Care Quality Commission

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Abbeydale Nursing Home

Inspection report

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Date of inspection visit: 5 and 6 November 2015
Date of publication: 11/01/2016

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection of Abbeydale Nursing Home took place on 5 and 6 November 2015. The purpose of the inspection was to monitor progress since the last inspection in May 2015 when breaches in regulation were identified.

Following the inspection in May 2015, the home was rated 'inadequate' overall. This meant the home was placed into 'Special Measures' by the Care Quality Commission (CQC). The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in Special Measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Abbeydale Nursing Home provides nursing and personal care for up to 36 people, many with a diagnosis of dementia. The home is located in Kirkdale, north of Liverpool City Centre. The home is located near to public transport links and other community facilities.

A registered manager was not in post. A manager had been appointed and commenced in post and they had applied to the Care Quality Commission (CQC) as the registered manager and this application was in process. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living in Abbeydale and staff had a good understanding of safeguarding procedures and how to raise any concerns. However, appropriate action in respect of peoples' safety had not been taken by the provider since the previous inspection. In addition to this, new risks had emerged where fire safety was concerned and people were still at risk of harm.

Risks regarding people's health and safety were not always assessed. We found some risk assessments had been completed inaccurately. This meant that appropriate measures may not always be put in place to minimise risks.

The environment and equipment within the home, were not monitored in order to ensure they remained safe. For instance, chemicals were not always stored securely and fire safety procedures were not sufficient to ensure people's safety. Processes were not in place for all equipment to ensure they were in safe working order, such as wheelchairs and bed rails.

There were not sufficient numbers of staff on duty at all times to meet people's needs in a timely way. Safe recruitment processes were not always followed when employing new staff to ensure they were of good character.

Medicines were not managed safely. For instance creams were not stored securely and stock balances were not correct for all medicines.

Applications for deprivation of liberty safeguards had been made, however not all staff had a clear understanding of this process and when it may be necessary. Consent was not always sought in line with the principles of the mental capacity act 2005.

Staff received regular supervision, however the induction process was not robust and did not follow the principles of the care certificate. Staff completed training in a number of areas, yet there was no evidence that staff had received training to guide them in supporting people with dementia.

People were supported by external healthcare professionals and staff made appropriate referrals based on people's needs, in order to maintain their health and wellbeing.

Feedback regarding meals was positive and people had choice.

Some adaptations had been made in order to make the environment suitable for people living with dementia.

People told us staff were kind and caring and we observed people's privacy and dignity being maintained. Staff we spoke with knew people well and care files recorded people's preferences with regards to their care.

Summary of findings

Records of people's involvement in their care planning was inconsistent. Relatives told us they were kept informed of any changes in their relatives care needs.

Most care plans were detailed and reviewed regularly, however some plans contained inconsistent information in relation to people's care needs. People's preferences were evident within their care files.

People told us they had choices regarding their daily routines and enjoyed participating in the activities available within the home.

Audits were completed in areas such as accidents, medicines and care files, however they were not comprehensive and did not reflect the issues raised during the inspection. Even though the provider visited the home and completed checks, they too failed to pick up on the concerns we found on this inspection.

There was a lack of risk assessments in place regarding potential risks within the home and there were no processes in place to monitor equipment, such as wheelchairs.

Records regarding people's care and treatment were completed retrospectively and not at the time of care provision.

Feedback regarding the management of the home was positive and people felt able to raise any issues with the manager.

The homes policies and procedures contained information that was not current and did not provide staff with clear guidance regarding the homes processes.

Some incidents had occurred that the home were required to notify CQC of, but not all of these incidents had been reported to CQC.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People felt safe living in the home and staff had a good understanding of safeguarding procedures.

Risks regarding people and the environment were not always effectively assessed to enable measure to be put in place to minimise risks.

There was not sufficient numbers of staff on duty at all times to meet people's needs. Safe recruitment processes were not always followed when employing new staff.

Medicines were not always managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

Consent was not always sought in line with the principles of the mental capacity act 2005. Not all staff had a clear understanding of the deprivation of liberty safeguards.

Induction for staff was not role specific and staff did not receive training to support them to care for people with dementia.. Staff were supported in their role through regular supervisions.

People received specialised advice and support from external healthcare professionals as required.

People told us they enjoyed meals and there was always choice available.

Some adaptations had been made to the environment to make it suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and people had their dignity and privacy maintained by most staff.

Staff knew people, their care needs and their preferences well.

People's views were sought through regular meetings and completion of quality assurance surveys.

