Innovation Health Care Ltd

Abbeydale Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 23 and 24 October 2017. Abbeydale Nursing Home is registered to provide residential and nursing care for up to 24 adults. Accommodation is situated on two floors with access to all internal and external areas via a passenger lift and ramps. The home has enclosed grounds with car parking space to the front of the property and a garden to the rear. The home is within walking distance of Eccles town centre and public transport systems into Manchester and Salford. At the time of the inspection there were 19 people using the service.

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

The home was last inspected on 01 February 2017 when we rated the service as requires improvement and the service was found to be in breach of five regulations, including two parts of one regulation; these were in relation to person centred care, safe care and treatment, good governance and staffing. Following the inspection we asked the provider to take action to make improvements to person centred care, safe care and treatment, good governance and staffing and we received an action plan from the provider.

During this inspection, we found seven breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in respect of staffing, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, person-centred care, fit and proper persons employed and premises and equipment. We are considering our enforcement options in relation to these regulatory breaches.

The home was rated as requires improvement at our two previous inspections and at this inspection we found the quality of service provided to people living at the home was not continuously improving over time.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

Processes were in place to sustain a safe environment to aid the protection of people using the service, their visitors and staff from injury. Fire risk procedures were in place and annual fire risk assessments were followed. The provider had a business continuity plan in place.

People told us they felt safe living at Abbeydale but staff were often busy; our observations supported this perspective and staff appeared to be very busy and did not have time to sit with people and engage in meaningful conversation.

Redecoration work had commenced since the date of the last inspection and was on-going. This included carpet replacement and painting. There was 'dementia friendly' directional signage in place for lounges, dining room, toilets, bathrooms and bedrooms that would assist people to mobilise around the building.

Policies were in place to give guidance to staff on how to ensure that people lived in an environment where their diversity was celebrated and respected and where they could live free from discrimination and prejudice.

People we spoke with told us they received care which was satisfactory. The service followed the six steps end of life care programme which is intended to enable people to have a comfortable, dignified and pain free death.

We did not see any activities being undertaken during the two days of the inspection, other than a baking activity which involved kitchen staff assisting people to decorate cup-cakes.

The service had a complaints system in place to handle and respond to complaints and systems were in place to seek feedback from people using the service and their relatives.

Nursing care plans did not always fully capture how care was planned, implemented and evaluated. This included the management of resident's medicines, when both nursing care and medication administration involved care home staff and district nurses.

There were some inconsistencies in the process of administering medications, specifically in the recording of 'as required' (PRN) medication administration, the accuracy of the timing of administration, accurate allergy status documentation and the storage of prescribed emollient creams.

The registered manager had not made any enquiries into how unexplained bruising for four people had happened and had not referred these to the appropriate authority. An accidents/incidents book was kept but had not been audited to identify any trends or patterns to prevent re-occurrence. We contacted the local safeguarding authority to inform them of our concerns.

The registered manager had failed to comply with legislation set out in the Health and Social Care Act 2008 and the Safeguarding Vulnerable Adults Act 2006 and had also failed to follow the providers own safeguarding policy.

The provider had failed to operate safe and robust recruitment and selection processes and appropriate checks were not in place prior to new staff starting work at the service.

Staff employed at the service did not receive sufficient supervision, training and support that would enable them to carry out their job roles safely and effectively.

The process of auditing was not effective and did not identify the concerns we found at this inspection in relation to person centred care, safe care and treatment, fit and proper persons employed, meeting nutritional and hydration needs and staffing.

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.

Medicines and creams were not managed safely.

Accidents and incidents had not been managed appropriately.

Referrals to the local safeguarding authority had not been made as required.

Safe recruitment procedures had not been followed.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not consistently receive training and supervision as required.

Staff did not receive a sufficient period of induction to enable them to develop the skills necessary to undertake their role.

There was unsafe egress from the dining room into other parts of the home presenting a risk to people who used the service.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Staff did not always interact with people who used the service in a caring manner that respected their dignity.

People were left in lounges with little engagement and staff oversight to maintain their safety.

People were not engaged in meaningful activities.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Care did not always meet people's needs and reflect their preferences.

Accurate records were not always maintained by staff with regards to people's care.

A complaints system was in place and people were aware of how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not understand their legal responsibilities in respect of safeguarding.

The service undertook a number of audits to monitor the quality of service provision but they did not highlight some of the concerns we found during our inspection.

The provider had failed to improve the overall rating of the home since the last inspection.

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 checked 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 23 and 24 October 2017. The first day was unannounced which meant the provider did not know we would be visiting on that day.

