Barchester Healthcare Homes Limited

West Abbey

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
West Abbey is a purpose-built home that can accommodate up to 97 people. The home is divided into three distinct units, each unit has its own staff team. On the ground floor there are two units, one is primarily for younger adults with acquired brain injury, this unit does not have a specific name. The other unit is called Lyde and is for people living with dementia. People living on the third unit on the first floor require general nursing and some people are receiving end of life care, this unit also did not have a specific name. A registered nurse is on duty on each unit 24 hours a day. At the time of the inspection 87 people were living at West Abbey Care Home and there were two people being admitted during the inspection.

People's experience of using this service and what we found
The main shortfalls within this service relate to the unit called Lyde. Feedback from people and relatives on the other two units was more positive. We have made this clear throughout the report.

Medicine management was not robust. Staff did not follow the providers medicine management policy and people did not receive their medicines safely.

People were not always supported to have maximum choice and control of their lives and staff on Lyde did not always support people the least restrictive way possible and in their best interests; Some decisions did not always involve people or their representatives, and dignity was not always upheld. For example, people were left unkempt and staff did not always interact with people in a meaningful way.

Safe practice was not always followed to ensure people's medicines were safely administered, particularly on Lyde, which placed people at risk. The environment on Lyde was not well maintained, we found several health and safety concerns that placed people at risk, including trip hazards and poor management of infection control. The provider could not be sure people on Lyde were being supported by enough staff who had the skills and knowledge to meet their needs.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. People on Lyde did not have communication profiles, which meant there was no evidence, that where needed, the service supported people to communicate and understand according to their needs. Activities were not based on everyone's ability to communicate or their individual likes and dislikes.

Governance systems included internal and provider level audits and regular checks of the environment and service to ensure people received good care. We found these systems were not always fully effective in driving improvement. Whilst it was not evident this had any significant impact on people, it did not evidence a fully effective governance system was in operation and placed people, specifically on Lyde, at risk.

We saw some positive interactions during the inspection, with most staff being kind and friendly when supporting people on the brain injury unit and the general nursing unit.
The environment on the brain injury and general nursing units, was homely. Meal times were sociable and the feedback from relatives living on the brain injury unit was positive. One relative told us, "[Relatives name} doesn't want to go home she likes it so much here now."
We found fire maintenance, gas, electrical safety, and safe use of water outlets were all up to date. The provider had identified some of the concerns found on Lyde, during the inspection. The provider assured us the care on Lyde would be reviewed and a refurbishment plan was due to begin in April 2020.

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 in August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to medicines management, staffing levels, dignity and respect and the overall management of the service at this inspection. We have made three recommendations in relation to, risk management, accessible information and communication and personalised activities.

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 fully safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-Led findings below.

West Abbey

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
The inspection was carried out on day one of the inspection by two inspectors and two specialist advisors. Both specialist advisors were registered nurses with experience in elderly and dementia care. On day two, the inspection was carried out by one inspector.

Service and service type
West Abbey 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 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 on day one of the inspection and announced on day two.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection-
We spoke with seven people who used the service and nine relatives about their experience of the care provided. We spoke with 20 members of staff t, the operational manager, clinical nurse manager, unit

manager, registered manager, deputy manager, registered nurses, nurse practitioners and health care assistants.

We reviewed a range of records. This included nine people's care records and 61 Medication Administration Records (MAR). We looked at six 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.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We received additional information from two professionals about their experience of the care being delivered at West Abbey Care Home.

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. 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.