Visitors were able to visit the home without restriction.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's involvement in their care planning was inconsistent. Relatives told us they were kept informed of any changes in their relatives care needs.

Not all the care files were reviewed regularly to ensure they reflected people's current needs.

People told us they had choice regarding their daily routines.

Activities were available and people told us they enjoyed participating in them.

People had access to a complaints policy and felt they were able to raise any concerns.

Is the service well-led?

Inadequate

The service was not well led.

Audits completed did not identify issues raised at the inspection. Risk assessments were not in place to identify all potential risks within the home and there were no records to show that equipment was monitored to ensure it was in safe working order.

Records regarding people's care were completed retrospectively.

Feedback regarding the manager was positive and people felt able to raise any concerns and were confident they would be listened to.

The homes policies and procedures did not provide up to date guidance.

Not all notifiable incidents had been reported to CQC.

Abbeydale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place over two days on 5 and 6 November 2015.

The inspection team included an adult social care inspector, an inspection manager, a pharmacist inspector, an expert by experience and a specialist advisor in health and safety. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The 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.

We looked at the notifications the Care Quality Commission (CQC) had received about the service. We contacted the Merseyside Fire and Rescue Authority, the local Clinical Commissioning Group (CCG), Liverpool Social Services and the local infection prevention and control team and asked for any updates about the service.

During the inspection we spoke with the manager, provider (owner), cook, seven members of the care team, eight people living at the home and five relatives.

We looked at the care files for four people living at the home, four staff recruitment files, medicine administration charts, staff rota's and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some bedrooms, bathrooms, the dining rooms and lounges.

Inadequate

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Abbeydale Nursing Home in May 2015, we identified breaches of regulation in relation to keeping people safe. The 'safe' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to safeguarding people from abuse; staffing levels; the recruitment of staff; the management of medicines; risks associated with the environment and equipment and the unsafe use of equipment.

In relation to staffing, at the previous inspection we found that there was insufficient staff to meet people's needs and maintain people's safety. During this inspection we found that adequate numbers of staff were still not available to meet people's needs.

We looked at how the home was staffed. On the first day of inspection there was a manager, one nurse, one senior carer, two carers, a cook, one domestic and a laundry person, providing support to 22 people living in the home. The manager told us this was the usual staffing level and overnight there were usually two carers and one nurse on duty. The staffing rotas we viewed showed the staffing levels were mostly consistent to those described by the manager. Care files included individual dependency assessments, however these were not used to inform a staffing analysis tool to identify the number of staff required. The manager told us staffing levels were agreed with the provider and were altered based on feedback from staff.

People we spoke with told us there was not always enough staff on duty to meet their needs. Comments from people living in the home included, "Not enough staff especially holidays and weekends, could do with more, they're trying to do everything", "Not enough staff" and "I have to wait for a while for [support]." Some relatives we spoke with agreed, they told us, "There are not enough staff, they never stop" and "There isn't enough staff." Our observations showed us there was not enough staff on duty during the inspection. We observed a person in a lounge requesting support from staff. There was only one staff member on the floor at the time, though there were two at other times during the day. The staff member was busy looking for another person who lived there who had left the lounge. The person requesting support became distressed and told us they needed support to access the toilet and often had to wait a long time as staff were too busy. They told us they tried not to go to the toilet too often because they knew staff were busy. We also observed one staff member support a person sitting in the lounge, into a hoist sling and attach the straps to the hoist. The person then had to wait nine minutes for a second staff member to assist as they had gone to another floor to answer a call bell. This showed that there were not enough staff on duty to meet people's needs. Although some staff we spoke with told us there were enough staff to meet people's needs, one staff member told us it was very busy at times as some people walked around the home and required supervision. The staff member told us it would be beneficial to have an extra member of staff to ensure they could meet people's needs.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2015 we found that medicines were not handled safely and we told the provider they must take action to improve the safe handling of medicines. On this inspection, we looked at how medicines were handled for six of the 22 people living in the home. We found some improvements had been made in the safe handling of medicines. For instance, photographs used by nurses when administering medicines to ensure that people were given the correct medicines were now in place, daily medicine checks were completed and care files contained care plans regarding medicines. We found further significant and serious concerns with regard to other aspects of medicines handling for all six people.

We found the provider failed to put into place safe operating procedures and policies for nurses to follow to enable them to handle medicines safely. The medication policy was undated and still had not been updated to include the recent NICE guidelines for managing medicines in care homes (2014). NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care services. The provider failed to ensure that the nurses administering medicines were skilled and competent to administer and oversee the safe administration of medication.