The inspection team consisted of two adult social care inspectors and an assistant inspector from CQC, a specialist nurse advisor and an expert by experience. The expert was experienced in dementia and mental health in a residential, community and NHS setting.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. Prior to the inspection we also liaised with Salford local authority safeguarding team.

During our inspection of Abbeydale Nursing Home we spoke with four people who used the service, two visiting relatives, four members of staff directly involved in providing care, the deputy manager, the registered manager and the provider. We also spoke with a visiting healthcare professional.

We undertook 'pathway tracking' of care records, which involves cross referencing people's care records via the home's documentation. We observed care within the home throughout the day in the lounges and communal areas and looked at six staff personnel files.

We observed the morning medicines round and the breakfast and lunchtime meal. We toured the premises and looked in various rooms. We also reviewed previous inspection reports and other information we held about the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Abbeydale and although at times it could be busy for staff, their needs were met in a suitable amount of time. Comments included, "Oh yes, I do feel safe here. I have my medication regular; the lady gives it to me. Staff are around and about, always busy though, but no I don't have to wait. I can get up and get around myself though which helps." A second person told us, "Yes I do feel safe. It seems very short of staff at times. I have to be patient at times like that and I have the call bell here next to me, but there is only this one; I buzz for others if they need anything." Similarly relatives we spoke with told us they felt their loved ones were safe and cared for. One relative commented, "Yes I do believe [person name] is safe living here." We checked the provision of nurse call-bells and saw there was only one nurse call-bell in the lounge which was not accessible to people who were not sat near to it.

The provider's safeguarding systems had been ineffective in ensuring people were protected from abuse. There were safeguarding vulnerable adults and 'whistle blowing' (reporting poor practice) procedures for staff to refer to. Training levels for safeguarding were low, with half the staff not having received training in this area. Although staff spoken with could describe what safeguarding was we found incidents of safeguarding were not being identified and referred to the local authority. For example, during the inspection we observed four people had skin tears and/or bruises to their arms. We looked at the accident and incident records of these injuries to determine how they had occurred. Although we noted in some cases body maps had been completed and had been placed in each person's care file, we did not see any completed accident or incident reports. Furthermore the registered manager had not carried out any analysis in relation to how these bruises had occurred.

In cases where an unexplained bruise or injury occurs to a vulnerable person whom is unable to explain how this has happened, whether through cognitive or communication difficulties, the provider has a duty to refer to the local safeguarding authority for further investigation and analysis. We noted the provider's safeguarding policy also highlighted unexplained bruises as possible indicators to poor care practice or neglect. Therefore, it was the duty of the safeguarding lead (in this case the registered manager) to act in line with the policy and refer to the safeguarding authority. We spoke with the registered manager about this and he confirmed he had not made any enquiries into how these had happened nor had he referred these under safeguarding arrangements to the local authority.

Following the inspection we contacted the local safeguarding authority to inform them of our concerns. These are currently being investigated by the local authority.The service had failed to protect people from abuse and improper treatment by not following the systems and processes in place, which ensure any allegations or signs of injury are investigated promptly. In addition the service had also failed to inform appropriate authorities of such injuries for further investigation.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We sampled six staff files to assess if safe recruitment procedures were in place. We saw two of the six files

did not have a current Disclosure and Baring Service (DBS) check in place. All newly appointed staff should be subject to a DBS clearance check before commencing work with vulnerable adults and children. The registered manager had failed to comply with this legislation. In addition the registered manager had also failed to follow the providers own safeguarding policy which stated, 'Abbeydale Nursing Home have appropriate systems and procedures in place to ensure the safe recruitment of all staff and volunteers within the organisation. This should include requirements set out by the Disclosure and Barring Service (DBS).' The registered manager's actions were also in conflict with the providers recruitment policy, which stated, 'Prior to appointment a full CRB, police check and ISA must be completed.' Following the inspection we received an email from the registered manager to inform us an application to the DBS had been submitted for these staff members.

We also found a lack of consideration had been made by the registered manager, in relation to perceived risks which may be posed to people due to disclosures recorded on staff DBS documents. Risk assessments were not in place to manage such disclosures to ensure people remained protected from any potential abusive practice. The provider had failed to operate safe and robust recruitment and selection processes. We found the recruitment and selection policies and procedures were not being followed and appropriate checks were not in place prior to new staff starting work at the service.

This is a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed.

At our last inspection on 01 February 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. During this inspection we checked the progress the provider had made since the date of the last inspection and found the service to be in continued breach of this regulation.

We saw evidence of staff training in medicines management on the electronic staff training matrix. We looked at the medicines room which held the medicine trolley and the controlled drugs (CD) cupboard and medicines fridges. We checked the CD register and the record log for monitoring the medicines fridge temperature and found these had been completed correctly.