Using medicines safely

- Medicines management was not robust. For example, the provider's medicine management policy did not reference how many litres per minute oxygen administration should be prescribed at.
- There were two people receiving oxygen at the time of the inspection. One person's Medicine Administration Chart (MAR) was prescribed at three litres a minute, the second person did not have their oxygen written up on a MAR chart. We established this person was prescribed two litres a minute, but staff were administering one and half litres a minute. The registered manager was not aware of this but assured us they would update this persons MAR chart immediately.
- The provider's medicine policy did not reference the use of antipsychotics (medicines used to treat mental health problems) , the need for regular review, their side effects or how this medicine should be used as a last resort following behavioural strategies.
- We found two people had been prescribed antipsychotics, both people had not had their antipsychotics regularly reviewed, one had not been reviewed since May 2019.
- The provider's medicine policy had clear instructions on how staff should carry out enteral administration (a specific way of giving medicines). The policy states enteral medicines must not be 'crushed or altered without clear instruction from both pharmacist and provider'. However, we found one person had all their medicines through Enteral Percutaneous Endoscopic Gastrostomy (PEG) feeding. The GP had agreed for the crushing of this person's medicines but there was no signature from a pharmacist and one of the medicines clearly stated it was not suitable for crushing.
- People did not always receive medicines as prescribed. One person had been prescribed diazepam 1- 2 mg three times a day. They also had been prescribed diazepam as required (PRN). The PRN prescribing also stated a max of 3mg in 24 hours. Staff could not be sure they were administering the correct dose as 2mg three times a day equated to 6mg.
- One person was allergic to fish. This person had been prescribed anaphylactic medicine if required (for an allergic reaction). This person's prescription was incorrectly written.
- The provider's medicine management policy had no specific insulin provision within the policy.
- Insulin was not always prescribed clearly. One person's insulin dose on the MAR was handwritten and signed by the registered manager, not a GP or district nurse, this was also unwitnessed.
- Staff told us people living on Lyde, who had been prescribed insulin, often refused it. Staff had not risk assessed this or created a management plan in the event the person should become unwell from refusing their insulin.
- One person did not have a hypoglycaemic agent prescribed to reduce the risk of hypoglycaemic episodes (low blood sugar). Another person did not have the required dose of insulin written on their MAR chart to

indicate the dose that had been prescribed, this person had been prescribed a hypoglycaemic agent but had no specific glucose ranges stated to suggest when this might be required.
● We reviewed medicine errors over the past 12 months. We identified that on Lyde staff had not reported any medicine errors during this time. However, staff on Lyde told us they had raised significant concerns with the provider. These concerns had not been investigated appropriately and this put people at risk.
● Following the inspection, we received further concerns about how the provider managed medicines in the home from professionals who had recently visited West Abbey Care Home. One professional told us, "Completing the drug round is lengthy resulting in timed medication not being given on time and medication such as pain relief not having correct amount of time between doses." They added, "West Abbey is meant to have rectified this by providing a second person to help with the medication round."
● During the inspection we did not observe a second person helping with the medicine round. We did observe the length of time it took to administer medicines. Staff started the medicine round at 8am and people were still receiving their medicines at 11am. Staff told us this was because they did not have enough staff on duty.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicine management was safe. 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
● Staffing levels were not robust across all three units in the home. Relatives of people living on Lyde told us they visited often and felt there were not enough skilled staff to meet people's needs. One relative said, "[Person] just does not get the care required."
● On the first day of inspection we observed the staffing levels on Lyde. The lounge and dining area were unstaffed between 09.00am and 11.00am. During this time, we observed one person sat alone and distressed calling out for help. This person said they were thirsty, in pain and cold. We had to seek out staff to assist them.
● Staff working on Lyde told us, "There is not enough staff and the impact is people aren't getting good care." They added, "Bells are not answered compromising personal care and meals are late."
● The registered manager told us they used a staffing dependency tool to assess peoples' dependency levels and calculate the number of staffing hours required.
● The registered manager told us, "We have six staff in the morning and five in the afternoon which is right for the number of people living on Lyde." However, the assessment did not consider the individual needs of people, the skill mix and abilities of the staff team working on Lyde or how the unit manager deployed staff on the unit.
● We observed the unit manager on Lyde leave the unit six times during day one of the inspection. This left no one in charge of the unit. They told us they had to go off the unit to support other staff with signing of medicines.
● Many of the staff team were newly employed, and the provider was using agency staff to fill vacancies. This meant staff were not familiar with people's needs on Lyde. There had also only been one registered nurse on Lyde for the past 16 months, who was also the unit manager. These issues had not been factored into the staffing assessment to ensure the service was able to meet people's needs in a person-centred way.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate there were enough suitably skilled staff to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment

checks were carried out as standard practice.