Most medicines were stored safely. However, we saw that creams were still being stored in people's bedrooms and risk assessments still had not been done for all creams stored in this way to confirm it was safe to store them there.

Inadequate

Is the service safe?

We saw that three people had not been able to have one of their prescribed medicines because they were unavailable in the home. If medicines are unavailable people's health may be placed at risk. We saw that the records about medicines were inaccurate and did not always account for medication. When we compared the records with expected stock levels of medicines we found that there were discrepancies. In some cases more medicine remained in stock than was expected if the medication had been given as prescribed. We found that there were a number of discrepancies when we looked at the expected stock levels of analgesics and one antipsychotic medication, in that tablets/liquids were missing or unaccounted for. All medication must be accounted for to prevent misuse. The nurse appointed as the clinical services manager, could not explain the discrepancies and had not been aware that they existed.

We saw there were very few records made to show creams had been applied. One carer told us that they "don't make records when applying creams; we just apply the cream that is in the person's bedroom". We spoke with the manager about the lack of records and she was unaware that staff failed to make records about the application of creams. We saw that no records were made about the use of prescribed thickening agents used to thicken people's drinks to prevent them choking. It is important that accurate records are made to ensure that people are receiving the medicines they are prescribed.

We saw that there was still either no information, or insufficient information to guide staff when administering medicines which were prescribed to be given 'when required' or as a 'variable dose'. If this information is missing, especially for people with dementia, medicines may not be given effectively or consistently and people's health could be at risk. We found that some arrangements had been made to give regularly prescribed medicines at the correct time with regard to food. However, we saw that one person was prescribed an antibiotic to be given on an empty stomach. We saw that it had been given for four days with a tablet which needed to be given with or just after food. The records showed that these tablets were both given at 10.00 am which was after the person had eaten breakfast. If medicines, such as antibiotics, are not given at the correct times they may not work properly, which places people's health at risk of harm.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found safe recruitment practices were not always evidenced. Not all staff had evidence of a Disclosure Barring Service (DBS) check; references were not available in all personnel files and records showed nurse's registration had expired. During this inspection, we found that some improvements had been made, such as files containing DBS checks, however further concerns were identified regarding staff recruitment.

We looked at how staff were recruited. We looked at four personnel files and evidence of applications forms, references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. All files viewed contained a DBS check, however one DBS evidenced previous convictions and there was no system in place to assess any potential risk and ensure the person was suitable to work with vulnerable people. The records showed that the most relevant references were not always sought as part of the recruitment process. For instance, one person's file did not contain a reference from any of their previous employers. This meant that effective recruitment procedures were still not undertaken to ensure the suitability and good character of staff. Staff registered with a professional body had their registration checked and this was recorded.

This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified a number of concerns in relation to environmental risks and risks relating to equipment. These included, carpets being in poor condition and one had cigarette burns in; there was a malodour within the home; adequate window restrictors were not in place; not all people had access to a call bell; some furniture was broken; cleaning products were accessible to vulnerable people; people's evacuation plans contained conflicting information and there was no evidence that equipment was monitored to ensure it was in safe working order.

Inadequate

Is the service safe?

During this inspection, we found that although the environment had improved in terms of decoration, there were still a number of concerns identified. We looked at what arrangements were in place for checking the environment to ensure it was safe. There was a completed health and safety audit which recorded that the home had a health and safety committee, that a register of all equipment was in place and that health and safety meetings were held. The manager however, told us these were not in place. The audit also stated that fire alarm tests were completed weekly, records we viewed evidenced that tests were completed but not always recorded accurately. The last test documented was 4 October, despite tests before this being recorded at later dates in October and this should have read 4 November.

Safety checks in relation to gas, electric, legionella and the fire alarm system were undertaken and employer liability insurance was in place.

A fire risk assessment of the building was in place. We viewed a fire policy which was due to be reviewed in February 2014 but there was no evidence this had been reviewed to ensure information was correct and up to date. The fire service had visited the home in August 2015 and had made recommendations, however not all of these had been completed. For instance, not all identified fire points had been changed to the recommended green break glass boxes. This meant that if the electrics were to become redundant in the event of a fire, people would not be able to get out of the home.

