Abbey Park House

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on the 15 October 2018. The inspection team consisted of two inspectors.

Abbey Park House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Abbey Park House accommodates up to 28 people in one adapted building. Eighteen people lived at the home at the time of our inspection visit.

At our last inspection in January 2017 we judged the home to be 'requires improvement' in the key questions of safe, effective, responsive and well-led. We found the service to be in breach of regulation 17: Good governance. The systems in place to monitor and improve the quality of the service were not robust and had failed to ensure people received safe and a good quality of life.

This inspection took place on 15 October 2018 to follow up on our previous findings. We returned on this occasion to check whether people were safe and that the provider was taking the necessary action to improve the quality of care and reducing the risks to people. We found the service had not improved following our last inspection and had deteriorated. We also identified breaches of regulations 9, 10, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in addition to regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have considered that those breaches of regulation were exposing people to the risk of unsafe or inappropriate care. We are considering what further action to take.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always kept safe because risks were not always assessed, monitored or mitigated. People were not protected by the provider's procedures for the prevention and control of infection. Environmental risks were not well managed or addressed in a timely manner. People were not always protected from the risk of abuse. Staffing levels were insufficient to meet people's needs in a timely manner. Accidents and incidents were not being consistently investigated and followed up. Where lessons could be learned to improve the service, and make the care people received safer; these were not always identified and addressed. People received their medicines as prescribed.

The provider's systems did not ensure staff had the skills, training, knowledge or experience to meet the needs of the people who lived at the home. People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible. The environment was not to a consistent standard to meet people's needs and well-being. There was a lack of signage to assist people

to orientate themselves around the home. Staff involved and consulted a range of health and social care professionals to ensure people's healthcare needs were met. However, the advice given by these professionals was not always followed, put into practice or reflected in peoples care records. People we spoke with told us they were supported to eat well in accordance with their preferences.

People told us that staff were kind and caring. However, people's dignity was not always maintained and respected. Staff did not have time to spend quality time with people. Staff did not have information about people's social history or interests and were task focused with their approaches and engagement with people.

People did not always receive care and treatment that was responsive to their needs or provided in a person-centred way. There was no information available about people's protected characteristics to ensure all of people's needs were identified and met. People were not supported to be involved in the planning or review of the care they received. Care plans had not always been updated to reflect changes in the support people received. People had limited opportunities for social stimulation. People did not have the opportunity to join in community based activities. People told us they felt confident to raise a complaint. However, Information about how to raise concerns had not been produced in an accessible format for people who had a visual or cognitive impairment. People could not be confident that their wishes during their final days and following death were respected.

People who lived at the home did not benefit from a service which was well-led. There had been a failure in the leadership and governance of the service. There were no effective systems to monitor or improve the quality of care and no strategic vision or provider oversight. Ineffective leadership in the home had impacted on the people who lived at the home and the staff team. The ethos of honesty, learning from mistakes and admitting when things had gone wrong was lacking. The provider had not met their legal responsibilities to inform the Care Quality Commission of significant events which had occurred in the home. It is important that we are notified, to enable us to monitor the quality and safety of the service people receive. People's views about the quality of care they received had not been sought effectively. People and staff told us the registered manager was approachable and supportive.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question of overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report. 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.

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.

Risks to people's health, safety and welfare were not assessed, monitored and mitigated. People were not always protected from the risk of harm or abuse.

Accidents and incidents were not robustly reviewed, investigated and followed up to ensure lessons were learned for the future.

Staffing levels were insufficient to meet people's needs in a timely manner.

People were not protected from the risk associated with the control and spread of infection.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were no effective systems in place to ensure staff had the skills, knowledge and experience to support the people who lived at the home.

People were supported by staff whose performance was not regularly monitored.

The provider and staff did not demonstrate an understanding of nor did they follow the requirements of the Mental Capacity Act 2005 (MCA) and DoLS.

