Abbey Lodge Care Limited

Abbey Lodge Care Home

Inspection report

Cranmere Avenue
Tettenhall
Wolverhampton
West Midlands
WV6 8TW

Tel: 01902745181

Date of inspection visit:
18 January 2022

Date of publication:
20 May 2022

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 providing personal and nursing care to up to 26 people. The service provides support to older people, some of which were living with dementia. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
People were not supported by trained staff who understood their needs. People did not have care plans and risk assessments in place which contained accurate and up to date information about their needs. People were not supported safely when they were eating and drinking. People did not receive safe support with their medicines. There were not always staff on shift to support people with their 'as required' medicines at night.

People were not supported by staff who understood how to recognise and report safeguarding concerns. The provider also failed to ensure potential safeguarding concerns were reported to the local authority for investigation and review. People were not supported by staff who understood how to support them safely in the event of an emergency.

People were not supported by staff who understood current COVID-19 guidance and were adhering to this. People were not supported by sufficient staff to meet their needs in a timely way. People did not always have access to external professionals when they needed these resulting in significant risk of harm.

People were not supported to know who the management team were and how they could raise concerns. Quality assurance tools were either not in place or effective at identifying the concerns we found at this inspection. The culture of the home did not enable open communication with people and their relatives when things went wrong to promote learning and drive improvements.

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 30 July 2021).

Why we inspected
The inspection was prompted in part due to concerns received about the quality of care, people's safety and the leadership and oversight at the home. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. 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.

Enforcement and Recommendations

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 monitor the service and will take further action if needed. We have identified breaches in relation to people's safe care and treatment, staffing

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
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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.

Details are in our well-Led findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 team consisted of four inspectors. Three inspectors completed visits to the home over the period of 18 and 21 January 2022 and one inspector supported the visits off site by making calls to relatives, staff and professionals that work with the service.

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. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
These inspection visits were unannounced.

Inspection activity started on 18 January 2022 and ended on 21 January 2022. We visited the home on both of these dates.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to help plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with eight people who used the service and two relatives about their experience of the care provided. We spoke with thirteen members of staff including the provider, deputy manager, HR manager, senior carers, care workers, domestic staff and a cook.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to review the information sent to us by the provider. This included staff training records and staff rotas. We also spoke with multiple professionals that work with the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had failed to ensure people had risk assessments in place which gave staff clear guidance to follow to meet people's needs safely. For example, a person with diabetes had no care plan or risk assessment in place in relation to this and staff were not diabetes trained. This placed people at significant risk of harm.
- The provider had failed to ensure staff had guidance in place to support people living with dementia when they were distressed or anxious. For example, people's care plans advised staff restrain people during periods of distress. One staff member told us, "I don't think staff understand dementia, staff think people are just being awkward." Staff told us they had not restrained people at the service, however, there had been new staff who may have followed this guidance. This placed people at risk of harm.
- The provider had failed to ensure timely action was taken when people had lost weight. For example, one person at the service had lost a significant amount of weight over 12 months and no action had been taken. Not identifying weight loss in a timely way and ensuring effective action placed people at significant risk of harm.
- The provider had failed to ensure there was clear guidance for staff to support people safely in the event of an emergency. Staff we spoke with were also unclear as to how to support people. This placed people at significant risk.
- People were not supported safely by staff to safely eat and drink. For example, at lunchtime we observed staff supporting a person to eat whilst they were lying down placing them at increased risk of choking. A staff member told us, "[Person's name] is supposed to be sat up to eat and drink, the seniors are aware but nothing is done."
- Lessons were not always learned where things went wrong. Following our initial inspection visit we raised concerns about people being supported by staff to eat and drink laid down. At our second inspection visit we saw staff continued to support people to eat and drink whilst laid down. This continued to place people at increased risk of choking.

Systems were not in place to assess, monitor and mitigate risks to people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

Using medicines safely

- The provider had failed to ensure there were always trained staff on shift at the home during the night to administer people's medicines. This placed people at risk of harm.
- People were at increased risk of poor skin health and infections as the provider's medicine management systems had not identified poor staff practice in administration and recording of topical medicines,

(creams).
● Where people were prescribed medicines on an 'as required' basis, the provider had failed to ensure there was clear guidance in place to enable staff to support people to receive their medicines as prescribed. This placed people at risk of not receiving their 'as required' medicines in line with their needs and in a safe way.

People not being supported safely with their medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

Systems and processes to safeguard people from the risk of abuse
● The provider had failed to ensure people were supported by staff who were trained in safeguarding and understood how to report concerns. One staff member told us, "No one listens to our concerns, I think staff have stopped raising them now, they just accept it or leave."
● The provider had failed to ensure all potential safeguarding concerns had been referred to the local authority safeguarding team. For example, following staff supporting a person to drink using the wrong cup causing them to choke no referral was made to the safeguarding team. This placed the person and others at prolonged risk of harm.
● Despite this, the management team had shared other concerns around people's safety with the local authority safeguarding team.

The provider had failed to ensure systems and processes were effectively operated to prevent abuse of people. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities).

Preventing and controlling infection
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

●During our initial inspection visit the management team failed to ensure the inspection team had been fully vaccinated against COVID-19 and had to be prompted to do this prior to allowing them entry into the home.
● We were not assured that the provider was admitting people safely to the service. For example, the IPC Lead was not clear on how long new admissions to the home would be required to isolate. This placed people at increased risk of transmission of COVID-19.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises as there were multiple gaps in cleaning records.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed as the staff member responsible for IPC was not clear about current COVID-19 guidance.
● We could not be assured that the provider's infection prevention and control policy was up to date as despite us asking to see this on multiple occasions we did not receive this.
● We were assured that the provider was using PPE effectively and safely.
● People and staff were involved in a testing regime in line with current government guidance.