A light fitting in a linen cupboard was observed to have a foil tray surrounding it which created a fire hazard, as although this was an integral part of the light, it was not covered. The Fire Safety Officer confirmed this was a fire risk during the inspection and advised a cover should be fitted to the light. We observed two fire doors that did not close fully and one had a screw in the door handle mechanism preventing it from closing securely. The manager removed the screw on the day of inspection. On the first day of inspection we observed two loft access points without any cover. There were oil based paints that were stored directly beneath the loft hatches. This meant that in the event of a fire, it could easily spread to other floors and straight up to the roof of the building. The manager was made aware of this and on the second day these openings had been covered and the paints had been removed.

We made the fire service aware of our findings on the first day of the inspection and they visited Abbeydale on the second day of the inspection. The fire officer spoke with staff about the identified concerns and risks involved.

Records we viewed showed that staff had completed fire awareness training and staff we spoke with confirmed this. One staff member told us recent training included the use of equipment used to evacuate people in the event of an emergency.

Care files contained a personal emergency evacuation plan (PEEP), however they did not provide sufficient information to ensure staff could evacuate people from the home in the event of an emergency. For example, one PEEP advised staff to use a hoist to transfer a person into a wheelchair, however their room was on the first floor and there was no information to advise how to support the person to evacuate the home. It would not be appropriate to use a hoist for transfers in the event of an emergency evacuation, other measure should be in place to ensure people can be evacuated safely.

There was no evidence that bed rails were checked regularly to ensure they were in good working order. We observed that one bed rail was broken. This meant that there was an increased risk of entrapment and injury to the person. We observed a wheelchair with only one foot plate, a toilet frame that was unsafe and two dining chairs that had broken arms. This meant that equipment within the home was not maintained in order to ensure people's safety and wellbeing.

We observed data sheets in place for the chemicals in use within the home, however specific risk assessments had not been created to provide information in relation to the risks they may pose. We observed chemicals that were not stored securely, for instance cleaning chemicals within a sluice, and paint in a cupboard that was not locked. This meant there was a risk that vulnerable people could access the chemicals.

The kitchen had a sign advising that only staff should access the kitchen. However, one person living in the home was observed in the kitchen without any protective clothing on. The kitchen door handle was broken. This meant that the kitchen was not secure; vulnerable people had access to the kitchen and were at risk of injury.

We also found that risks regarding people's safety and wellbeing had still not been assessed appropriately. Four

Is the service safe?

care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as skin integrity, moving and handling, falls, nutrition and use of creams. We found however, that not all risks had been assessed. One care file showed that a person was using bed rails, yet there was no risk assessment completed to ensure these were safe for the person to use. One person who had previously been smoking in their bedroom did not have a risk assessment to identify risks and ensure appropriate measures were put in place to reduce the risks. A care plan was observed but this did not identify any risk reduction measures. A bed sheet was observed in the laundry with a burn hole in and burns were observed on carpets in some areas of the home. The manager told us no safety measures, such as fire blanket or heat proof mattress had been provided as the person should not smoke in their room. The manager told us however, that the person did not always comply with this. Not all risk assessments that had been completed in order to monitor people's health and wellbeing, had been completed accurately. For instance one nutritional risk assessment we viewed did not reflect the person's correct body mass index, therefore the risk level identified was not accurate. This meant that potential risks had not been assessed and appropriate safety measures had not been implemented.

Records showed that staff had received manual handling training; however we observed staff supporting a person to transfer in an unsafe way. This put the person at risk of personal injury.

This was a breach of Regulation 12(1)(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns regarding infection control and cleanliness were identified at the last inspection. For instance, dirty towels and bed linen were observed in people's bedrooms; flooring in one bathroom was torn; some hand towel dispensers were empty and there was a strong smell of urine evident from the ground floor carpet.

During this inspection, people we spoke with did not have any concerns regarding the cleanliness of the home. Comments included, "Everywhere is clean and tidy," "It's beautifully clean" and "Spotless." The records we viewed showed that cleaning schedules were in place as well as audits. The carpet on the ground floor had been replaced, although there was some malodour evident on the first and second floors. People we spoke with told us the odour had greatly improved over the past months. Mops should be stored inverted in line with infection control guidance, however we observed mops stored head down in buckets of used water. The manager agreed to ensure these were stored correctly. We observed gloves and aprons available around the home and staff told us they always had a good supply of these. Paper towels and liquid hand soap was available in bathrooms in order to ensure effective hand washing.