The element of administering medicines at the 'right time' within the overall process was not consistently adhered to. We noted some inconsistencies across the MAR charts in the approach to recording (signing the MAR) for the administration, or otherwise, of 'as required' (PRN) medications for pain relief. A number of MAR's contained prescriptions which were administered only by visiting district nurses (DN's) and this was noted on each MAR. However, given the limited amount of written evidence of communication between DN's and care home staff, this approach lacked effective and robust inter-professional communication and extended opportunities for error.

We saw there was a prescribed emollient cream left on a bedside cabinet in one person's room. We also saw another person's emollient cream had been left in a small lounge downstairs and was also not stored safely. We noted one person's evening medication had not been signed for on the day prior to the inspection. We queried this with the nurse who was unaware of this or the reason for the omission. We noted the allergy status of one person differed on two documents. The person had three allergies documented on the prescriber sheet but 'none known' was documented on their MAR.

We observed medicines scheduled for administration to two people at lunchtime on the first day of the inspection had not been administered. We were informed by the nurse that since our earlier observation

and presence had delayed the morning administration these medications were to be given later.

These issues meant there was a continuing breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We looked at risk assessments for six people. One person's risk assessment captured the need for a sensor mat to be situated in their room, due to not being able to use a nurse call bell. In addition to this, hourly checks were to be carried out when the person was spending time in their bedroom. We saw other risk assessments in people's files covering areas such as mobility, pressure relief, diet, self-neglect and communication, pressure ulcer risk assessment (Waterlow), malnutrition universal screening tool (MUST). Where people had been identified as being at risk of falls, referrals had been made to the falls team via the person's GP.

Processes were in place to sustain a safe environment to aid the protection of people using the service, their visitors and staff from injury. Risk assessments, which included the internal and external environment were in place and considered areas such as the control of substances hazardous to health (COSHH), stairs and stair lift, electrical safety and smoking. Equipment such as kitchen and bathroom aids, hoists and lifts were serviced by an external agency. The service employed a maintenance person whose duty was to ensure the environment was safe and fit for purpose.

We saw the service had fire risk procedures in place and annual fire risk assessments were followed. These risk assessments covered areas such as monitoring the fire alarm, fire extinguishers, emergency lighting and signage. People had personal emergency evacuation plans (PEEPs) in place; we found these contained information such as mobility, responsiveness to fire alarms and prescribed medicines.

The introduction of the Regulatory Reform (Fire Safety) Order 2005 places the onus on providers to ensure that everyone can evacuate safely in the event of a fire or emergency evacuation. In order to comply with legislation, a PEEP needs to be devised by the responsible person. A PEEP is designed to ensure the safety of a specific person in the event of an emergency evacuation and must be drawn up with the individual so that the method of evacuation can be agreed. The PEEP will detail the escape routes, and identify the people who will assist in carrying out the evacuation.

Prior to the date of the inspection we were made aware that the passenger lift was broken as from 13 September 2017. The lift engineer was called immediately and advised the lift should not be used till refurbishments were completed and the time frame given for repair was four weeks. The provider wrote to us identifying the action they had taken to mitigate the potential risks regarding evacuation and people had been moved to alternative rooms on the ground floor and their PEEP and risk assessments had been updated. Two people remained upstairs and two new fire evacuation chairs had been purchased.

Whilst the lift was being repaired we were made aware that fire-fighters had attended a further incident at the premises due to the works within the lift shaft which had caused a small amount of smoke. We held a telephone call with the provider and Greater Manchester Fire and Rescue Service (GMFRS) whilst they were visiting the premises and were informed GMFRS had audited the premises and the home was complying with information given and had completed remedial works with further works on-going. A more robust fire risk assessment was also undertaken and an additional staff member was placed on shift to specifically monitor for fire during the night. When we inspected the service we found the lift had been repaired and people were in the process of moving back upstairs.

We found the dining room door adjoined the access and egress to the kitchen, downstairs basement offices

and external back door, but there was no securing mechanism, due to the door being used as a means of escape, which meant mobile people could potentially walk through this door to the outside of the building or access the steep concrete steps to the basement offices which presented a risk of falls, or to the open kitchen which could present a risk of scalding or sharps injuries. The kitchen door and basement room door were not kept locked at all times to mitigate this risk.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises and equipment.

The provider had a business continuity plan in place. The aim of this plan was to set out the procedures and strategies to be followed in the event of a disruption affecting the ability of the home to deliver services as usual. It considered areas such as the minimum levels of staff required to still enable the provision of safe care to people, provision of food and drink for people and cooking facilities, provision of suitable beds, bedding and clothing for residents and provision of medication, clinical and sanitary products, accountability and roles of key staff, responsibility and authority.

