Abbey Lodge Care Limited

Abbey Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Abbey Lodge Care Home is a residential care home that can provide personal care for up to 26 people. The service was supporting 21 people at the time of the inspection.

People's experience of using this service and what we found
People had been placed at significant risk of harm. The provider had failed to ensure people were protected against the risks of cross infection in regard to COVID-19. The provider had failed to ensure adequate infection control practices and relevant actions required to mitigate potential risks were followed, which placed people at risk.

Medicines were not effectively managed. Some medicines including controlled drugs were not stored or administered safely. Records were not in place for topical medicines and 'as required' medicines did not have specific instructions available which could put people's at risk.

People were at risk as a suitably qualified member of staff was not available at all times to administer medications.
People's care plans were not reviewed to ensure they contained accurate information about their needs to enable staff to deliver the care they required.
Staff had not received adequate training to do their jobs effectively to ensure people were supported safely.
Staff were rushed and care they delivered was task focussed, leaving no time for one to one time or any activities.

Adequate quality assurance systems were not in place. Audits had not been carried out consistently or could not be located. This meant improvements to the service were not identified and acted upon.

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 7 June 2018).

Why we inspected
The inspection was prompted by a notification of a specific incident. Following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risk throughout the home.

You can see what action we have asked the provider to take at the end of this full report.

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 safe care and treatment, staffing and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Is the service well-led?

Inadequate

The service was not safe.

Abbey Lodge Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors

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

The service did not have a manager registered with the Care Quality Commission. However, recruitment for a new manager was in progress.

Notice of inspection
This inspection was announced. We gave less than 24 hours short notice of the inspection because we needed to be sure members of the management team would be there to speak to us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We had also been given information from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with five people who were using the service about their opinions of the care they received. We spoke with two carers briefly, the deputy manager, the provider and the area manager. Calls were made after the inspection to four staff members.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. We spoke with the management team regarding

After the inspection
We continued to seek clarification from the provider to validate evidence found and this was provided.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection; Assessing risk, safety monitoring and management

- People were not protected against the risk of cross infection. During the inspection we saw poor infection prevention and control practices in relation to COVID-19 and measures recommended by the Government were not being followed.
- People who had recently moved into the service were not socially isolated from other people to prevent the potential spread of COVID-19. People were sharing mobility aids without cleaning in-between uses. High traffic areas within the home were not subject to any additional cleaning.
- The provider had failed to ensure risks to people were adequately assessed, and plans were put in place to mitigate them. People and staff had not been risk assessed to identify if they were at additional risk of Covid-19 due to additional health conditions or being from Black Asian Minority Ethnic heritage (BAME).
- Service user's care plans and risk management plans were not reviewed regularly. Many of the people using the service had been discharged from hospital to the service for support to recover prior to returning home. This meant that their needs may change quickly as they recovered and we could not be sure staff had accurate information to enable staff to support the person safely.

Using medicines safely

- Medicines guidance was not always in place or followed by staff. One person's prescribed medicines that should not have been administered together, had been administered together on several occasions. Another person was being given their medicines in a covert way, with no guidance for staff to administer these medicines safely. This meant people were at risk of not having their medicines administered safely.
- Topical medicines were not being consistently applied. There were gaps in recording of these medicines which meant people were at risk of not getting their medicines as prescribed.
- 'As required' (PRN) medicines records had not been reviewed. For example, one person had not had their PRN protocols reviewed since they arrived at the service. This meant the person was at risk of not having their medicines when needed.
- Controlled drugs were not always managed safely (Controlled drugs can cause serious problems and harm if they are not used properly, therefore they need strict legal controls in place). We found that staff removed controlled drugs from the cupboard and placed them in the medicine trolley during the medicine round without being signed for. We also observed a controlled medicine was kept in the medicines trolley as opposed to the controlled drugs cupboard. This increased the risk of controlled drugs stock errors occurring.
- Medicines were not stored safely. One person had their medicines left out in their room. The service accommodates people who had a dementia diagnosis or had confusion, which put them at risk of taking medicines not prescribed for them as they were not securely stored.

Medicines were not being managed safely, and risks to people and staff had not been assessed or planned

for with regards to infection prevention control. 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.