In relation to safeguarding people from abuse, at the previous inspection we found that newly recruited staff did not have a clear understanding of what constituted abuse and not all staff had received safeguarding training. During this inspection, we found that improvements had been made in order to safeguard people from abuse. Staff we spoke with had a clear understanding of what constitutes abuse and staff had received training with regards to safeguarding.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with told us they had completed safeguarding training recently and the training records we viewed confirmed this. Staff had a good understanding of abuse and the processes to follow should a concern arise. A safeguarding policy was available, however this required updating as it referred to agencies no longer in existence and did not contain relevant contact details. The local authority safeguarding procedure was available within the home which contained a contact number for people to ring should they have any safeguarding concerns. The manager had developed signs which were situated around the home which gave people details of who to contact should they have any concerns; these signs had been titled "Stand up, Speak up."

The manager kept a folder with outcomes of safeguarding referrals and records we viewed showed that appropriate safeguarding referrals had been made to the local authority for investigation.

People living in the home, staff and visitors told us they felt Abbeydale was a safe place to live. One person living in the home told us, "I'm definitely safe, and my belongings are safe" and a relative told us, "I honestly do believe my relative is safe here, and I come in every day."

Requires improvement

Is the service effective?

Our findings

At the last inspection in May 2015, we identified breaches of regulation in relation to the effectiveness of the service. The 'effective' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to staff training; staff supervision; seeking consent in line with the Mental Capacity Act (MCA) 2005 and a lack of choice and support regarding nutrition.

In relation to consent, at the previous inspection we found that consent was not always obtained in line with the principles of the Act; there was a lack of understanding regarding deprivation of liberty safeguards and mental capacity assessments were not decision specific. During this inspection we found that these concerns remained.

We looked to see if the service was working within the legal framework of the MCA. The 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 make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us a number of DoLS applications had been made and eight had been authorised and were now in place. Records we viewed showed that staff had attended training in relation to DoLS and staff we spoke with confirmed this. Some staff we spoke with had a good knowledge of DoLS, however others lacked understanding regarding the process and which people within the home DoLS related to. For instance, we were told DoLS could now be used for people who had capacity and one staff member was only aware of two people in the home who had a DoLS in place. We viewed the home's policy regarding DoLS; dated 2009, it did not include current guidance. This meant that people were at risk of having their liberty restricted unlawfully as there was a lack of knowledge and understanding regarding DoLS within the staff team. The records we viewed regarding DoLS were in date.

During discussions with staff they told us they always asked for people's consent and we observed this during the visit. For instance, before entering a person's bedroom to put their belongings away, and when assisting with personal care.

Some care files we viewed contained evidence of consent regarding photography and care planning signed by the person receiving care. One care file contained consent to the use of bed rails and to care planning, both signed by a family member and another care file did not contain any consent as it stated the person lacked capacity to consent. There were mental capacity assessment forms in people's care files, however these were not decision specific and therefore did not follow the principles of the MCA. One person's capacity assessment recorded they did not have any impairment of the mind or brain and did not lack capacity, yet the assessment continued which was not in line with principles of the act or the guidance within the assessment form. A list of activities attached to the assessment, recorded that the person had variable capacity in relation to some activities. For people who had been assessed as lacking capacity, there was no evidence that decisions were made in their best interest and were the least restrictive option. This meant that people were receiving care and treatment they had not consented to, or that had been agreed in their best interest if they were unable to consent.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that effective processes were not in place to support staff in their role, such as regular supervision and training. During this inspection, we found that staff now received regular supervision, however no training had been provided to staff to guide them to effectively support people living with dementia.

Staff told us the induction they received was sufficient .We looked at personnel files to establish how staff were inducted into their job role. The files contained a tick list induction which covered areas such as policies and procedures, values of care, the home, service user care and

health and safety. These were all signed as having been completed on one day. Records showed that the induction was the same for staff in all roles. The provider and the manager had not developed an induction that demonstrated how the principles of the care certificate were met. The care certificate is an identified set of standards that health and social care workers must adhere to in their daily working life. This meant there was a risk that staff may not be suitably inducted into their role.

We looked at on-going staff training and support. Staff told us they were well supported in their role and received regular supervisions. The records we viewed confirmed this. People living in the home and visitors told us they felt staff were adequately trained to enable them to meet people's needs. People told us, "They seem well trained, I'm well impressed with them" and, "They certainly know what they're doing." Staff we spoke with told us they had completed training in areas such as medicines, mental capacity and DoLS, manual handling, safeguarding and infection control. The training matrix we viewed also showed training in areas such as person centred care, health and safety, food hygiene and fire awareness. Staff we spoke with had not all received training to support them in caring for people with dementia. Not all nursing staff we spoke with had the appropriate clinical knowledge regarding covert medicines or pressure ulcer grading. Some of the capacity assessments completed which did not follow the principles of the mental capacity act, had been completed by a registered nurse. This meant people were at risk of receiving support from staff who were not sufficiently trained to meet their needs and ensure their safety and wellbeing.