We observed staff throughout both days of the inspection. Staff appeared to be very busy and did not have time to sit with people and engage in meaningful conversation. People's comments, which were that staff always appeared busy but were able to meet their needs, supported our observations. Staff we spoke with told us at times it could be very busy and on the first day of inspection it was an extremely busy day due to, "Two new admissions over the weekend and both people need two staff when providing personal care." One staff member added that the registered manager was aware of this and was to recruit more staff to accommodate the current needs of people using the service; however we did not see any evidence of a recruitment drive at the time of inspection.

We asked to see the provider's dependency tool used to calculate staffing levels. The registered manager showed us a dependency document that had been supplied to him by the provider and said he did not understand how it worked. The registered manager then showed us another different dependency tool that had already been completed by the provider and again stated he did not understand how to use it but actual staffing levels were adequate to meet people's needs safely. This meant the registered manager had not clarified with the director how to use the tool correctly which could result in unsafe staffing levels.

Requires Improvement

Is the service effective?

Our findings

At a previous inspection carried out on 18 July 2016 we had concerns relating to staffing because the provider could not demonstrate the appropriate support and professional development of staff and this was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection on 01 February 2017 we found although some improvement had been made further improvements were needed to meet the requirements of this regulation.

We checked to see how the provider ensured staff had the required knowledge and skills to undertake their roles. Following the last inspection the provider identified the action they intended to take to make improvements. They told us the staff training matrix had been updated and arrangements made for a variety of training. The action plan stated mental capacity act (MCA) training had been arranged for 01 June 2017 and 15 June 2017 but this was not identified on the staff training matrix provided to us during this inspection. The matrix stated MCA training had last taken place on 20 January 2017. This meant the statements made in the action plan were not reflective of what we found during the inspection and we were unable to determine if this training had been provided because no other records of this training were provided to us.

These issues meant there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

The training matrix supplied to us at the inspection on 23 and 24 October identified only 7 staff had completed training in MCA and the Deprivation of Liberty Safeguards (DoLS) out of a total of 25 staff. We saw only 10 staff had undertaken training in dementia despite there being 12 residents living with dementia at the location and only 5 staff had completed food safety training. The training matrix also did not identify any training the registered manager had undertaken.

We asked staff if they felt they received sufficient training. One staff member said, "I did an NVQ level 2 in dementia care and have done safeguarding, moving and handling and fire training." A second told us, "We watch training videos to keep up to date with best practice and we go on training courses." A third commented, "We keep up to date with best practice by reading leaflets and six-monthly training." A fourth told us, "I haven't had MCA or DoLS training for ages; training was poor under the previous manager but [manager name] is trying to sort it out; new training is in progress."

We looked at the process of staff induction to ensure they were properly trained and supported to carry out their job role. At the last inspection on 01 February 2017 we could not find any evidence of staff undertaking a process of formal induction when they first started working at the service. At this inspection we found that although there was a new staff induction form in place, this only covered a period of three days. Day one related to general activities that the staff member would undertake such as supporting people with personal care, assisting with meals and policies and procedures. Nursing staff also completed care planning and medication. Day two concerned mental health including dementia, bereavement and loss; whilst day three covered therapists and rehabilitation equipment.

A staff member told us, "Induction was voluntary, I came in in my own time to see if I enjoyed the job; I mucked in but was supervised, and this was my own choice." We asked the registered manager if any other records were available or completed regarding staff induction and they told us no other information was completed. We found the process of induction to be insufficient and there was no information to identify an on-going process of monitoring to ensure newly recruited staff members were competent.

We asked staff if they received regular supervision from their line manager. One staff member said, "I have never been supervised with nursing duties. I had an appraisal, I think it was in April, the registered manager did it but I can't remember what we said." A second told us, "I have never received supervision in this job." The provider's supervision policy stated, 'Supervision will be carried out at least once in 6 months.' However when we looked at historical records we found that staff had not received supervision in accordance with this policy. The manager told us the existing supervision matrix as out of date and needed updating to reflect the changes in staffing and shortly after the date of the inspection we received an updated supervision matrix from the manager.

These issues meant there was a continuing breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing.

We asked people and their relatives if they felt the service effectively met their needs and if staff had the necessary skills and experience. One relative told us, "The staff speak to us if [person name] needs change, it was the staff here that suggested [person name] be screened for dementia; they noticed she was increasingly confused, ruled out a medical cause then requested dementia screening. We were involved in [person name] discussions about resuscitation but I am not aware of any best interest decisions or discussions; [person name] has capacity."