Assessing risk, safety monitoring and management
● The provider did not always identify or address risks, to keep people safe. All radiators within the home were uncovered. Although a general risk assessment for radiators stated that remedial action would be taken if radiator heat exceeded 43 degrees, the provider had not taken account that people with fragile skin can be burnt if there is prolonged contact with a surface below this temperature. One person's bed on Lyde was pushed up against a radiator which meant they could be lying against a hot radiator all night. These risks had not been identified or mitigated. The registered manager said they would ensure all radiators are covered and they would move the person's bed away from their radiator immediately.
● On Lyde, bathrooms were used as storage rooms, we found two out of three communal bathrooms had large amounts of equipment in them preventing them from being used as a bathroom. There was no signage to ensure people did not wander in and fall over the equipment. Staff told us, "We are a dumping ground for the other units." The registered manager told us, "One of the bathrooms should be marked out of use." Adding, "We will make sure a sign is put up and the other one is emptied out so people can use it." This was actioned before the end of the inspection.

We recommend the provider consider current guidance on managing risks in care homes and act to update their practice accordingly.

● There were risk assessments and guidance in place for areas such as skin integrity, smoking and choking risks. For one person living on the brain injury unit there were detailed instructions on how staff should cut up their food to prevent them from choking.
● Personal emergency evacuation plans (PEEPs) were in place for people on all three units. These provided information on how each person should be evacuated in the event of an emergency.
● The provider considered environmental risk across all three units. For example, fire maintenance, gas, electrical safety, and safe use of water outlets.
● The provider employed a maintenance team for managing the day to day maintenance of the home, and contractors came in to service equipment such as the hoists to ensure it was safe to use.
● We reviewed the providers business continuity plan that ensured the service would continue if an emergency happened.

Preventing and controlling infection
● The home was generally clean, although infection control risk had not been fully considered.
Despite there being a clear, dirty to clean, flow in the home's laundry room we saw clean laundry hung over open dirty laundry. These practices increased the risk of cross contamination and air borne infections. Staff acted to improve this system during the inspection.
● The provider employed a house keeping team who understood their role and responsibilities for keeping standards of cleanliness and hygiene in the home.
● Staff had access to personal protective equipment such as disposable gloves and aprons.

Systems and processes to safeguard people from the risk of abuse
● The provider had safeguarding systems in place. Safeguarding concerns had been raised and investigated appropriately. The registered manager had informed the necessary organisations.
● People who were able to communicate told us they felt safe living at West Abbey Care Home.
● One person said, "I do feel safe, I don't want to go home." Another person said, "Yes I'm safe here." A relative told us, "I don't worry now my relative is in the home."
● The registered manager and staff understood their responsibilities to safeguard people from abuse.

Records showed staff had received training in how to recognise and report abuse. Staff knew what actions to take to protect people. One staff member told us, "We have safeguarding training, we look for changes in behaviour."