This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns had been identified at the last inspection in relation to the lack of choice available regarding meals and lack of appropriate support provided to people to ensure they maintained their nutritional status. During this inspection, we found that improvements had been made regarding these concerns.

We observed the lunch time meal on the second day of inspection. Some people chose to sit at the dining tables whilst other people chose to sit in lounge chairs with a table in front of them. Dining tables were laid with a table cloth, paper napkin and cutlery. The menu displayed advertised different meals than those which were served and the chef told us they had altered the menu as they knew people would prefer what had been served. Feedback from people regarding meals was positive. Comments included, "Food is good there's plenty of it and the quality is very good. There's choice and if I don't like it I'm offered an alternative," "Plenty of drinks, water, juice and tea," and "Food is good, I have choice too and plenty of drinks." Records showed that people were regularly asked for their feedback regarding meals. We observed juice to be available in both lounges throughout the visit.

We observed staff supporting people to eat in one lounge. There was a relaxed atmosphere and people were not rushed. Staff ensured people had finished their meals before removing their plates. Care files evidenced that people's nutritional risk was assessed. Staff monitored and recorded what people ate and drank when there were concerns regarding their nutritional intake and referrals were made to relevant health professionals when required.

We spoke with the chef who told us they are informed of people's dietary needs and preferences by staff. There was a board in the kitchen recording this information. The chef told us they cater for people's dietary requirements, such as diabetic diets, high protein or pureed meals.

People living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as an optician, dietician, G.P, social worker, speech and language therapist and district nurse. People we spoke with told us staff would contact a doctor if they were unwell and one person told us, "A Podiatrist comes regularly."

We observed the environment of the home and found that the manager had started to make adaptations towards the environment being appropriate for people living with dementia. There were signs on some doors, such as the bathroom and dining room and people had photographs and names on their bedrooms doors. This helped to orientate some people and promote their independence. One person however told us they did not want their picture on the door and that staff had removed it when requested. Walls along the corridor had been painted and some items had been put up on display to stimulate people's senses. This however, had only recently been commenced and some walls remained bare.

Good

Is the service caring?

Our findings

At the last inspection the "caring" domain was rated as requires improvement and we found that staff were not always as caring as they could be towards people living at the home. During this inspection however, we observed positive interactions between staff and people living at Abbeydale. People told us, "Staff are kind and caring," "Staff all treat me with dignity and respect. They're kind and listen to us," "I'm treated respectfully" and "Staff listen to me, I'm not rushed and they have time for a chat." Visitors we spoke with agreed that staff were caring and treated people with respect. One staff member told us, "I treat people the way I'd want my mum treated, I always treat people with respect."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering and referring to people by their preferred name. Personal care activities were carried out in private. We observed staff offering reassurance when supporting people, such as when assisting a person to transfer in a hoist. A staff member explained how they were going to support the person and reassured them throughout the transfer. The manager had allocated a number of staff to be dignity champions and these details were on display in the home. We did however, observe a person becoming distressed when having to wait to receive support and a staff member told the person, "Wait a minute" in a harsh tone of voice.

Care files contained a document called, "This is me" which recorded information about the individual, their needs, preferences and their history. Care plans we viewed provided brief details regarding people's preferences, in areas such as time to go to bed, get up of a morning, religion and personal care. This enabled staff to get to know and understand people and their experiences. Staff we spoke with had a good understanding of people's needs and preferences. For instance, one staff member told us a person preferred female staff to support them and another member of staff told us in detail how a person was supported in line with their preferences.

People's needs in respect of their religion and beliefs were recognised and one care file included a plan of care to advise how staff could support the person to continue practising their religion and meet their spiritual needs.

People living at the home were able to express their views and had their opinions heard through monthly residents' meetings and quality assurance surveys. People told us staff listened to them and they felt their opinions were valued. For example, one person told us their room was being decorated and they were able to choose the colour scheme. Another person told us staff removed their picture from their bedroom door quickly when requested. Relatives we spoke with also told us their views were heard. One relative had requested a new room for their relative and this was arranged by staff.