People told us they were supported to have enough to eat and drink and had access to health care professionals when they were unwell.

The environment was not to a consistent standard to meet people's needs and well-being.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were friendly and caring. However, staff did not pay sufficient regard or priority to maintaining people's dignity and self-respect and did not recognise their responsibilities to maintain and promote people's dignity.

The provider had not ensured that people had information available to them in a format they could understand dependent on their individual communication needs.

Choices and options were not always explained to people so they could make decisions about the care they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive care and treatment that was responsive to their needs or provided in a person-centred way.

People's views were not considered when planning and reviewing the care they received. Care records were not accurate or up to date and did not reflect people's preferences.

Staffing levels impacted on people's engagement with meaningful activities and involvement with their local community.

People felt confident to raise complaints. However, the complaints procedure had not been produced in accessible formats for people.

Is the service well-led?

Inadequate

The service was not well-led.

People did not benefit from a service that was well-led. There continued to be poor leadership and managerial oversight impacting on the safe running of the service.

People were not protected from an ethos of honesty, learning from mistakes or admitting when things went wrong. Where information was collected, this was not analysed for trends and risks.

The provider failed to notify the Care Quality Commission of significant events which occurred in the home.

People's views about the quality of care they received had not been sought effectively.

People and staff told us the registered manager was approachable and supportive.

Abbey Park House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on the 15 October 2018. We undertook this inspection to follow up on our previous findings. We returned on this occasion to check whether people were safe and that the provider was taking the necessary action to improve the quality of care and reducing the risks to people.

As part of the inspection process we had already asked the provider to complete a Provider Information Return (PIR) earlier in 2017, so we did not ask them to complete this again. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account when we made the judgements in this report. We also reviewed the information we held about the service. We looked at information received from the local authority commissioners, Healthwatch and the statutory notifications the registered manager had sent us. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with seven of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. We spoke with four relatives of people and two health care professionals to get their views. In addition, we spoke at length with the nominated individual, the registered manager, one senior care assistant, four care assistants and the cook.

We sampled care documentation for six people, medicines records, two staff files, staff supervision, appraisal and training records. We also looked at other records relating to the management of the service including audits, quality monitoring systems and action plans; accident and incident records; surveys; meeting minutes and complaint records.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017 we rated the registered provider as 'Requires improvement' in this key question. We found people were placed at risk because the provider did not have safe systems in place to reduce the risks associated with their care. The management of medicines required improvement. At this inspection in October 2018 we found that the issues had not been addressed and the service had significantly deteriorated. The provider had failed to ensure people received consistently good, safe care that was compliant with the legal regulations and were now in breach of regulations.

People were not consistently protected from the risk of abuse. Staff did not demonstrate a consistent understanding of safeguarding practices and procedures, and recognising types of abuse. We identified a person who had unexplained bruising on their arm. We discussed this with the registered manager who was unaware when the injuries had been sustained as staff had not brought this matter to their attention. We found there was no body map in place to identify this unexplained injury. This had not been recorded or reported by staff. This meant staff were not familiar with good safeguarding practice guidance. We identified a person with a serious skin ulcer that had been acquired at the home. This had been assessed to be of a grade that would be notifiable as a safeguarding concern. The registered manager advised us and records confirmed that this had not been notified to CQC or the local authority safeguarding team. Although the staff we spoke with said they would report any concerns and had received safeguarding training, some were unsure of how to report concerns to external bodies and were unsure about the whistle-blowing procedure. We were unable to source assurances that staff and the management team were routinely following safeguarding policies and procedures to ensure people living at the service were being kept safe.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

People we spoke with told us they felt safe. One person said, "I feel safe here." However, people did not always receive safe care and support. Risks associated with people's care and support were not effectively identified, assessed or mitigated. Where action had been taken to address risks, care documents and staff knowledge were unclear. For example, people identified as being at risk of malnutrition were not always supported appropriately. We found that food and fluid monitoring charts had not always been completed fully. For example, on one person's food and fluid chart we found their individual nutritional intake was not quantified and their fluid intake was not calculated on a daily basis to ensure their nutrition and fluid intake was adequate to maintain their health. Staff we spoke with were not aware of the person's targets. We found that the failure to monitor, whilst at the time had no direct impact on people possible risks of not having enough to eat and drink not be easily identified.