Learning lessons when things go wrong

● The provider reviewed accidents and incidents to look for trends or ways to prevent a recurrence. For example, the time, place, and any contributing factor related to any accident or incident was considered to show patterns and check if changes to practice needed to be made. Although the provider did not demonstrate learning from medicines errors.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People living with dementia and complex health needs lived at West Abbey Care Home. This affected their ability to make some decisions about their care and support. Mental capacity assessments and best interest paperwork were in place for some people. However, the mental capacity assessments and related best interest decisions were not decision specific and most had not been reviewed as required.
- One mental capacity assessment stated that the person did not have capacity. However, the related best interest decision stated they did have capacity. Other best interest decisions did not have related mental capacity assessments and there was no recorded input from relevant professionals or others involved in the person's care.
- Staff had made decisions for people without capacity. We found they had not considered mental capacity assessments or best interest decisions. These included decisions such as the receipt of a flu jab and the administration of covert medicines. Peoples' capacity to agree to this support had not been assessed and the views of their representatives had not been sought.
- The registered manager had made a best interest decision for one person, to not attempt resuscitation. The individual referred to did not have an independent mental capacity advocate (IMCA) to act in their best interest. There was no health professional input recorded or that of relatives in line with the principles of the Act.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate how the provider ensured peoples' rights were upheld in line with Mental Capacity

Act legislation was a breach of Regulation 11 (Consent) of the Care Quality Commission (Registration) Regulations 2009

● DoLS applications had been made appropriately and adhered to for people that required them.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● One relative said, "There is a gap in knowledge, and staff don't always follow up health outcomes."
● A visiting health professional said that staff always 'acted' on their advice and were willing to come back to them if their advice was not working. Although a relative of one person living on Lyde told us, "Staff don't always follow up health outcomes such as physio, especially if the (relatives name) showed reluctance." Adding, "Staff don't encourage (relatives name) they accept no and leave it at that".

● All care plans we viewed had information in relation to routine health appointments. There was information about appointments attended and when regular appointments or reviews were due.
● Oral health care plans provided detailed guidance for staff about people's oral health care and when people should be referred to their dentist.

Adapting service, design, decoration to meet people's needs
● The decoration within the service had not been consistently maintained to meet people's needs across all three units. On the brain injury and general nursing units the décor was modern fresh and everywhere looked very homely.
● On Lyde where people were living with complex dementia needs , the décor was tired, there were few adaptations to support people living with sensory impairment or dementia to navigate independently around the home, for example pictorial signs. There was no attempt to differentiate between areas on Lyde which would be helpful for visitors as well as for people living on the unit.
● The registered manager told us they had a plan in place to refurbish Lyde. Staff told us, "They were meant to redecorate last year then they said February 2020 but the plans to decorate Lyde always get cancelled." The operational manager assured us the plans to refurbish would begin in April 2020.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager visited people prior to them being admitted to the home. Care assessments identified people's needs and enabled staff to create care plans for people.
● Staff had information on how best to meet people's needs and choices in line with best practice guidance.

Staff support: induction, training, skills and experience
● All new staff completed an induction when they started working at West Abbey Care Home. Staff told us, "The induction is an introduction to the company, then we did shadow shifts and e-learning specific to what your role is." Another staff member said, "[Staff members name] does our training, they did safeguard training and related it to the home, it got the right message across." Staff said they get some specialist training, for example huntingtins training and non-invasive. However, there were mixed views about staff skills and knowledge. Relatives of people living on Lyde told us, "Staff are not skilled, my relative has contractures, the physio gave staff exercises but staff don't do them." Another relative said (relatives name) is not getting their hair washed." Adding, "On Lyde, people look unkempt, that's basic care needs."

Supporting people to eat and drink enough to maintain a balanced diet
● Peoples dining experiences varied depending on which unit they lived. The main dining areas on the brain

injury and general nursing units looked like a restaurant, they had menus on tables and people had china cups to drink from. There was a floral arrangement on each table, condiments and cutlery laid out.

● There were lots of staff on hand to attend to people. People were served the courses of their meals so that each course was at a suitable temperature and available when requested.

● Drinks were regularly offered to people. The dining experience was a social occasion and completely different to people's experience on Lyde.

● During lunchtime on the Lyde staff were not always available to assist people. People were given plastic beakers to drink from. The tables had tablecloths and cutlery but there were no menus, condiments, crockery or flowers on the tables. Staff told us, "We don't put anything out for anyone because [person's name] takes it all off."