A second relative said, "They always tell me if [person name] needs change; I told them to make sure they do and I am involved in best interest decisions. I do think staff have the necessary skills and knowledge." A third commented, "I wouldn't want [person name] to move anywhere, she is happy and safe here, the care staff are excellent and look after [person name] very well. I am a nurse and am very involved in [person name] care; the nurses need a push at times to be insistent if a GP refuses to visit."

Comments from people who used the service included, "Staff are good; look after each other. I would say it's ok here," "I feel the staff know what they are doing yes. They are very good; regulars especially, agency not so good," "Regular staff are good. They use agency a lot and they are not good especially at night; they don't know us well enough. When I first came here it was good, not now."

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

We asked staff about their understanding of DoLS and the MCA, the importance of consent to care and treatment and how to act in peoples best interests. One staff member said, "DoLS is about anyone who doesn't have capacity to make decisions and are cared for by staff, we need to know their whereabouts at all times. We have one person who displays challenging behaviour and can be physically aggressive; I try to reassure them and the other residents; the GP is also involved in their care." A second staff member said, "I seek consent verbally or with physical signs; if someone with no DoLS wanted to leave I can't stop them." A third commented, "I seek consent verbally, or if it's in their best interest and they lack capacity I speak nicely to them but act in their best interest. If someone with a DoLS asked to leave I would speak to their family and GP and social worker or even the police."

There were appropriate records relating to the people who were currently subject to DoLS. A list of people subject to DoLS was kept in the office and was up to date. Applications for DoLS had been made where required and these were up to date. There were appropriate MCA assessments in place along with best interest decisions which were linked to screening tools and restrictive practice tools which outlined the issues and concerns. Best interest assessments had been completed by the local authority.

We looked at ten care files to ascertain whether people's nutritional needs were being met. There was a four week, seasonal menu cycle in use, which was nutritionally balanced and offered a good range of choice. The menu was displayed on the dining room wall and was hand-written. Early morning drinks, afternoon tea and late evening snacks were also provided. People's food preferences were recorded on admission and discussions regarding food were held at residents' meetings.

At the last inspection on 01 February 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider had not maintained accurate, complete and contemporaneous records for each person using the service. Following the last inspection the provider identified the action they intended to take to make improvements to meet this regulation.

At this inspection we saw people had eating and drinking care plans in place, which identified their individual needs, for example if they required a soft or fortified diet. However, when we looked at the kitchen records, although there was a 'dietary requirements for residents' sheet on the kitchen notice board which identified their different diet types, the cook did not have any specialist dietary instruction on how to make up different food or fluid textures, which was actually stored in people's care files, but was able to describe how they made up different food and fluid textures for different people. This could increase the risk of people not receiving the correct consistency of diet type.

We asked people and their relatives for their views on the food provided. Comments included, "Food's ok, it's alright. A girl comes round to ask what I want; it's tasty and hot, "The food is quite nice. If you don't like it you can have something else. I like the puddings. We are having cauliflower cheese today, I like that because it slides down better," "Food is not my cup of tea but I get by. I get a choice it's just not what I want sometimes. They do offer something else."

A staff member told us, "We know about special diets as they are in the care plans, some people have soft diets and thickened fluids." A second said, "The cook has a list of special diets, all staff are aware and it is detailed in the care plan." We saw staff had documented people's food choices in their daily records.

There was no hand washing offered to people prior to eating lunch, which could increase the risk of infection or cross-contamination. Tables were laid with plastic tablecloths and dried flowers and people

were offered plastic aprons to wear in order to protect their clothing.

We found there were people living at Abbeydale who were living with dementia. Some adaptations had been made to the premises such as hand rails that would assist people when using the bathroom or toilet, and the provision of a variety of different seating to suit different people's needs. Redecoration work had also commenced since the date of the last inspection and was on-going. However handrails, grab rails and toilet seats were not all contrasting in colour which would assist some people living with dementia to use these facilities independently. Dementia may affect how well a person can tell the difference between colours. It may also affect how people see objects in three dimensions. Using bright and contrasting colours for furniture and furnishings helps everybody see things more easily. Guidance from Alzheimer's Society identifies toilet seats and lids should be in a contrasting colour to the rest of the toilet so they are easier to see and rails should be in a different colour to the walls.

We saw the wallpaper in the lounge had large flowers on it and some carpets were striped, which can cause anxiety for people living with some forms of dementia as these could appear to be moving. There was 'dementia friendly' directional signage for lounges, dining room, toilets, bathrooms and bedrooms that would assist people to mobilise round the building or understand where they were if assisted by staff.

