records did not give consideration to their diverse needs in terms of culture, religion or sexuality for example.

There was a lack of meaningful occupation. The registered provider employed an activities coordinator. However, they had not performed this role for the three weeks prior to this inspection because they were undertaking a carers' role.

Regular staff meetings took place and staff felt informed. Staff felt the manager was supportive and effective.

Some care records were inaccurate and incomplete. Some audits were not robust and did not identify many areas for improvement, which were highlighted throughout the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that

providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not always identified and actions to mitigate risks were not always effective.

Safe care and treatment was not always provided, in line with people's assessed needs.

Staff were not recruited safely.

Systems were in place to manage medicines safely but staff did not always follow safe procedures. Improvements in recording of medicines was required.

Is the service effective?

Inadequate

The service was not effective.

Staff had received induction and training but some training had not been effective. Clinical staff lacked appropriate supervision.

The registered provider was not acting in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People's nutritional and hydration needs were not met.

Is the service caring?

Inadequate

The service was not caring.

We observed some staff provide care intervention without speaking with the person they were assisting.

Some staff did not treat people with dignity and respect.

Staff did not always recognise when support was required as the call system was, at times, disconnected. Therefore when people required assistance and used the call bell staff did not respond as there was no sound to alert staff.

Is the service responsive?

Inadequate

The service was not always responsive.

Person centred care was not embedded within practice.

There was a lack of meaningful occupation for people living at the home.

Some care plans lacked details and people had not been involved in reviews of their care, however, the manager had begun work to address this.

The registered provider had a clear complaints policy and this had been transcribed into another appropriate language.

Is the service well-led?

Inadequate

The service was not well led.

People and staff told us they felt the manager was effective.

Contemporaneous records were not kept in relation to people's care.

Some regular auditing took place but these were not sufficiently robust to identify areas for improvement that were highlighted during the inspection.

Abbotsford Nursing Home - Manchester

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.

The inspection took place on 7, 14 and 19 December 2017 and was unannounced. The first day of the inspection was carried out by four adult social care inspectors and an assistant inspector. The second day of the inspection was conducted by two adult social care inspectors and, on the third day, the inspection team consisted of two adult social care inspectors and an assistant inspector. An interpreter accompanied the inspection team on the first two days of the inspection.

On 18 January 2017, the registered provider submitted a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information is used to help inform our inspections. On this occasion we had not asked for an updated PIR.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority contracts, commissioning and safeguarding teams as well as information we received through statutory notifications.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We used the Short Observational Framework for Inspection (SOFI) to observe the communal dining area. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people who lived at the home, two relatives, two visiting professionals, eight care and

support staff, two registered nurses (one of whom was also the deputy manager), two domestic staff, the cook, the maintenance person, the manager, the nominated individual and director for the registered provider.

We looked at 11 people's care records, five staff recruitment files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and communal areas within the home.

Inadequate

Is the service safe?

Our findings

With the assistance of an interpreter, who was able to speak Cantonese, we spoke with six people who all to told us they felt safe living at Abbotsford Nursing Home. One told us, "I feel well looked after and safe." Two health care professionals told us they did not have any safety concerns regarding Abbotsford Nursing Home and one told us they felt there were sufficient numbers of staff to keep people safe. However, despite this, our observations and evidence we reviewed meant we had concerns about the safety of care provision.

The registered provider had a safeguarding policy in place and the staff we asked were able to identify signs which may indicate someone was being abused. Staff were able to outline the appropriate actions they would take, including whistleblowing if they felt this was necessary. However, we found staff did not always identify and meet people's needs which placed people at risk of harm.

In order to meet the requirements of regulation and safeguard people from abuse and improper treatment, registered providers must have a zero tolerance approach to unlawful discrimination. However, through our observations and inspecting the registered provider's records, we found evidence of discriminatory practice. We observed people who were unable to speak English did not receive the same level of care as people who were able to communicate in English. Furthermore, a care plan we inspected indicated a person was unable to make a particular choice based on the language they spoke, as opposed to their capacity to make that choice. This meant they were subject to discriminatory practice.

Furthermore, registered providers must have robust procedures and processes in place to prevent people from being abused or receiving improper treatment. This includes degrading treatment or disregarding people's needs. We observed practice of people's needs not being met and we saw some people were treated in an undignified manner. We observed staff not responding to some people's requests. For example, when a person requested a drink, this was not provided. When another person was cold due to a window being open, one member of staff failed to take action, even when a person had asked them to do so. This showed the registered provider did not have systems in place to prevent improper treatment.

The above demonstrated a breach of Regulation 13(2) because systems and process were not established and operated effectively to prevent abuse and improper treatment.

A range of risk assessment tools were used in order to assess risks to people, for example in relation to falls, skin integrity and weight loss. These were evaluated monthly. However, they were not always effective at identifying risks.