We observed relatives visiting throughout the day and the manager told us there were no restrictions in visiting times, encouraging relationships to be maintained. People we spoke with told us they could have visitors at any time and visitors we spoke with agreed. One visitor told us they were always, "Made welcome and can come at any time."

For people who had no family or friends to represent them, contact details for a local advocacy service were available and staff told us advocates were supporting some people in the home.

Requires improvement

Is the service responsive?

Our findings

At the last inspection in May 2015, we identified breaches of regulation in relation to the responsiveness of the service. The 'responsive' domain was judged as 'requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to the lack of activities available to people.

During this inspection, we found that improvements had been made regarding the provision of activities in order to meet people's individual needs.

We asked people to tell us about the social aspects of the home. An activities co-ordinator had been employed three days per week and we spoke with them regarding the activities available to people. The activities co-ordinator told us they had spent time with people and their families, developing records that include information on people's lives, enabling them to get to know people and their interests. They were due to attend training in dementia care, after which memory boxes wold be made available for use in the home. Activities included bingo, knitting, painting, games and films. Activities were also provided on an individual basis, such as shopping. One person told us they enjoyed going out to the shops and having their nails painted. Another person told us the activities co-ordinator, "Gets everybody going." A relative told us about a recent Halloween event in the home which included traditional activities such as "duck apple". The relative told us, "They always include the family." We observed one person colouring in the lounge and a film was played in the afternoon which a number of people enjoyed. The hairdresser visited each week and we observed people attending the salon within the home. One person told us they did not join in with the activities but enjoyed socialising with people in the home and regularly went out with their family.

We looked at how people were involved with their care planning. Records we viewed showed that when people were able, they had been involved in developing their care plans and people had signed to evidence their agreement with plans in place. Other care files evidenced that people's relatives had been consulted with regards to the care plan in place. One care file recorded that the person was unable to be involved in the development of their plan of care, however there was no evidence that their care had been discussed with their family. Relatives we spoke with told us staff kept them informed of any changes regarding their relatives health and care needs and that they were also kept up to date through regular relatives meetings.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs. This was achieved through staff handover as well as reading people's care plans.

Most care plans we looked at were reviewed regularly, this ensured people's current needs were documented and staff had guidance on how to support people. However, one care plan we looked at, had not been reviewed since August 2014. This meant there was a risk the plan did not include information that reflected the person's current care needs in this area.

Care plans provided information in areas such as skin integrity, personal care, mobility, overnight care and nutrition. Some plans we viewed were detailed and specific to the person. For instance, we viewed one care plan that provided detailed information on how to support a person who could display behaviours that challenge. The plan guided staff on techniques to support the person during those times and maintain their safety and wellbeing. Care files contained information regarding people's social interests, their family and their preferences in relation to some aspects of care and support. This enabled staff to get to know the person and provide care specific to the individual.

Other care files we observed included conflicting information on how to support a person with their care needs. For instance one file contained a plan regarding specialised equipment to be used to maintain a persons skin integrity, however the person's personal care plan recorded different information as to how and when the equipment should be used. Staff we spoke with however, were clear regarding the use of the equipment. Another care file evidenced that a person required support with their nutritional intake, however a risk assessment indicated that the person was independent with their meals. Staff we spoke with were aware of the person's needs and confirmed that the individual did require support when eating meals. This meant there was a risk staff may not be provided with clear guidance regarding people's care needs.

Requires improvement

Is the service responsive?

People told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges or spend time in their rooms. Care files evidenced people's choice with regards to their daily routines, such as when to go to bed. People we spoke with told us, "I can have a shower whenever I want" and, "I get up early at about 6.30am and go to bed early. I like this as I used to do this when I lived at home." Staff we spoke with agreed that people could make choices, such as whether they preferred male or female staff to support them with their personal care needs. One person we spoke with told us they only want female staff to support with their personal care and that this was respected.

People had access to a complaints' procedure and this was displayed on notice boards within the home. We looked at the complaints record, which showed that any complaints received, were addressed by the manager and that complainants were happy with the outcome. People we spoke with told us they did not have any complaints but would speak with staff or the manager if they did. People told us they would be listened to and relatives we spoke with agreed that any concerns could be raised and would be addressed.

Inadequate

Is the service well-led?

Our findings

At the last inspection, we identified breaches in regulation regarding how the service was led and the "Well led" domain was rated as inadequate. Concerns raised were in relation to the lack of processes in place to gather feedback regarding the service, policies and procedures were not specific to the home, the statement of purpose did not reflect the services provided and the lack of effective processes to monitor the quality of the service.