We recommend that the service seek advice and guidance from a reputable source, about designing dementia environments.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if staff treated them with kindness and respect and received mixed comments. One person told us, "The regular staff are lovely; they have to be don't they. [Staff name] comes round with a book checking what I want and I've only got to ask, very nice people. I can lock my door for privacy; no one comes in unless they knock. I can do things for myself no problem there." A second person said, "Yes the regular staff are lovely to me and care is good. I have my own chair from home which I like; no one sits in it except me and that's good. I feel as though I am treated with respect. I am cared for like that you know."

However a third person commented, "Staff are very good to me; they just haven't got the time. We are neglected, that's the thing here and I don't feel listened to. I say things but it goes nowhere." A fourth person also said, "[Staff name] walks round talking to people. Agency staff are used but regulars are better. Sometimes we get one out of the ranks, you know what I mean."

We asked people and their relatives if staff promoted their independence. One relative told us, "They do support [person name] to be independent. The deputy manager always encourages [person name] to walk to the toilet, even though this can take 30 minutes and she is always very patient. It would be easier for her to put [person name] into a wheelchair but she always makes the time to do the best thing. I visit at least twice a week, [person name] is really happy here, the staff really care about her, they even worry about her when they go on holiday."

Another relative commented, "Staff are kind and caring; they are supportive and considerate. [Person name] isn't capable of being independent anymore, I had to buy her special cups and put her name on them. There was an issue under the previous manager where [person name] was left with a hot drink and she scolded herself. I choose to be involved in [person's name] care."

A visiting healthcare professional told us, "Care seems good and I have no concerns; they manage skin okay and they always phone us straight away. We do dressing changes and they let us know about any issues. We have no concern about bruises."

We observed care in the home throughout the day and interactions between people who used the service and staff members. Conversations were of a friendly nature and staff attitude to people was polite and respectful referring to people by name. However we observed one staff member demonstrating a lack of respect when supporting one person. The staff member brought the person into the lounge and said, "Can I park you there a minute, I need another pair of hands for you."

Staff took the time to check on people's welfare, for example as people got up in the morning staff asked them if they were well and if they would like a drink prior to breakfast. At the lunchtime meal we saw a person who did not want what was identified on the menu offered an alternative; the staff member said, "[Person name] would you like to have brown bread and butter with your sandwich." However we observed a person sitting in the dining room with a drink in front of him from for two hours until they were taken into

the lounge. The drink remained untouched despite this person being unable to propel himself or give himself a drink.

We saw people were left alone in the communal lounges with little engagement and oversight to maintain their safety or respond to their needs as staff were engaged in other duties. The activities coordinator was not in work during the inspection and staff did not have the capacity to spend any significant amount of time with individual people. We also noted the high volume of the two televisions playing different programmes simultaneously in the lounge was distracting.

The communal lounge area was split into two separate sides and had an open adjoining connection with no door. In each side there was a television playing loudly which meant it was impossible to listen to either programme without overhearing the other television. On one of these televisions, we saw a DVD was constantly repeating the introduction section which lasted for approximately 30 seconds. Staff had not realised this despite one person being seated in this area.

We also observed a staff member wheeling a person in their wheelchair into the lounge. As the staff member brought the person through the door they banged the person's foot on the door frame. The person shouted out anxiously in response and as the staff member went through to the lounge they said to the person, "Right let's have a look - looks okay." No apology or other form of reassurance was offered to the person. This type of incident requires the service provider to complete an accident/incident form, however when we returned the following day we found no form had been completed.

During our inspection we looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the provider had policies and procedures covering advocacy, dignity and privacy, safeguarding, end of life care, communication, whistleblowing, residents' charter of rights, equality and diversity, bullying, privacy and dignity and equal opportunities. These policies gave guidance to staff on how to ensure that people lived in an environment where their diversity was celebrated and respected and where they could live free from discrimination and prejudice.

We looked at how end of life care (EoL) was delivered. The service followed the six steps end of life care programme which is intended to enable people to have a comfortable, dignified and pain free death.

We saw where people had been willing to discuss end of life wishes, advanced care plans were in place which documented the person's wishes at this stage of their life. Care files documented whether a person had a DNACPR in place, with a copy of the form located at the front of their file. At the time of the inspection no person was on receipt of end of life care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in February 2017 the service were not offering meaningful activities for people to participate in. Following the inspection the provider submitted an action plan. At this inspection we found the service to be in continued breach of this regulation. The action plan submitted had stated, 'The service now has a dedicated activities coordinator.' However when looking at staff rotas and the training matrix we identified the activities coordinator was also a health care support worker, meaning they were not dedicated to the role of activities but worked a dual role between this and care.