One person had been assessed as being at risk of weight loss and they had lost over 10% of their body weight over the previous five months. Staff were not completing the malnutrition universal screening tool (MUST) correctly because they were not looking at the weight loss over a six month period. Therefore an accurate reflection of weight loss was not always considered in the assessment. This meant assessments for identifying people at risk of malnutrition were ineffective.

Some people had bed rails in place, which stop a person from falling out of bed. We saw, where bed rails were in place, the risks associated with their use had been assessed. However, one risk assessment indicated the person was at greater risk with bed rails being used, yet the person had bed rails in place. Further, the risk assessment had been reviewed monthly and consistently indicated the risk would be greater with bed rails in place. We raised this with the manager, who assured us the person was safer with bed rails and confirmed the risk assessment had been completed incorrectly. The manager took action to review and amend the risk assessment during our inspection. However, this showed not all risk assessments were fit for purpose.

The above demonstrated a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because risks to the health and safety of people had not been appropriately assessed.

Where records showed a person had diabetes, there was an associated risk assessment and we found care records included information to help staff identify any complications. The records we inspected showed blood sugars were checked as required. This helped to ensure people received safe care in relation to their diabetes.

We identified first aid boxes were not appropriately stocked. The manager told us there were three first aid boxes. However, when we checked we found there were only two first aid boxes and both of these were inadequately stocked. For example the first aid box in the kitchen contained two sterile pads only. This meant sufficient supplies of safety equipment had not been maintained. When we raised this with the registered provider, they took immediate action to order supplies. Following the inspection, the registered provider advised us the treatment room was fully stocked with dressings, dressing packs and bandages should they be needed. However, this meant sufficient supplies of safety equipment had not been maintained.

We saw some safe moving and handling manoeuvres, where staff appropriately assisted people to transfer with the use of equipment. However, we also saw some unsafe moving and handling practices, such as a staff member placing their hand behind a person's neck to pull the person forward. We shared our findings with the manager and nominated individual and advised they arranged for staff to be re-trained by a competent person as a matter of urgency. This was arranged and had taken place for all staff by the final day of our inspection.

On the third day of our inspection, an emergency situation occurred and emergency services were called to assist a person. We observed basic assistance, such as protecting the person's airway, was not provided. This put the person at serious risk of further deterioration. Upon arrival of the paramedics, the person needed to be transferred to move twice because the ambulance stretcher would not fit in the lift to the person's room, which was on the third floor. This caused further pain to the person and caused a delay in transporting the person to hospital. Following our inspection, we made a safeguarding referral to the local authority regarding how this incident was managed. Following the inspection, the registered provider challenged our view and told us they had investigated the incident and found the nurse acted appropriately. However, we asked on four occasions for the scope and outcome of this investigation and this was not provided.

Wound management was not effective. A person had been assessed as being at risk of further deterioration of their skin integrity. The person had pressure ulcers that were being monitored and dressed by the nurses employed by the registered provider. The care plan detailed the dressing to be used. However, there was no record of wound condition, size or deterioration/improvements documented when the wounds were re-

dressed. It was therefore not clear if the wound care was effective. This meant risks to the person were not being appropriately managed.

Records showed care and treatment was not provided in line with people's care plans and assessed needs. For example, the records for a person who should have been assisted to reposition every two hours showed at times there were over four hours between position changes. We looked at another person's record titled, 'Toileting Regime Chart.' The record indicated 'Special instructions: At least 2-4 hourly.' However, records showed the person had not been assisted for periods of up to nine hours. This meant risks to people were increased because it was not possible to determine whether care and support was provided in line with assessed needs.

Some people living in the home experienced behaviour which may challenge others. Records showed a person had been aggressive at times and was more energetic than usual and therefore the person's GP had been contacted. Records indicated, 'Continue to monitor and record any outburst.' Although a behaviour chart was in place, this had not been completed in a way which would enable triggers to be identified and the record lacked information in relation to appropriate distraction techniques which may help to keep the person, and those around them, safe. The person's care record did not contain this information. This meant there were increased risks to the person's, and other people's, safety.

The above examples demonstrated a breach of Regulations 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not do all that was reasonably practicable to mitigate risks to people, arrangements were not in place to take appropriate action in a medical emergency and staff delivering care and treatment were not competent.

Personal emergency evacuation plans (PEEPs) had been developed for people living at the home. These provided relevant information for staff or emergency services in order to ensure people could be evacuated safely in an emergency. However, the file which contained the PEEPs contained a plan for a person who was deceased and two people's plans were incorrect because they had moved rooms and the plans did not reflect this. This meant the PEEPs for those two individuals would not be effective in the event of an emergency because they contained incorrect information. When we highlighted this, the manager assured us this would be updated immediately.

In the basement of the home there was a cupboard under the stairwell which had been used to store combustible materials. In the event of a fire, smoke from this could have made the stairwell inaccessible to people in an emergency. We shared our concern with the manager, who told us they would arrange for the material to be removed and, following our inspection, we shared our concerns with the fire service.

On the first day of our inspection we saw a basement store room which contained paint and other hazardous substances. Although the room was lockable, the room was seen unlocked and unattended. This posed a risk to people who could access hazardous substances.