● We observed people being served their lunch late, there were people still eating food at 2pm, which, by then was cold. Staff did not offer people choices of meals, on day one of the inspection, we mentioned this to the registered manager. On day two of the inspection staff did offer a choice of meal. A relative said, "I've never seen staff offer meal choices before, that is because you are here."

● There was no effort made to promote a sociable dining experience for people on Lyde and one person didn't get served their lunch until 3pm, there was nothing in their care plan that stated they liked their lunch that time of day.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity.

● People living on the units supporting people with brain injury or general nursing needs were treated with respect and their dignity was maintained. However, the provider had not ensured that people living on Lyde were treated well with regard to their privacy and dignity.

● The provider had not ensured everyone in the home was able to decide how their care was delivered. There was one bath on Lyde and it was not in working order. People did not have their own ensuite facilities and told us they would like to have a bath but had been told they could not. One staff member said, "It [the bath] hasn't worked for about two years. We have asked so many times and nothing gets done." We discussed this with the clinical lead who arranged for the bath to be fixed, they told us, "It will be fixed this week."

●Peoples with continence needs were not supported well. There was a smell of stale urine on Lyde which had not been identified by the staff. The smell was there throughout the inspection. We highlighted this to the manager who agreed there was a 'smell' and requested the carpet to be cleaned.

● Staff were meant to monitor another person's continence on Lyde. We reviewed the care records that stated staff had checked this person at 6:20am, 8:35am 11am and 3:30pm. That meant this person went four and half hours with no continence support even thought their care plan stated they should be offered support every two hours.

● People living on Lyde did not receive adequate support at meal times. We observed people interfering with each other's meals, we also saw one person go to hit another resident, a relative prevented this by coming in between them and distracting them. During this time there were no staff to reassure or help people.

● Staff did not promote respect and dignity for people with living with dementia on Lyde, we saw that people were unkempt wandering around the unit, staff made no effort to help people, adjust their clothing, change soiled clothing or make sure everyone had shoes on.

● We observed one person wondering around the unit all day with nothing on their feet. There was nothing in her care plan that said they preferred to be without shoes on. We also observed staff walking into communal areas multiple times and not acknowledging people.

● We saw a box full of shoes in a communal area, staff told us, "People lose their shoes, we find them and throw them in the box."

● On day two of the inspection we observed staff sat around a communal table discussing peoples' care needs and could be overheard. This meant peoples' personal information was not being kept confidential.

● Staff told us, "We can't win, yesterday we were all in the office and told we should be out on the floor."

We found no evidence that people had been harmed however, the provider did not ensure that people using the service, in particular those living on Lyde were treated with respect and dignity at all times while they were receiving care and treatment. This was a breach of Regulation 10 (Dignity and respect) of the Care Quality Commission (Registration)

● People on the brain injury unit told us, and we observed, staff promoted their independence. We saw people coming in and out of the home. People were laughing and joking with staff. Staff knocked on people's doors before entering.

● We observed respectful interactions with people on the acquired brain injury and the general nursing units. Relatives were very complimentary about the care being delivered to their loved ones. One relative told us, "Staff are so lovely here." Another relative said, "Staff are kind to [relatives name]." One person told us, "Staff, we have a laugh, I don't want to go home." Adding, [staff members name] did prayers and held my hand."

● We saw compliment cards in the registered managers office, one said, "Thank you to staff who showed mum compassion and grace."

Supporting people to express their views and be involved in making decisions about their care

● One person was unable to have a shower due to the correct equipment not being available to support them. On the brain injury and general nursing units' bathrooms and appropriate equipment were available. People on the brain injury unit told us they could choose to have a bath whenever they wanted.