On both days of the inspection we were told the activities coordinator was on leave. We did not see any activities being undertaken during the two days of the inspection, other than a baking activity which involved kitchen staff assisting people to decorate cup-cakes. We observed people were sat in both lounges for long periods of time without stimulation. People were unengaged for most of the day and this was consistent over the two days of inspection. We saw an activities notice displayed in the building for the month of November but there was nothing displayed for October.

Televisions were playing loudly and in one lounge we observed a DVD playing one song on continual loop as the play button had not been pressed. A member of the inspection team had to intervene and press play so the film could be seen, as staff had not noticed this happening. People we spoke with confirmed our observations; one person commented, "It's very quiet here. We play cards sometimes that's all. I can get out if I want to; others can't sit here all day." A second person stated, "We do activities just occasionally, dominoes sometimes. We have had throwing a ball sometimes but not a lot. I've heard about a pantomime coming up but that's about it." A third person stated, "A lady has come in sometimes to sing but not often. Not much goes on at all."

We noted one person's care plan stated, 'Staff to encourage [person name] to spend time in the lounge to prevent social isolation.' It also stated, 'If [person name] wishes to remain in their room staff are to spend time with them during the day and engage in conversation.' This care plan was reviewed in September and was signed to say this guidance was still applicable. However, we did not see staff following this plan and spending time with this person. We spoke to one member of staff who stated, "We only spend time with [person name] when we are carrying out personal care or assisting them with food."

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care.

Care plans contained a pre-admission assessment, which identified people's support needs. Information from this was used to create a more detailed service care file for each person. In most of the care files we saw we noted consent forms signed by either the person or a family member. Care files contained information to enable staff to care for people and detailed information about the person's wishes and preferences and information about the person's daily living needs. Monthly evaluations were completed to ensure all information was still relevant to the person. One staff member told us, "People's needs are reviewed monthly or as and when they change. Keyworkers usually review care files, we only discuss this

with relatives if there is any change. If it's not urgent we will discuss face to face when they visit, if it can't wait we would call them. Formal reviews are also done when social workers visit, whichever registered general nurse (RGN) is on duty would usually take care of this."

Daily reports provided information to show people had received care and support in line with their preferences. These reports also showed information about people's dietary needs and mobility issues. Staff told us they received a pre-shift handover before each shift started. This detailed any information which staff needed to know about people's immediate care.

The service had a complaints system in place to handle and respond to complaints. We saw the service had a policy and procedure in place. Relatives and visitors we spoke with confirmed they were aware of the complaints procedure and how to access any information around making a complaint. Relatives told us they would speak with the registered manager should they have any problems. However most of the people we spoke with told us they had never made a complaint, therefore could not comment on how complaints were dealt with. We noted, 'complaints forms' were situated at the main entrance of the service which gave people the opportunity to complete one should they need to.

Compliments from relatives were also seen. One stated, "Please accept our very grateful thanks for the way [person name] was taken care of. I feel he could not have received better care, love and attention anywhere else. It was like visiting a big happy family with the main focus being the care of all the residents."

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. 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.

The home was rated as requires improvement at our two previous inspections. This meant the provider had failed to improve the overall rating of the home from 'requires improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'good' or 'outstanding' at this inspection. This had not been the case, as we found the quality of service provided to people living at the home was not continuously improving over time.

At an inspection carried out on 18 July 2016 we had concerns relating to good governance, because the service failed to assess and monitor the quality of service provision effectively and ensure confidential information was stored securely. At the following inspection carried out on 01 February 2017 we found although improvements had been made, further improvements were needed and the service was still in breach of this regulation and the domain of Well-Led was rated as inadequate. Following the last inspection the provider identified the action they intended to take to make improvements, however at this inspection we found a continuing breach of this regulation.

The action plan submitted by the registered manager following the last inspection on 01 February 2017 identified action had been taken to meet the requirements of regulations, however the information in the action plan was not consistent with what we found at this inspection and we found continuing breaches of four regulations which gave rise to concerns regarding the quality of management oversight.

Day-to-day clinical and operational leadership of staff was inadequate and the provider, Innovation Health Care Ltd. had failed to provide sufficient oversight to recognise and respond to emerging issues identified at this inspection. We looked at records of provider audits for June, July and August 2017 and saw these covered audits, discussions with people using the service, the food experience, new admissions, complaints, safeguarding, CQC notifications and action plan progress, previous actions completed/in progress. These audits identified all CQC notifications were up to date, however at this inspection we found notifications had not been sent to the Commission in relation to unexplained bruising for four people and the registered manager had not followed the provider's policy on raising safeguarding alerts with the local safeguarding authority.

In addition there were no accident and incident forms in place to identify these bruises had occurred, which demonstrated a lack of understanding by the registered manager in relation to their statutory responsibilities. Providers are required by law to notify CQC of certain events which occur in the service. Records indicated that the provider had failed to notify CQC as required.