On the first day of our inspection we found some call bells were either not within reach of people or the system was disconnected. This put people at risk because they were not able to call for assistance. We requested the manager and registered provider take immediate action to address this and, on the second day of our inspection, action had been taken and people were able to access their call bells and a system was installed which meant call bells could not be unplugged.

We found doors onto stairwells were able to be pushed open, without the security code being entered. This was highlighted on the second day to the manager. The nominated individual told us, during the third day of

the inspection, this had been resolved. However, we found we were still able to push one of the doors to the stairwell open. This increased the risk of falls to people.

The above examples demonstrated a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the premises and equipment used by the registered provider were not safe for their intended purpose.

Some safety checks were completed. Records showed up to date checks had been completed in areas such as gas, electrical, fire safety and safe water temperatures. Servicing of lifting equipment had also taken place. Records showed emergency systems such as fire alarms, emergency lights and fire extinguishers were tested regularly. The lift had broken down during our inspection and was not in working order on the second day. The registered provider shared with us their contingency plan and showed they had measures in place to help keep people safe, such as additional staff. One person living at the home posed a particular fire risk to themselves and to others. Actions had been taken by the manager and registered provider to reduce the risk, including installing additional smoke alarms and ensuring no other residents were residing in the same fire zone. This showed some systems were in place to keep people safe from risks associated with equipment and fire.

We checked whether private and confidential information was safely stored, to maintain confidentiality. We found some records were stored securely in a lockable room or lockable trolley which helped to keep records safe. However, four medication trollies were stored in the dining room with the medication records accessible to everyone. This meant records were not always kept safe and secure.

Accidents and incidents were recorded, actioned and analysed appropriately. This meant the manager was able to identify and trends.

We looked at whether sufficient numbers of staff were deployed. The registered provider used a dependency tool to identify the number of staff required to support people safely. However, this was not always scored correctly or reviewed when there were changes. Therefore it was not evident there were adequate staffing hours provided to meet people's needs. The dependency tool identified people as low or medium dependency and the scores used to determine the levels made it very difficult to reach a score of high. People who had a high level of nursing care needs were assessed as medium needs on the provider's dependency tool. This meant we could not be assured sufficient numbers of staff were deployed because the dependency tool was not effective.

We found staff were not always deployed effectively, taking into account the layout of the building over four floors, especially at peak times. In the early morning, during staff hand over there were no staff available on the floors apart from the ground floor. However, as an inspector walked around the building at this time, some people required assistance.

Staff told us they felt there were enough staff on duty to meet people's needs. However, they said at times the layout of the building, and the slow speed of the passenger lift caused issues with responding to people's needs in a timely way. Some people we spoke with told us there could be more staff. One person said, "I have been ringing the bell for ages and have had no response," and another person told us, "The staff work hard but I don't think there are enough of them. I don't want to trouble them."

The above demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because sufficient numbers of suitably qualified staff were not deployed appropriately to meet people's needs.

We inspected five staff recruitment files. We found safe recruitment practices had not always been followed. Identification had been verified and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. However, records showed gaps in employment history were not explored and records did not indicate discrepancies between dates of employment recorded on application forms and dates of employment from applicants' referees had been explained. This meant the registered provider could not demonstrate they were aware of the employment history of some staff members working at the home. We highlighted this to the registered provider. This demonstrated a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems in place to ensure staff were fit and proper and of good character.

We found medication procedures were in place to guide staff and ensure safe medication administration. We saw most of the procedures were followed by staff. Some people were prescribed medicines to be taken as and when required, known as PRN (as required) medicine. Some protocols for taking this medicine lacked detail. They did not explain fully when to give the medicine or detail how people presented when they required the prescribed medicine, or detail whether the medicine was effective. Some people were living with dementia so were not able to verbally tell staff when they required PRN medication. Therefore the protocols were required to guide staff to be able to determine if people required any PRN medicines.

We found the systems in place for recording topical medicines were not followed. For example people were prescribed cream directed to apply regularly from one to four times a day. We found the medication administration record (MAR) was not always signed by staff to confirm when it had been applied. It was therefore not possible to determine if creams were being administered as prescribed. These issues were addressed by the registered provider following our first visit.

Medicines were administered by staff who had received training to administer medicines. The manager told us all staff had received competency assessments, yet we observed staff did not always give appropriate support to people when they administered their medicines. The National Institute for Health and Care Excellence (NICE) guidance states care home staff must record medicines administration, on the relevant medicines administration record, as soon as possible and ensure that they complete the administration before moving on to the next resident. We observed one member of staff sit at a table and sign all the MARs together, after they had administered the medicines. This was not safe practice and meant increased risk of errors.

The above demonstrated a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely.

We checked the Controlled Drugs, which are drugs covered by misuse of drugs legislation. We found these were managed safely.

