Barchester Healthcare Homes Limited

Adlington Manor

Inspection report

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Date of inspection visit:
23 September 2021

Date of publication:
28 October 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Adlington Manor is a residential care home providing personal and nursing care to 59 people aged 65 and over at the time of the inspection. The service can support up to 70 people. Care is provided in two units: Rowan Unit which provides specialist care for people living with dementia and Cedar Unit which provides general nursing care.

People's experience of using this service and what we found
Risks to the health and safety of service users were not always safely assessed. People had not always received oral healthcare, nailcare or footcare in keeping with their identified need. Bathrooms were not always clean and tidy. Medicated creams were not stored appropriately in people's bedrooms.

Health and safety checks were carried out. People, relatives and a healthcare professional gave positive feedback about the service with the exception of one complaint received before the inspection.

There were enough staff on duty on the day of the inspection. However, agency staff did not always have an appropriate induction so they could familiarise themselves with people's needs. We have made a recommendation about staffing.

Manager audits had not identified the concerns we found during the inspection. Complaints were not always captured on the complaints register. The management team did not respond with all the information we requested following the inspection. Staff appeared to be motivated and had a positive attitude about their roles.

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

Rating at last inspection
The last rating for this service was good (published 05 December 2019).

Why we inspected
We received concerns in relation to falls management and the supervision of residents. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Adlington Manor on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, infection control and leadership at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Adlington Manor

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors and a specialist nurse advisor.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also requested feedback from Healthwatch - Cheshire East. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with and observed the care of six people. We spoke with five relatives about their experience of the care provided. We spoke with 10 members of staff including the deputy manager, the quality manager, nurses, a domestic and care staff. We reviewed a range of records. This included six people's care records and associated risk assessments. We looked at three staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including health and safety records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and statutory notifications. We spoke with one healthcare professional who regularly visits the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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

Assessing risk, safety monitoring and management

● The registered manager and provider had not always mitigated against risks to people. For example, we observed staff supporting people using mobility equipment that had not been safely assessed for people's personal use. Risk assessments relating to the use of safety belts had also not been carried out for all wheelchair users.

● The registered manager and provider had not always ensured that neurological observations were recorded in line with organisational policy. This meant we could not be sure people had been subject to appropriate observation following a head injury.

● People had not always received oral healthcare, nailcare or footcare with their identified need. This put people at increased risk of injury, illness or pain. Risk assessments and care plans to support people who routinely refused support with personal care were not robust and were not always followed by staff.

Risks to the health and safety of service users were not always safely assessed. This placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had completed appropriate health and safety checks and servicing of fire safety equipment had taken place.

Preventing and controlling infection

● The registered manager and provider had not ensured that bathrooms were tidy and clean. This put people at increased risk of infection.

● Staff were observed to support people with shared moving and handling equipment. For example, we saw different people supported to use the same walking frame and the same carrier slings without appropriate cleaning between uses. This put people at increased risk of infection.

● We were assured that the provider was taking full action to prevent visitors from catching and spreading infections. For example, visitors had to present a negative rapid COVID-19 test result before they were able to access the home.

● We were assured that the provider was promoting safety through the layout and hygiene practices throughout the remainder of the premises and that people were admitted safely to the service.

● We were assured that the provider was accessing COVID-19 testing for people using the service and staff. A healthcare professional told us, "I was particularly proud of how well the staff fared in extremely challenging times during the height of the COVID [-19] pandemic. Their care and professionalism was outstanding."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The registered manager and provider had not shared safeguarding information the CQC in line with their statutory obligations.

The registered manager and provider did not notify us without delay of incidents that occurred during the carrying on a regulated activity. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● Staff had completed safeguarding training and knew how to report incidents of concern.
● People currently residing at the home and their relatives told us that they felt safe. The management team had carried out internal investigations into safeguarding allegations and liaised with the local authority appropriately.
● A healthcare professional told us, "I feel that there are policies and procedures in place to keep people safe. There is a caring attitude towards residents.

Staffing and recruitment
● The registered manager and provider had ensured there was an appropriate number of staff on duty on the day of the inspection. However, staffing levels included agency staff that did not know people's needs. The provider had a system in place to safely induct agency staff that had not previously worked at Adlington Manor, however this system had not always been followed.

We recommend the provider ensures that all agency staff have an appropriate induction and introduction to the service.

● Staff told us the service was well staffed but was sometimes short of staff that knew people's needs well. The deputy manager told us, "Recruitment is ongoing and we hope to be fully staffed soon. We do try to book the same agency staff to improve the continuity of care for residents."
● The registered manager and provider had ensured that safe recruitment practice was followed for permanent and bank staff.

Using medicines safely
● People's medicated creams were not always stored safely and had been left out in multiple bedrooms. We also found an expired and unlabelled medicine in one person's bathroom cabinet. The management team assured us they would take immediate action to store these items safely following the inspection.
● People's medicines were otherwise managed safely. Nurses who administered medicines were competent for this role and supported people in a caring and patient way. Records showed that people received their medicines in the way prescribed.
● Medicines in the medicines room were stored at the right temperature. Medicines that are controlled drugs (subject to stricter control because of the risk of misuse) were handled in a safe way.
● Protocols describing when to administer any medicines prescribed 'when required' were kept with people's medication administration records (MARs). Protocols were up to date. Medicines prescribed 'when required' to relieve pain or agitation were used appropriately.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● Management and senior staff completed a variety of regular checks and walkarounds of the service; however, these were not effective in ensuring appropriate levels of quality and safety were being maintained at the home. Systems failed to identify where people's needs were not being met or identify and mitigate risks associated with people's safety and personal care.

The provider did not have effective systems in place to ensure the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team completed a range of effective clinical audits that were reviewed by the provider. The audits had already identified that record keeping was an area for improvement and the management team was working with staff to achieve this.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care
● The registered manager and provider had not ensured that all complaints were captured on the home's complaints register. One relative told us before the inspection that the management team had not responded to a complaint they made. We saw that complaints that had successfully been recorded on the complaints register had been responded to in keeping with the provider's complaints policy.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us that Adlington Manor was a busy but positive place to work. One staff member told us, "I love working here. The provider and registered manager are supportive and responsive when I need them." We observed that staff appeared to be confident and motivated.
● Staff told us that managers were available and consistent.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The staff utilised the 'resident of the day' programme to gather feedback from people using the service.

The 'resident of the day' was visited by the kitchen staff to get feedback about the food provision and their bedroom, a key worker would make sure they had necessary toiletries and their bedroom was deep cleaned.

● Staff had access to supervisions with their manager and were invited to team meetings to share their thoughts about the service and discuss their performance.

Working in partnership with others;
● The staff team at Adlington Manor worked with a variety of healthcare professionals. A healthcare professional said, "I feel the home liaises with me very effectively."
● The staff team had made appropriate referrals to the dietician and speech and language therapy team. We identified that a number of residents had not received appropriate footcare and nailcare. A staff member told us the service had struggled to source podiatry services since the start of the COVID-19 pandemic but would prioritise this area.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that they assessed the risks to health and safety of service users. Regulation 12 (2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure the quality and safety of the service. Regulation 17 (2) (a)