During this inspection, we found some improvements had been made in relation to gathering people's views of the service and some processes had been implemented to monitor the quality and safety of the service. However, in the five months that have passed since the previous inspection, the provider had not made sufficient changes to ensure people were safe and protected from the risk of harm.

Although the fire authority have been involved and the risks in relation to fire safety have been mitigated, it was concerning that any improvement was only being done at the requirement of the fire authority. The provider should have been pro-active rather than re-active in preventing such risk in the first place.

We looked at how the manager and provider ensured the quality and safety of the service provided. The manager told us the provider visited regularly and was involved in the running of the home. The provider completed regular provider monitoring visit forms which reviewed areas such as accident reporting, the recording of staff and resident's meetings and ensured completion of audits. however they did not pick up on the concerns identified during the inspection.

We viewed audits in regards to care plans, however they did not evidence whether identified actions had been completed to ensure the care plan was accurate and up to date. We checked the care plans they related to, and found that the actions had been completed. Audits had been completed in areas, such as complaints and kitchen cleanliness. Medication audits had been completed by the nurse appointed as clinical services manager, however these were brief and did not identify the issues we highlighted during the inspection. There was a monthly record of accidents and incidents in place. This did not lend itself to analysing any trends/themes, which meant that measures may not always be put in place to reduce the risk of incidents re-occurring. However, we did see actions had been taken following some incidents to reduce the possibility of the person being injured again.

There were no records relating to internal checks of pressure relieving mattresses or electrical profiling beds. We observed one pressure relieving cushion to be damaged. The manager was not able to provide evidence on the day of inspection that the slings and hoists had been examined by a competent person as required in accordance with The Lifting Operations and Lifting Equipment Regulations 1998. Since the inspection the manager has provided evidence that these checks had been completed.

We looked at the policies and procedures of the service. The policies were not specific to the home and did not provide staff with clear information on the company's processes which they should work within. A number of policies viewed began with a statement that it was the responsibility of the manager to develop a policy in the area the document related to. The policies referred to agencies that were no longer in existence. The mental capacity policy contained an assessment tool no longer in use within the home. This meant that staff did not have access to up to date information to guide their practice.

We observed people's records regarding the care and treatment they had received, being completed retrospectively. For instance, one staff member was seen to complete records regarding people's diet and fluid intake and repositioning support provided. These notes were completed late in the afternoon but related to the support provided since people woke that morning. The staff member was completing the records or all people requiring this support at the same time and on behalf of other staff members who actually provided the support. This meant there was a risk that records would not accurately reflect the care and treatment people received.

This was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found on inspection that one issues requiring the home to notify the Care Quality Commission (CQC) had not been made. This notification was in relation to an allegation of abuse. The allegation had been referred to the local

Inadequate

Is the service well-led?

safeguarding team as required, for investigation. Other required notifications had been made, such as those relating to serious injuries and deprivation of liberty safeguard authorisations.

This was a breach of Regulation 18(1)(2)(e) of the Care Quality Commission (Registration) Regulations 2009

There was no registered manager in post. A manager had been appointed and commenced in post and they had applied to the Care Quality Commission (CQC) to register as manager, and this application was in process.

We asked people their views of how the home was managed and feedback was positive. People living in the home told us the manager was, "Very nice" and, "Approachable." One person told us the manager had made a lot of changes, such as decorating and including people in the home in decision making. Staff also told us there had been many improvements since the manager had been in post, such as the environment, cleanliness and general happy atmosphere of the home. One staff member told us the manager was, "On the ball" and "Pushing to change things round." Relatives we spoke with also agreed that the manager was approachable and told us, "The manager is a lovely person, she runs the home well" and, "The manager does her best to make sure resident's are well looked after."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue. Having a whistle blowing policy helps to promote an open culture within the home.

There were systems in place to gather feedback regarding the service. We viewed records of residents and relatives meetings and people we spoke with told us they could raise any issues they had with the manager. Quality assurance surveys regarding food were completed monthly and results showed that people were now more positive regarding meals. Staff told us they were encouraged to share their views regarding the service. Records we looked at showed that staff meetings were held monthly and staff we spoke with confirmed this. Staff told us they were asked for their opinions and their suggestions were acted upon. For instance, one staff member described changes made in the dining room following suggestions they had made.

The manager had commenced meetings with other professionals, such as the district nursing team, in order to build relationships and encourage partnership working. We viewed records from these meetings which showed that people's needs were discussed with relevant health professionals. This meant that people could receive appropriate and effective care and treatment.