Infection prevention and control systems were not effective. Although we saw decoration was ongoing at the time of our inspection there were many areas that were not well maintained and therefore could not be effectively cleaned. There were also areas in the home with a strong unpleasant odour.

We saw damaged wall plaster, loose and missing wall tiles, dirty and stained furniture, some carpets were threadbare and dirty with one which was damaged and causing a potential trip hazard. Some store rooms and cupboards had items stored on the floor which made them difficult to clean. Curtains were dirty and not fixed properly. Toilet seats, shower and bath chairs were dirty and not kept clean. We also found many toiletries including toothbrushes and toothpaste were stored on the toilet cisterns in en-suites. This posed a

risk of cross contamination and was not hygienic. We discussed this with the manager who agreed to develop a robust audit tool for infection prevention and control and ensure all areas that required attention were identified and actioned.

The above examples demonstrated a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems were not in place to reduce risks associated with infection prevention and control.

We observed people using mobility aids which were labelled with the person's name. Additionally, when we observed staff to assist people with the use of a hoist and sling, the slings were labelled for the individual. Staff we spoke with confirmed they used individual slings for people. This helped to ensure people only used equipment which had been identified for their use.

Inadequate

Is the service effective?

Our findings

We asked people whether they felt staff had the skills and experience to provide effective care. One person said of staff, "I suppose they know what they're doing."

The content of care records varied and some showed people's needs had been holistically assessed, whilst others did not. For example we found, although care plans contained a section relating to, 'Sexuality,' records showed no consideration had been given as to how people may wish to express their sexuality. Some care records had not considered people's language or communication needs, particularly for those people whose first language was not English. We shared our findings with the manager and registered provider who assured us care records were being reviewed and updated.

Records showed staff had received an induction into their roles and training in areas such as moving and handling, fire prevention and evacuation drills, safeguarding and health and safety. However, we observed some unsafe moving and handling practice and therefore asked the manager about the training staff had received. We asked to see a copy of the trainer's certificate, because moving and handling training was delivered in-house by a team leader. This could not be produced. We asked to view the content of moving and handling training and the manager told us, "It will be different depending on if it's new staff or a refresher," but the content could not be provided to us. This meant the provider was not able to evidence that staff had received appropriate moving and handling training. We also found not all staff followed safe moving and handling practices, and people were being assisted to move in unsafe ways. We raised our concerns and the manager and registered provider immediately arranged for additional moving and handling training.

The registered nurse told us their clinical support came from a community care support team, which was a community based team providing support to residential and nursing homes in the district. However, we were told, and records confirmed, there was a lack of clinical support provided for the nurse by their employer, the registered provider. Records showed no formal observations of practice or competency assessments had taken place. One to one supervision was provided by the manager, who was not clinically trained. This meant insufficient support was provided to clinical staff deployed at the home. We raised our concerns with the registered provider and they implemented a structure to manage clinical supervision more effectively.

The above demonstrated a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff did not receive appropriate support, training, development and supervision to perform their duties effectively.

A care worker told us they had formal supervision every three months and they felt supported. Staff confirmed to us they shadowed more experienced members of staff prior to commencing their roles. Care workers received regular one to one supervision. This is an important aspect of staff development which can provide an opportunity for staff to reflect on their performance and discuss any concerns or training needs.

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.

The care workers we spoke with were able to outline the principles of the MCA and they had a basic understanding of the requirements of the Act. However, we found the principles of the MCA were not followed. For example, one person's file contained an assessment of their mental capacity to participate in the care planning process. This assessment determined the person lacked capacity to participate. However, there was no record of any decisions, in relation to their care and treatment, being made in the person's best interests, as required by the MCA. Furthermore, the MCA requires mental capacity assessments to be decision specific. The assessments we inspected were generic in nature and did not address specific decisions.

We saw one person's care record indicated the person lacked capacity to consent to care. This person had bed rails on their bed-side in order to stop them falling from bed. Although the risks associated with this had been assessed, the person's mental capacity to agree to this had not been assessed and there was no evidence the decision to use bedrails had been made in the person's best interests. This further demonstrated the principles of the MCA were not being followed.

People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered provider had identified some people lacked capacity and were being deprived of their liberty. Therefore they had submitted DoLS applications. Many of these were in the process of being determined and the manager showed us they were following these up on a regular basis. However, we identified some people had not had an application made where this was necessary and we requested the registered provider submit an urgent DoLS application in relation to one person. This person told us they felt trapped and they did not want to live at the home. The person was being deprived of their liberty, without authorisation and appropriate safeguards being put in place. The registered provider made the application during our inspection.

The above demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because consent to care and treatment was not always appropriately sought and the registered provider did not act in accordance with the Mental Capacity Act 2005.