Although medicines had been audited regularly using a document titled 'medication audit' these interventions had failed to identify the issues we found during the inspection regarding the safe management of medicines. Following the last inspection the provider identified the action they intended to take to make improvements, however at this inspection we found a continuing breach of this regulation.

At a previous inspection carried out on 18 July 2016 we had concerns relating to good governance and audits undertaken by the provider and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection on 01 February 2017 further improvements were needed to meet the requirements of this regulation and at this inspection we found suitable improvements had not been made and the provider was still in breach of this regulation.

A number of audits had been undertaken including monthly kitchen dietary audits, infection control, wheelchairs and commodes, bed rails, nurse call-bells, mattresses and care files. However these did not highlight some of the concerns we found during our inspection in respect of person centred care, safe care and treatment, fit and proper persons employed, meeting nutritional and hydration needs and staffing.

Staff training had not been undertaken as identified in the action plan, supervision had not been undertaken in accordance with the provider's policy, and the process of staff induction was insufficient. This meant the statements made in the action plan were not reflective of what we found during the inspection.

During our inspection we found a lack of co-ordinated leadership, which was impacting on the quality of care provided. The manager's office was located in the basement of the building which meant they were not easily accessible to staff, people who use the service or their relatives. If staff required advice and support from the manager they had to go downstairs to the manager's office taking them away from the area in which they were working. We observed this to happen on several occasions during the inspection.

On several occasions during the inspection we asked the manager for a variety of different information about people who used the service and on several occasions the manager was unsure where this information was held and had to ask other staff members for its whereabouts, which demonstrated a lack of oversight of the service.

In addition we also found a lack consideration from the registered manager in relation to perceived risks which may be posed to people due to disclosures recorded on staff DBS documents and risk assessments were not in place to manage such disclosures. We found the provider had failed to operate safe and robust recruitment and selection processes, which were not being followed and therefore did not support a safe process and appropriate checks were not always in place prior to new staff starting work at the service.

We asked for records of staff meetings and saw the last meeting had taken place in April 2017. The deputy manager told us another meeting had been arranged but this had not occurred due to staff shortages. This meant staff had not been presented with the opportunity to discuss their work in an open setting, raise concerns and make suggestions about how the service could be improved.

These issues meant there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

We asked people if they knew who the manager was. One person told us, "Yes he's up the top, and his wife." A second person said, "It's a man I think. We have suggestions that we can do; that's about it." Whilst speaking with a third person the manager came in and the person said, "That's him, he's the gaffer; don't see him much. For me it's the toilet situation; people have to wait for the toilet and that's not right." The

manager knew this person's name when he spoke to them.

We asked people's relatives if they knew the manager and if they ever received any questionnaires about the service. One relative told us, "There is a suggestions box in reception, I am very vocal and will always speak to [manager name] if I am worried; I give positive and negative feedback. They do have relative meetings. A second relative commented, "We get questionnaires every so often, I always fill them in and return them. I am here regularly and involved in [person name] care. [Manager name] listens to me and I am happy that any suggestions I make are noted."

We asked staff about their views of management. One staff member told us, "[Manager name] is very fair and always approachable. He is always supportive; I suggested we need a hairdresser and he arranged one to come on Monday morning, I told him that was a bad time so he changed it and arranged a Thursday afternoon instead. I do enjoy working here, we all get on, we have a great atmosphere, we are like a community. The building isn't the best but you work with what you've got." A second staff member commented, "[Manager name] is fair, he listens to us but the directors are less fair; if I asked them for more staff they wouldn't want to spend more money. [Manager name] respects my ideas and suggestions; he knows I am on the floor more than him. I enjoy working here and we all get on and we are like family. I enjoy banter with staff and residents. I don't enjoy how busy we are and the bad and difficult days. I think the service is generally well led, it's better than it was. Things are moving forward, we still need to progress, we need to get behind staff supervision, we're behind due to staff holidays but will get there."

We asked about formal satisfaction surveys for people who used the service and their relatives. We were told no surveys had been undertaken for 2017 and we looked at the most recent survey undertaken in October 2016. We were provided with six responses which represented less than one third of the overall residency numbers. Responses to the surveys were mostly positive but one person had identified staff were busy and did not always respond to requests for support in a timely way.

The last meeting with residents and their family members had taken place in September 2017, further meetings had occurred in June and January 2017. We asked the manager if more records were available but none were provided to us. We saw discussions included food, the lift and involvement in care plans, complaints, activities, laundry, activities, surveys and personal money.

We saw the ratings from the last inspection were displayed in the home.