Staffing and recruitment

● The provider had failed to ensure there were sufficient suitably skilled staff to meet people's needs. People were unable to request 'as required' medicines during the night as no medication trained staff were available. For example, the senior member of staff designated to administer medicines during the week of the inspection was on annual leave. This meant service users were at risk of being left in pain if no staff member was available to administer their medicines.

● Support provided was task based. During the inspection we saw staff were very busy and there was no time for any quality time or activities with people using the service. One person told us, "I watch how much I drink because I don't know how long I have to wait for the toilet… I press the buzzer and they don't come."

● People waited a long time for their meals, during the inspection we observed people being seated at the dining table for their lunch and were still sat there over an hour later as staff were busy.

The provider had failed to ensure there were enough trained and competent staff to support people and ensure people were able to receive their medicines when needed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from abuse. There had been a recent serious incident that had raised concerns about the safety of people at the service. This had resulted in a Police investigation and the local safeguarding authority being involved. The provider was working with both organisations to investigate concerns and put measures in place to protect people.

● We could not always be assured that safeguarding concerns had been reported as systems were not in place to record and monitor these. Some staff told us they had not received training in how to recognise potential abuse or how to report their concerns.

● Staff told us they felt able to raise any issues with a senior member of staff but didn't know they could report concerns to the local safeguarding authority themselves. One staff member said, "I have had no safeguarding training, we just tell a senior… I don't think I have to write it down I would just tell them, I haven't reported anything, so don't know."

Learning lessons when things go wrong

● The provider could not be assured lessons were learned when things went wrong. Quality assurance systems were either not in place or robust enough to ensure issues had been identified and any necessary actions had been taken to reduce the risk of reoccurrence.

Inadequate

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 inadequate This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- Records had not been maintained to ensure the service was safely and effectively managed and people were being kept safe. The management team were unable to locate records or be sure if they were in use for the day to day monitoring of the home. The provider had failed to have effective systems in place to monitor the service and keep people safe.
- Systems were not in place or had not been kept up to date to monitor the service and ensure people were kept safe. The systems to investigate any accidents or incidents were not up to date, there were no medication audits being undertaken and records of safeguarding incidents could not be located.
- Infection Prevention and Control (IPC) or environmental audits had not been carried out. Information in relation to COVID-19 had not been sufficiently passed onto staff which meant this placed people at extreme risk of contracting COVID-19. Some areas of the home had fallen into disrepair. This meant service users and staff had been placed at increased risk as extra precautions advised by the government had not been followed in relation to COVID-19.
- The provider had failed to ensure service user's care plans were reviewed regularly and contained accurate information. One person's care plan did not contain detailed information regarding the use of the hoist, e.g. no specific guidance for staff to follow for the hoist straps to ensure they were safely transferred. This meant we could not be sure the information was correct to enable staff to support the person safely.
- Staff told us, and records confirmed that some staff had not received adequate training to enable them to do their jobs effectively. One staff member who had been employed for three months told us they had received some training but this was reading policies and procedures and had received no further training since starting at the service. Another staff member told us a they had received an induction and some training but had not received safeguarding or dementia training and no specific training for IPC.
- The providers lack of good governance processes meant a training matrix could not be found and the management team could not be sure of the training staff had received. This placed service users at risk of receiving care which was not in line with latest evidence and guidance around providing safe care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics ;Continuous learning and improving care; 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

● There was a lack of opportunities for people, relatives and staff to give feedback about the service. The management team could not locate any evidence of people or their relatives being asked for their opinion of the service.
● Staff told us they didn't have regular meetings and information was usually passed on by a senior member of staff. One staff member said, "We had one meeting a while ago but that was just to discuss [specific incident], we don't have them regularly." Another staff member told us, "I had one supervision when I started but that was ages ago, usually if I have any issues I go to the senior but I don't know if they write anything down."

Working in partnership with others
● Staff worked with other health professionals, however due to lack of effective systems in place some of this information was not recorded correctly in regard to medicines which placed people at risk.

The provider's lack of systems and quality assurance processes did not ensure a continuous improvement in the quality and safety of care that people received. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably trained staff on shift at all times to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risk of cross infection. People were not always kept safe as their medicines were not managed safely.

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not in place or had not been completed consistently to monitor and identify any areas for improvement.

The enforcement action we took:

Notice of proposal