Our observations, and the records we inspected, showed people's nutritional and hydration needs were not met. One person had been assessed as being at risk of weight loss and they had lost considerable weight over the previous five months. Although this had been identified, the person continued to lose weight and this had not been followed up to ensure they were reviewed by the dietician. The referral to the dietician had been sent on 1 November 2017 and the manager told us, "They don't review, and they don't visit the home when we send in a referral." We found not all the required information was submitted with the referral to ensure the dieticians had a full overview of the concerns because staff were not completing the screening tool correctly. Where people had lost over 10% of their body weight over a six month period this was not reflected in the assessment. We also saw the person had not been seen by their GP to review their weight loss. From the weight records we were shown, 14 people had lost weight over a six month period and seven of these had lost over 5% of their body weight. This meant appropriate steps were not being taken to effectively support people with their nutrition and hydration needs.

Food and fluid charts were not effective at monitoring people's intake. An improved chart was introduced during the inspection after we highlighted this. However, this failed to monitor the amount of food and fluid consumed. Where nutritious shakes were provided in order to increase calories, the amount consumed was not recorded. Portion sizes of food were not recorded so, when records indicated, 'ate all,' it was not clear how much had been consumed. This meant people's intake could not be monitored effectively.

The meal-time experience required reviewing. There had been an attempt to try and meet people's cultural needs in relation to diet. However, this lacked involvement of people living at the home and people told us they did not like the food. We observed people leaving their food and this then being taken away by staff, without an alternative being offered. Although the manager told us people were given meal choices, we observed this was not always the case. At breakfast we saw plates placed in front of people without people being asked what they would like. One person told us, "There is no choice for meals. I have to be hungry to eat. If I like it I will eat more." However, another resident told us, "I get plenty of food. I can't finish it."

Staff told us, in addition to drinks served at meal-times, drinks were offered in between meals and containers of drinks were kept in the dining room and we observed this in practice. However, some people who had asked for drinks were not provided with a drink and there were missed opportunities to provide people with extra calories. For example, we observed as the tables were being cleared after breakfast a person became confused about whether they had eaten or not and asked "Is there any food?" A member of staff shouted across the room, "Has [the resident] had breakfast?" and they were told that they had. The care worker replied, "Get [them] a cup of tea," and left without speaking to the resident to ask if this was what they wanted. The person may have still been hungry after their breakfast but staff did not ask the person in order to establish this. On another occasion, we observed a person asked a member of staff for a cup of tea and the staff member confirmed they would fetch one. The person left the room some time later, having not received their drink. This showed there was a lack of systems and processes in place to ensure people's nutrition and hydration needs were met.

The above demonstrated a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's nutritional and hydration needs were not met.

Some of the people who lived at Abbotsford Nursing Home were living with dementia. However, the environment was not suitable for people living with dementia. Although there was some pictorial signage such as for the lounge and dining areas, other signage was lacking. For example, some bedrooms did not have any signage such as room name or number on the door which may make it difficult for people to navigate to their rooms. We heard people repeatedly asking the day and time during our inspection. People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. There were no orientation boards on display.

We recommended the registered provider access national guidance and good practice in relation to effective surroundings for people living with dementia, with a view to improving the environment.

A communal lounge had recently been decorated in a Chinese style, featuring symbolic flowers such as water lilies and Chinese writing, saying, 'Welcome.' The lounge was popular with people of Chinese origin. A relative told us, "It's better, it's nicely painted and there's nice furniture and stuff here." The television in the Chinese lounge was tuned to a Chinese language speaking channel. People told us there were different channels available in Mandarin. This showed some steps had been taken to meet the needs of different cultures.

Records showed the manager worked with other health care professionals in order to meet people's wider

health care needs. For example, referrals had been made to a speech and language therapist, dietician, social worker and GP when this was appropriate. One record we inspected, where there had been recent changes to a person's behaviour, showed a multi-disciplinary meeting had been held which included input from different professionals such as speech and language therapist, psychologist, occupational therapist, a nurse and the manager. However, following input from, and referrals to, other health care professionals, appropriate actions were not always taken to improve people's health and well-being.

Inadequate

Is the service caring?

Our findings

Our observations showed a wide variation in the level of care provided by staff. Some staff demonstrated the ability to support people in a caring and dignified way and others did not. We observed staff assisted a person to move with the use of a sling and hoist. The two staff members spoke with the person throughout the manoeuvre and reassured the person, using phrases such as, "You're going up now [name]," and "You're okay." Appropriate touch was used to provide reassurance to the person.

We asked people whether staff were caring. One person told us, "Staff are alright. I get a good night's sleep and a good breakfast. What more could you ask for? I'm happy enough."

A care worker told us, "I love it," when we asked whether they enjoyed their role. Another told us, "I love what I do."

During one observation, we saw staff assisted a person to move with the use of a sling and hoist and, on this occasion, staff did not talk throughout the manoeuvre. There was no explanation or reassurance given. We were sat at the other side of the room observing and, when the person was being hoisted, we could see their back and part of the person's incontinence pad was showing. Staff did not wrap anything around the person, or pull the person's clothes down to protect the person's dignity.