We have signposted the provider to resources to develop their approach.

The provider had failed to effectively manage the risk of preventing and controlling the spread of infections. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008

(Regulated Activities).

Staffing and recruitment

● The provider had failed to ensure there were sufficient staff to support people in line with their nutrition and hydration needs and to administer their medicines. For example, we saw people who required prompting and encouragement were left without support at lunchtime. This placed people at increased risk of harm.

There were not sufficient staff to meet people's needs in a timely way. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).

● Staff were not recruited safely as the provider had failed to ensure they had obtained full employment histories from staff prior to their employment. The provider had also failed to ensure they had explored any risks to people arising from police investigations of staff.

The provider had failed to ensure fit and proper persons were employed. This placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities).

● The provider had failed to ensure there were sufficient staff in place to offer people choice and promote person centred care. For example, there were only two staff on shift at night. This meant people requiring support from two staff to move safely would have to go to bed prior to 7pm. This did not promote person centred care and choice and may have impacted on people's emotional wellbeing.

The provider failed to promote and practice person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- Following a previous inspection we imposed conditions on the provider's registration in relation to people's care files containing accurate and up to date information; staff being adequately trained and competent; having a medicines trained staff member on shift 24 hours a day; people having accurate documentation in terms of their 'as required' medicines; ensuring infection control guidance was understood and adhered to and having effective leadership and oversight at the service. At this inspection we found the provider was not complying with these conditions and people were at significant risk of harm. At this inspection we found the provider was in breach of multiple regulations.
- There was a lack of oversight at the service and where quality assurance tools were in place these had not identified the concerns we found on inspection. This meant action had not been taken to make improvements at the service. This placed people at prolonged risk of harm.
- The provider failed to have effective oversight of people's nutrition and hydration needs to ensure they received safe support in line with their needs. For example, we observed a person who required a soft diet being given carrots and broccoli. This placed them at significant risk of choking.
- There was no effective oversight of infection control procedures. This meant the provider was not aware of gaps in staff knowledge around people's isolation periods when newly admitted to the home, and gaps in cleaning records. This placed people, staff and visitors at increased risk of transmission of COVID-19.
- Reviews of people's care records had failed to identify where these did not contain comprehensive, accurate information around people's care needs. For example, following a person falling, their care records had not been updated to reflect this new risk, despite these being reviewed.
- Quality assurance tools had failed to identify where people's emergency evacuation plans did not contain sufficient guidance to enable staff to support them safely. This placed people at significant and prolonged risk of harm.
- The provider had failed to ensure there were quality assurance tools in place to effectively review staff recruitment files to ensure people were supported by safely recruited staff.
- There was no registered manager at the service. Whilst the provider had employed a deputy manager, this person had only commenced employment 10 days prior to our inspection and therefore was still settling in to their new role.
- The provider had not always notified CQC of significant incidents at the service as they had failed to identify where these incidents were safeguarding concerns that required reporting to the local authority.

The provider had failed to comply with the conditions of their registration and have sufficient and effective

oversight in place to ensure people received safe care in line with their needs. This placed people at significant risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

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

● There was a closed culture within the home which did not promote positive outcomes for people. For example, people we spoke with were not aware of who was managing the service and therefore who they could raise concerns with. This concern had been raised by people on resident questionnaires completed in November 2021, however no action had been taken to make improvements in this area.

● Staff we spoke with raised concerns around the culture and management at the home. One staff member told us, "A lot of staff have bad attitudes towards people, it's not somewhere I want to work." Another staff member told us, "There is no support from the manager, no one knows what they are doing."

● Relatives we spoke with were not aware of who was overseeing the service following the previous manager leaving. One relative told us, "There has been a change of manager, I don't know who runs the place now."

The provider had failed to seek and act on feedback to evaluate and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

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

● The provider had failed to ensure they were consistently meeting their duty of candour as following incidents at the home they had not always made contact with people's relatives to inform them of these incidents. For example, following a person being supported inappropriately to drink which resulted in them choking, no contact was made to their family to inform them of this incident.

The provider failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to people. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities).

Working in partnership with others

● People did not always have access to healthcare professionals when they required these in a timely way. For example, a person was not able to eat and drink safely without pain at mealtimes. Staff informed us of this concern, however had to be prompted by the inspection team to refer this person to medical professionals. This lack of action meant this person was in prolonged and unnecessary pain.

● Professionals we spoke with raised concerns around the oversight at the home. Professionals also raised concerns that the provider had consistently failed to identify where people required external healthcare support in a timely way. This was consistent with the findings of our inspection.

The provider failed to ensure risks to the health, safety and welfare of people were escalated to a relevant external health professional. This placed people at significant risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to recognise and report all potential safeguarding concerns to the Local Authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure appropriate assessment of risk had been completed where people had ongoing police investigations into their conduct.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to ensure they had acted in accordance with the duty of candour.

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 9 HSCA RA Regulations 2014 Person-centred care There were not sufficient staff to support people in line with their choices and preferences.

The enforcement action we took:

We have issued a notice to cancel this provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people were supported by trained staff who understood their needs. The provider had failed to ensure people had timely access to healthcare professionals. The provider had failed to ensure people received safe support with the medicines, nutrition and hydration needs. The provider had failed to ensure people had care documents in place which reflects their risks and gave clear guidance to staff to support them safely.

The enforcement action we took:

We have issued a notice to cancel this provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to comply with the conditions of their registration and ensure there was effective leadership and oversight at the service enabling people to receive safe care and treatment.

The enforcement action we took:

We have issued a notice to cancel this provider's registration.