● We discussed our concerns about the care on Lyde with the clinical lead, who assured us they would be working with the staff to improve practice. People on the brain injury and general nursing units told us they were involved in their care. One person said, "Yes I just have to say and staff will help me with it."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained now deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager was aware of their responsibility to make information accessible to people in line with their needs. However, guidance in peoples care plans varied. People on Lyde had difficulty communicating, and staff interaction with people did not assure us staff knew people's communication needs. For example, we observed one person living on the Lyde unit repeatedly fall throughout the inspection, this person did not verbally communicate. Staff told us, "They do this all the time, we don't see it happen, so we never know if they fall or put themselves there."
- The provider did not use pain monitoring tools for people with difficulty communicating verbally. This meant staff could not ensure that their pain level was being assessed regularly and responded to appropriately. Staff told us they knew people well enough to know when they are in pain.
- The registered manager told us the provider was developing the use of technology to help people communicate better.

We recommend the provider consider current guidance on the accessible information standard and act to update their practice accordingly.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
- The provider had an activities programme in place. However, on Lyde people living with dementia were not stimulated with activities that were meaningful to them. We saw people on Lyde walking around the unit entering other people's bedrooms, invading their privacy. We also saw people trying to leave the unit.
- The provider employed two activity coordinators. We observed one activity coordinator on Lyde engage people with cake baking. Staff asked one person to help them bake a cake, this person was happy to until staff said it was for Valentine's day. This person became upset and refused to help. When asked if they if they liked valentine's day, they said no. Staff had not considered peoples likes and dislikes
- We observed people enjoying watching the television on the general nursing and brain injury units. We asked people if they were enjoying the programme. People who were able to respond told us that staff checked what they would like to watch. We also observed staff checking with people what they would like to watch. However, on Lyde the television did not work.
- Relatives told us the more experienced staff knew people well and went out of their way to engage with

them. We observed this on the brain injury unit when a member of staff approached a person and reminisced with them about music they listened to in their youth and music concerts they had attended.
● One relative said, "Some staff go above and beyond, do treat [People] as individuals." We also observed that some staff were visiting people on the brain injury unit on their days off.

We recommend the provider consider activities based on individual hobbies and interest, particularly on Lyde and act to update their practice accordingly.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People had care plans in place but they were not very detailed. Staff working on the brain injury and general nursing units knew people's individual needs and preferences. People had their likes or dislikes written into their plan and their food preferences.
● Care plans were regularly reviewed and updated. Although there was no record of how people were involved in their care and treatment. People on the brain injury unit told us they had a care plan and confirmed staff did not deliver any care they did not want. However, on Lyde, staff told us they follow the care plans but were not sure who wrote them or where the information came from. Most staff on Lyde were new in post and did not know people well, which meant we were not assured that people on Lyde received person centred care.

Improving care quality in response to complaints or concerns
● People on the brain injury and general nursing units, and their family, knew how to complain and felt confident that if they complained, they would be taken seriously, and their complaint or concern will be explored thoroughly. One relative told us, "I'd speak to the staff they are very good." People on Lyde could not tell us how they would raise concerns and relatives said they knew how to complain but were not confident they would be listened to. One relative told us, "I constantly worry about [relatives name]." Another relative said, "Mum hasn't had glasses since Christmas."
● The registered manager told us, "We encourage staff to keep a log of concerns, the company keeps a record."
● Actions were taken from complaints received. One example of change from a complaint was how staff stopped putting labels on clothing as they came off and people still lost clothing. Staff now sew a button on the inside of clothing that identifies who it belonged to.