We observed a member of staff assisting a person to eat their meal. We did not see the person communicate verbally during our inspection. However, the member of staff did not attempt to engage with the person, other than saying words such as, "Open," and, "Open your mouth," and, "Open your mouth, come on now." Furthermore, the staff member broke off twice from assisting the person, in order to change the channel on the television, even though the person was not facing the television and the only other people in the room were inspectors. On one of these occasions, food was left around the person's mouth whilst the member of staff went to adjust the television.

We observed another member of staff assist the person to take their medication. This staff member also lacked warmth and did not engage with person, other than to say, "[Name], medication, open your mouth." We later checked this person's care record which indicated the person was nearing the end of their life and stated, '[Name] is unable to verbally communicate but staff has to talk to [Name] during intervention.' This demonstrated some staff lacked the skills to treat people with dignity and respect.

On the morning of the second day of our inspection, we observed three different people were in the dining room. All three people were wearing ill-fitting shoes. One person's shoes were too large and were therefore dropping from the back of their heel. This meant the person needed to 'drag' their shoes along the floor. Another two people's footwear had caved in at the heel. This was not dignified and, furthermore, could cause an additional falls risk to people. We highlighted this to the manager, who advised some families had been asked to provide footwear or funds and this had not been forthcoming but this was currently being followed up. However, we advised the manager that it would be feasible to pull the backs up from the shoes which had caved in at the heel, to make safer and more comfortable for people. The manager told us people

would not allow staff to assist them. However, we then heard the manager approach a person to assist with their footwear and the manager pulled the heel back into the correct position. This further demonstrated people were not always treated with dignity.

On the first day of our inspection, we observed staff assist a person into the lounge, where the person was to have their breakfast. We asked the person what they having for their breakfast. The person told us, "I've no idea. Whatever comes." The person was brought a bowl of cereal and ate this. We observed staff brought this and there was no engagement with the person. No drink was offered to the person, except for some cold water to take their medicines. The person told us they liked a cup of coffee with their breakfast in a morning. However they left the lounge, sometime later, after eating their cereal, without having had a hot drink. We observed the person was given their medication. The carer worker said, "Take your medication," and passed the person their medication with the glass of water. The carer worker then left the lounge. There was no conversation to ask how the person was, and no explanation regarding what medicines were being given. This demonstrated a lack of respect shown toward the person.

One record we inspected stated, '[Name] unable to indicate [their] choice of clothing and due language problem. Chinese.' This meant records indicated some people were not given the opportunity to make their own choices, due to the fact English was not their first language. This further demonstrated person centred care was not being provided and some people were at risk from discriminatory practice due to their language spoken. Of the five staff training records we inspected, none recorded training in relation to equality, diversity and human rights.

The above examples demonstrated a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always treated with dignity and respect.

There were 11 people living at the home that spoke Cantonese and did not communicate in English. On the first day of our inspection, there was a care worker who was able to speak Cantonese, and they were providing one to one care for a person (meaning they were required to support one specific person's needs). This person decided they wanted to go to bed, so this meant there were no Cantonese speaking staff in the communal area for a period of two hours. This meant, for those people who spoke only Cantonese, there was a lack of engagement from staff for long periods.

We asked a member of staff how they took into account people's characteristics such as cultural or religious backgrounds or disabilities. The care worker told us, "Care is paramount. No matter what background." We asked staff how people's needs were met in terms of equality and diversity. We were told by a member of staff a priest visited a person at the home weekly and a person from a Chinese Buddhist Temple visited the home occasionally. However, we found some care records contained information relating to people's religious and cultural needs and others did not. This meant consideration had not always been given to the importance of people's needs in terms of equality and diversity.

Some care records we reviewed included comments such as a person not always being, 'Compliant,' or a person, 'Misbehaving,' or, 'Can be very rude and aggressive.' These terms are not respectful and were not indicative of a caring, supportive environment.

Records showed some people had advocates involved in their care and they had regular visits from advocates. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

People told us their relatives were welcomed to the service and could visit them at times that were

convenient to them. People maintained contact with their family which helped to reduce social isolation.

Staff were able to explain to us ways in which they promoted privacy. One staff member told us, "I knock on a person's door and wait for a reply. I explain why I'm here. I use towels. I wouldn't allow anyone else in the room [whilst assisting with personal care]." This showed staff understood how to respect people's privacy. We observed staff knocked on people's doors before entering their rooms. Where no response was received, we heard staff called out the person's name and opened the door slowly. Furthermore, people told us they were able to choose the gender of their care staff. This showed staff respected people's privacy.

Care records indicated how people could be enabled to retain their independence. For example, one record indicated, '[Name] is able to wash [name] own hands and face if carer hands [name] the flannel and explains the process.' A member of staff told us they encouraged people to retain their independence by encouraging people to do as much as they could for themselves." This showed enabling people to retain their independence was considered at the care planning stage.

Inadequate

Is the service responsive?

Our findings

We found a lack of person centred care. One relative told us, "My [family member] spends all day in the living room apart from meals. [Family member] can't walk so they're stuck there and after tea [they] are taken back to bed." We observed, and people and staff confirmed, there was a lack of activities or meaningful occupation at the home.

