Raglin Care Limited

Abingdon

Inspection report

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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
Abingdon is a residential care home providing personal care and accommodation for up to 9 people. There were seven people living at the home at the time of this inspection. The home accommodates people with a learning disability and/or autism.

People's experience of using this service and what we found
People were placed at significant risk of harm because the provider had failed to adequately assess the risk of and control the spread of infection in relation to COVID-19. As a result, the provider was in breach of regulation. Infectious clinical waste was not disposed of safely, staff did not always don and doff PPE in line with the relevant national guidance and infection risks to people and staff had not been effectively assessed and managed.

Quality assurance processes at the home had failed to identify the failings in infection prevention and control measures that we found during our inspection. The provider's policy designed to specifically guide staff on managing COVID-19 did not consider or provide guidance on the safe disposal of infectious clinical waste.

People told us there were enough staff at the home. One person said, "The staff are there if I need them or need a chat." There was also enough staff on duty to carry out regular checks on people and provide them with assistance when needed if people had to self-isolate in their rooms.

People said they felt safe living at the home. One person told us, "I do feel safe. Staff know me, they know how to help me. I like all of them." Staff had received safeguarding training and safeguarding concerns were appropriately monitored and managed by staff.

There was a positive and caring culture amongst staff at the service. Staff knew people they supported well and cared about their wellbeing. People told us they were happy living at the home.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The home was in keeping with other domestic properties in the area and there were no distinguishable features which identified it as a care home, such as signage. The home provided people with shared housing that had a small-scale domestic feel. The layout of the home enabled people to share several spacious

communal areas or, if preferred, enjoy their own space and privacy in their rooms. Staff demonstrated a positive and caring attitude towards the people who lived at the home.

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 28 March 2020).

Why we inspected
As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control practice was safe and the service was compliant with IPC measures. This inspection began as a targeted inspection looking at the IPC practices the provider has in place. However, in light of our findings the inspection was extended to a focused inspection to review the key questions of safe and well-led.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led key questions section of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abingdon 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 a breach in relation to infection prevention and control measures at this inspection.

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 demonstrate 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.

Abingdon

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 one inspector.

Service and service type
Abingdon is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (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 is legally responsible for how the service is run and for the quality and safety of the care provided. At the time of this inspection the registered manager had been absent from the home on a long-term basis and an interim manager had managed the home since February 2020.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This gave staff time to explain to people living at the home that we would be visiting and provide them with any necessary reassurance regarding our visit.

What we did before the inspection
We checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also gathered feedback about the service from the local infection prevention and control team and local authority. We used all this information to plan our inspection.

During the inspection
We spoke with three people who lived at the service and one relative about their experience of the care provided. We spoke with seven members of staff including the area manager, manager and support workers.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two 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 also reviewed.

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 deteriorated to requires improvement. 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.

Preventing and controlling infection; Assessing risk, safety monitoring and management
• Used personal protective equipment (PPE) including gloves, aprons and masks, which became infectious clinical waste after being worn to support people who had tested positive for COVID-19, was not disposed of safely and in line with the relevant national guidance.
• The service did not have designated areas which were specifically for staff to don and doff PPE in line with national guidance.
• Staff did not always don and doff PPE in line with the relevant national guidance.
• Staff had received internal training on COVID-19 and PPE. However, our findings showed this training had not been effective and there were gaps in staff knowledge at the home.
• Infection risks to people and staff had not been effectively assessed and managed. For example, the provider had not adequately considered or put in place effective systems for the safe disposal of infectious clinical waste, i.e. used PPE. The provider's policy designed to specifically guide staff on managing COVID-19 did not consider or provide guidance on the safe disposal of infectious clinical waste.
• The provider did not have effective systems in place to ensure the communal toilets were cleaned when needed. This put people at risk of infection.

The provider had failed to adequately assess the risk of and control the spread of infection. This put people at risk of infection and significant harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. A new PPE donning and doffing area was set up at the home, refresher training was planned for staff and the provider was engaging with the local infection prevention and control team for further guidance and support.

• Fire safety was effectively managed.
• People had personalised risk assessments which were reviewed regularly and gave staff the information needed to manage the risks associated with supporting them.

Using medicines safely
• Medicines were safely administered, stored and recorded by staff who had the required knowledge and skills.
• The provider had systems and checks in place to ensure the safety and quality of medicines administration was maintained.

Systems and processes to safeguard people from the risk of abuse
• People were safeguarded from the risk of abuse. People told us they felt safe living at the home. One person commented, "I do feel safe. Staff know me, they know how to help me. I like all of them."
• Staff had received safeguarding training and understood their role in recognising and reporting safeguarding concerns.
• Information and guidance about how to raise safeguarding concerns was accessible and the provider had appropriate systems in place to manage concerns of a safeguarding nature.

Staffing and recruitment
• There were enough staff available to meet people's needs. People told us they felt there were enough staff at the home. Comments included, "Always staff around" and "The staff are there if I need them or need a chat."
• There were enough staff on duty to carry out regular checks on people and provide them with assistance when needed if people had to self-isolate in their rooms.
• Staff were safely recruited. Appropriate checks were carried out to ensure new staff were suitable to work with vulnerable adults.

Learning lessons when things go wrong
• Accidents and incidents were effectively monitored and managed by staff.
• The provider had systems in place to ensure appropriate action was taken in response to any accidents and incidents. This information was regularly reviewed by the registered manager to ensure lessons were learned and steps taken to prevent recurrence, when necessary.

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; Continuous learning and improving care
• People were placed at significant risk of harm because the provider had failed to adequately assess the risk of and control the spread of infection. As a result, the provider was in breach of regulation.
• Quality assurance processes at the home had failed to identify the failings in infection prevention and control measures that we found during our inspection.
• The provider's policy designed to specifically guide staff on managing COVID-19 did not consider or provide guidance on the safe disposal of infectious clinical waste.
• Ratings from the last CQC inspection were clearly displayed within the home and on the provider's website, as required.
• The service had a manager registered with the Care Quality Commission. However, at the time of this inspection the registered manager had been absent from the home on a long-term basis and an interim manager had managed the home since February 2020.
• CQC had been notified of all significant events which had occurred, in line with the registered provider's legal obligations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives were able to give feedback about their care and experience at the home. Examples of this included an annual satisfaction questionnaire and regular informal communication with staff. One person said, "Staff listen to me, I can say if I'm unhappy about something."
• Staff had supported people to keep in touch with their loved ones throughout the pandemic via socially distanced visits, when permitted, telephone and video calls.
• One relative said, "We have good communication with the staff. We have a weekly phone call with [Relative's] keyworker for any updates. If we have any concerns, we can raise them by phone or email. The staff always respond and take action."
• Staff held regular team meetings to share important updates and guidance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on their duty of candour responsibility; Working in partnership with others
• There was a positive and caring culture amongst staff at the service. Staff knew people they supported well

and cared about their wellbeing.
• The manager understood their responsibilities regarding the duty of candour and promoted openness and transparency within the service.
• The manager and staff worked in partnership with other agencies when required. This included engaging with the local infection prevention and control team in light of our findings during this inspection.

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 placed at significant risk of harm because the provider had failed to adequately assess the risk of, prevent detect and control the spread of infection in relation to COVID-19.

The enforcement action we took:

We issued the provider a warning notice in relation to failings in infection prevention and control measures we identified during this inspection. The provider must comply with this warning notice by 30 November 2020.