End of life care and support
● People's end of life wishes were discussed at their needs assessment or soon after they moved into West Abbey Care Home. People were able to state their preferences for end of life care, which respected people's protected characteristics, culture and spiritual needs.
● Staff talked passionately about this aspect of their role. The registered manager told us they got support from GPs and Macmillan nurses.
● The provider had an end of life champion. Staff told us they had a box for families, this included slippers and blankets in the event families had to stay over with their relative.
● The provider had also joined with Macmillan staff supporting a confidential health line where people can talk through any issues either face to face or over the phone.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There were systems in place to identify shortfalls in quality and risk. However, these had not been used effectively to sustain a good quality of service across all three units in the home. A number of breaches of regulation have been identified through this inspection.
- For example, current governance systems had not identified the concerns raised during the inspection around people's capacity to make decisions, or the issues found in relation to people's medicine management. In the Lyde unit medicine audits had not been completed since October 2019.
- The registered manager did not have full oversight of Lyde due to the current management structure. We observed the unit manager on Lyde leave the unit regularly. This left Lyde with no senior care staff or a registered nurse for long periods of time. The unit manager told us they had to go off the unit to support other staff administering controlled medicines.
- Lyde depended upon agency staff and had a history of medicines errors (by agency staff). Medicine error records over past 12 months identified three errors from the other units in the home and none from Lyde. However, the unit manager on Lyde reported significant concerns in writing on 10th February 2019.
- Staff told us this was not first error identified when agency nurses were on shift. Staff had not always reported medicine errors formally but had requested not to have agency staff on the unit.
- The provider did not promote a positive culture across the entire home. Staff on Lyde told us morale was low because the management was not providing clear leadership. One staff member said, "Staff are burnt out." Another staff member said, "We are the poor relations of the home." A third staff member said, "Lyde is used as dumping ground, nobody cares about people here."
- People we observed on Lyde were left with little interaction from staff. Several times we observed staff walking past people without any acknowledgement. This improved after the inspection team mentioned our concerns to the management team.

We found no evidence that people had been harmed, however, systems either not in place or effective enough to demonstrate the governance of this service was effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff working on other units gave positive feedback about how the home was led. Comments from staff included, "[registered managers name] is brilliant, no dumb question, even if you ask 10 times, they are supportive."

●The provider had a development plan to improve the service, we discussed this with the registered manager who told us they had plans to improve the environment on Lyde. For example, the unit was going to be decorated in line with best practice for people living with dementia.
● The clinical nurse lead assured us they would be reviewing the care delivery on Lyde to ensure people living with dementia had their needs met in line with national guidance.
● The provider had recognised staff morale was low and introduced Employee of the month. Staff told us they had their awards night coming up." Adding, "We sat down with [registered managers name] to get morale up."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●The provider had implemented ways of involving people in developing the service. These included monthly resident meetings, relative meetings and satisfaction surveys. People on the brain injury unit confirmed they had resident meetings where they could talk about things such as the menus and activities. However, on Lyde, there was no evidence of how people and their families were involved in the service. One relative said, "Informally working together doesn't work, I haven't wanted to make a complaint or sour relationships, I worry if I make a complaint."
●The provider was working in partnership with other agencies. Following the inspection, we received written feedback from three professionals. Comments included, "There is poor communication from West Abbey, and between shifts, at times, they state that the shift leader is often unavailable to speak to." And, "Inadequate staffing levels to support need – family raised concern to GP that staff had no awareness of the neuro rehab plan for [person's name]."
● Systems were in place to communicate information to staff through meetings. We received mixed feedback around the effectiveness of these systems. Staff we spoke with on the brain injury and general nursing unit said communication was satisfactory. However, a staff member on Lyde said, "We do have meetings, but we don't get much from the registered manager, they don't really come down here."

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 promoted the ethos of honesty and understood their responsibility to let others know if something went wrong in response to their duty of candour.
● Notifications had been received by the Care Quality Commission (CQC) which meant CQC could check appropriate action had been taken. They also ensured their current ratings were displayed for the public to see.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people using the service, in particular those living on Lyde were treated with respect and dignity at all times while they were receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not operate effective systems and processes to make sure medicines were effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to demonstrate how peoples' rights were upheld in line with Mental Capacity Act

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems and processes to make sure they assessed and monitored their service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not adapt staffing levels in response to the changing needs and circumstances of people.