During our previous inspection of December 2016, we found a breach of regulation 9(1), relating to person centred care. During this inspection, records at the home and our observations of practice indicated person centred practice was still not embedded in the home.

We inspected 11 care records. These contained information relating to people's abilities, areas of dependence and desired outcomes in different areas of care such as medication, falls, mobility, personal hygiene, continence needs, skin care, nutrition, mood and cognition, sleep and communication. Records showed care plans were evaluated monthly.

Although care records contained some information pertaining to people's choices and preferences, records did not indicate people were enabled to be continually involved in reviews or assessments of their care. Furthermore, none of the records we sampled for people who did not communicate in English had been translated, which indicated some people would not be able to read for themselves the content of their care records. This meant people were not involved in developing and reviewing their care needs.

One person we spoke with was clearly able to communicate with us, through an interpreter, and talk to us about their life history. However, this person's care record indicated they lacked capacity to consent to care and there was no evidence in the person's care record to show they had been involved in any reviews or evaluations of their care. This person's communication needs care plan indicated the person understood very little English, and stated therefore, 'Cantonese speaking staff can talk to [name] and find out if [name] wants anything.' However, there was no evidence the person had been involved in decisions about their care planning.

The registered provider employed four Cantonese speaking staff, one of whom worked in the laundry and another was providing one to one care for an individual. This left two care assistants who were able to speak Cantonese and neither of these staff worked night shifts. This meant, at night-time, there were no staff available to communicate verbally with the 11 people who did not speak English. This meant person-centred care could not be provided for those people.

We asked a member of staff how they communicated with people who did not speak English. We were told, "To be honest, it's difficult. We try to read body language." A member of staff told us they had previously used pictorial cards to assist with communication but said these were no longer used. A relative told us, "It's difficult because [my relative] doesn't speak English and only two or three staff speak Chinese and some staff know the odd word." This showed effective measures were not in place to assist people to communicate their needs to care workers

This demonstrated a continued breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not involved in continually discussing their care and treatment and information had not been provided in an accessible format for people to understand.

The care records we reviewed contained a photograph of the person and included relevant information relating to people's previous medical history. Some records indicated people's individual preferences in relation to their care and support. Another record, which indicated the person was dependent on staff choosing the person's clothing, indicated the person's preferred choices in relation to their attire. All of the staff we asked told us they read people's care plans in order to understand the care and support people required. This helped to enable staff to provide appropriate support to people.

Some care records did not contain information specific to culture, religion or background, despite people clearly identifying with a particular culture. The manager told us they had updated some care records to make them more person centred. We therefore asked to see a record which had recently been updated and we inspected this care record. We saw this record contained some information relating to the person's preferences and choices and these were recorded, including end of life wishes. The care record included a document called, 'My life story.' This included detail such as the person's family history, childhood memories, work, hobbies, favourite television programmes, choice of music, food and drink for example. This showed work was ongoing to improve the content of care plans to enable personalised care and support to be provided.

Some areas and doors in communal areas of the home contained pictorial signage such as the bathroom, lounge and dining area. There was a 'Chinese lounge' which had been decorated in culturally appropriate ways for people from Chinese culture. This showed some steps had been taken to make the home culturally relevant for the people living there.

The registered provider employed an activities coordinator. The activities coordinator engaged well with people living at the home and people responded positively with smiles when the activities coordinator spoke with them. However, we were told by staff the activities coordinator had not worked in this capacity for three weeks, because they were providing care to people. At the time of our inspection, we were told no planned activities had taken place since the beginning of December because the activities coordinator was not working in this capacity. This meant there was a lack of meaningful occupation for people living at the home. Although we had not seen activities throughout our inspection, following the inspection, the registered provider advised us that activities in December had included a children's nursery, Christmas fayre, choirs and a visit from the Chinese community.

We observed a person to be isolated on the third floor and we shared our concern with the manager and registered provider at the end of the first day of the inspection. The person remained isolated, in their room on the third floor, on the other two days of our inspection. This was despite the person's care record stating the person 'Likes the company of others.' We spoke with the person and they told us they were not happy living at the home and that they sat in bed all day, on the third floor, away from everyone else. They told us they were conscious staff had to go up and down four flights of stairs and therefore did not like to keep ringing them. The person told us they felt trapped. This meant the person was socially isolated and actions had not been taken to prevent this.

At our previous inspection we found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to receiving and acting on complaints. We checked during this inspection and found improvements in this area. The complaints procedure was displayed in communal areas and this had also been transcribed into Chinese text. The registered provider had a process in place

for dealing with complaints. No formal complaints had been received at the time of this inspection. The manager told us they had an 'open door' policy where people living at Abbotsford, their visitors, and members of staff could approach them at any time to discuss any complaints or concerns they had. However, the manager did not speak Cantonese so people who spoke Cantonese and did not speak English would not be able to raise their concerns at any time.

Some people's care records contained information in relation to their end of life wishes where this was appropriate. However, this was not consistent and records showed end of life care wishes had not been considered for some people. The manager was aware this was an area which required further development.

Inadequate

Is the service well-led?

Our findings

The home had a manager in post who had been appointed since the last inspection in December 2016, although at the time of our inspection, they had not registered with the Care Quality Commission to manage the service. They had submitted an application to become registered on 1 November 2017 and this application was invalid and returned to them on 3 November 2017. They submitted a further application on 12 December 2017, during our inspection. Following our inspection we received confirmation the application was being processed.

The registered provider did not have effective systems in place to monitor and improve the quality of service at the home. We found some records were conflicting or incomplete and we saw evidence the registered provider had not acted in a way which ensured people received safe care and treatment.

All of the staff we asked told us they felt supported by the manager. A member of staff told us the manager was, "Approachable and visible," and, "The best manager the home's had." This staff member told us the manager was supportive of people and staff. A further member of staff said, in relation to the manager, "As a leader, they're very good. I feel supported and valued 100%."

Staff told us there was an open culture at the home. A member of staff told us, "If I made a mistake, I'd be able to say to. It's important to be open."

A visiting health care professional to the home told us they felt the manager was, "Turning the home around." We were told the atmosphere at the home had improved since the appointment of the manager. Another visiting health care professional added, "The manager has residents' interests at heart."

Following our previous inspection of December 2016, we issued requirement notices to the registered provider and requested an action plan to show how the registered provider would address the breaches of Regulations we identified. We did not receive an action plan following the last inspection. This demonstrated a breach of Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to provide an action plan when requested by the Care Quality Commission.

During our previous inspection of December 2016, we identified a breach of Regulation 17(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to good governance because there were ineffective systems in place to assess and monitor the quality of service. We checked during this inspection and found systems remained ineffective.

There was a system in place to monitor the quality of the service provision. Some audits we were shown had identified areas that required improvement and actions were in place to address this. For example the analysis of accidents and incidents was very thorough. The tool looked at times, occurrences and locations of incidents and, as such, would identify themes and trends to be able to minimise risk.

However, some other systems for reviewing and monitoring quality were poor. We saw the audits for weight monitoring were completed and identified weight loss. However, they were ineffective as they did not identify the assessment tool was being incorrectly applied, so increased risks were not being identified. Lack of basic first aid equipment had not been identified. Audits of care plans did not identify conflicting information or that some assessments, such as those relating to mental capacity and best interests decision making, were missing. There was no infection control audit tool and no robust system in place to identify areas that required attention. The manager told us they completed walk-rounds and picked up issues and addressed these with the maintenance team, but did not formally document these on an action plan. The registered provider agreed to devise a more robust environment and infection control audit tool.

Contemporaneous records of care and support provided were not always kept and some records contained contradictory information. For example, one record indicated a person should be supported to reposition two to three hourly. However, when we could not find records of this, the manager told us the person did not require assistance to reposition. Another record we reviewed contained contradictory information relating to the required consistency of food a person required. Furthermore, other records such as personal emergency evacuation plans were not up to date. This meant care records were not always an accurate reflection of the care people required and this had not been identified through any quality auditing.

The above demonstrated a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were ineffective systems in place to assess, monitor and improve the quality of service and the registered provider failed to maintain accurate and complete records.

Staff told us and records showed, staff meetings had been held regularly. We looked at records of some meetings and saw items such as cleanliness, staff sickness and contract monitoring issues were discussed. We noted during one meeting the manager told staff they must treat Abbotsford as, 'People's home.' Meetings are an important aspect of a manager's responsibility to address staff and to come to an informed view about the home.

Residents' meetings had been held in January, February, March and September 2017. We were told, however, unless there was a staff member who could translate, people who could not speak English would not be included in the meetings. This meant residents' meetings were not inclusive. We asked the manager to share with us any questionnaires or other formats that may have been used to gather people's views but these could not be provided.

The manager and registered provider were responsive to the areas of concern we highlighted during our inspection. Immediate actions were taken to help assure us people living at the home were safe. During and following our inspection, the registered provider submitted service improvement plans which identified the areas of concern and showed what action would be taken, when and by whom and regular updates were provided.

The manager was fully aware of what was required to ensure compliance with regulations. They told us they were supported by the nominated individual and the registered provider. This meant they were able to access the resources to ensure improvements were possible. They explained they had introduced new quality monitoring systems since they had been in post, which were still work in progress. They had identified the care plans were out of date and required reviewing. They told us this had commenced and they had, at the time of our inspection, reviewed and rewritten a number of care plans. The manager was aware improvements were required in communication, in particular for people whose first language was not English. Before our inspection was completed, the registered provider had advertised a new post for a multi-

lingual worker and had received some applicants.

The manager told us they had been made aware of an allegation of abuse by a member of staff. They were able to show us this had been dealt with appropriately and all necessary action taken to safeguard people. They were aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. They confirmed any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed a number of notifications had been received. This demonstrated the manager understood their roles and responsibilities.