Where people were at risk of developing pressure sores appropriate action had not always been taken to ensure risks relating to peoples' skin integrity were effectively managed. We saw one person had pressure sores that had been acquired at the home and they were supported and cared from their bed. Most of the staff we spoke with told us they repositioned the person on a regular basis to prevent any further skin

breakdown. However, both feedback from staff and the records we reviewed were conflicting around the frequency of the repositioning. There was no detail in the care plan that the person was supported from their bed or how to manage their skin integrity. This made it difficult to establish their specific skin care needs. Although we saw a pressure relieving mattress was in use, the care plan did not identify this or what the correct setting of the mattress should be. We spoke with a health professional following our inspection who told us they had made recommendations to reduce the risk of skin breakdown. We found that these initial recommendations had not been actioned in a timely way to ensure the risk of the person skin breaking down was mitigated.

Appropriate action had not always been taken to assess, monitor and reduce risks associated with choking. We saw one person's most recent choking risk assessment assessed them as being high risk. We could not see that a Speech and Language Therapist (SALT) referral had been made to help to mitigate the choking risk and to provide staff with advice or examples of what high risk foods were for this person. The staff we spoke with were not sure about what foods were high risk for the person. The person's nutritional care plan stated they 'had no difficulties with eating'. It was identified that the person required soft food and was to be monitored by staff at meal times. However, a staff member told us, "[name of person] does not have to be monitored at all times when eating." Whilst on the day of our inspection we observed the person eating a soft diet we noted the person was eating alone without staff supervision. This meant the registered provider could not be assured appropriate action was being taken to reduce this assessed choking risk.

We observed that staff were using unsafe practices to support people to move that increased their risks of falls. We observed staff support one person to stand. The staff supporting advised the person to pull themselves up using their frame and staff place their foot on the bottom of the person's frame. On our arrival to our inspection the registered manager advised us that no-one required the use of moving and handling equipment. However, we identified that one person had been assessed as requiring a slide sheet for all transfers. We observed the equipment was available for staff to use. However, whilst staff told us they used this equipment to move the person there was no risk assessment in place with guidance for staff how to undertake this safely.

We found the maintenance room was left unsecured and unlocked at the time of our inspection. Within this room we found risk items including cleaning products, methylated spirits and other items of risk. These products present a serious risk to people if they are ingested inappropriately. People who were living with dementia were able to access this room freely and who would not recognise the dangers. On finding this room open at 10.00 am we requested for these risks to be addressed as a priority and at 12.00 noon the room remained accessible to people. In addition, we found bottles of cleaning fluid being stored on top of and unlocked cupboards. This put people at risk of harm as substances hazardous to health were not being managed safely. We looked at other risks, such as those linked to the premises. We found fire risk assessments were completed and staff we spoke with were familiar with the emergency procedure at the home. People had Personal Emergency Evacuation Plans (PEEPs) in place. However, they were not always comprehensive and up to date. For example, one person's PEEP was not reflective of their current needs and did not state how many staff were required to safely move them or how. In addition, when we checked records for servicing of moving and handling equipment and the passenger lift we saw they had not been serviced in a timely manner and were overdue by ten months. This meant equipment being used may not be safe which posed a potential risk of injury to people.

People did not enjoy a clean home and were not protected from the prevention and control of infection. A relative described their relations room as, "Having a bit of a smell in there." There were unacceptable levels of cleanliness at the home which placed people at risk of cross infection. We found numerous carpets, chairs, floors, table tops, bedrooms, bedding, mattresses and communal bathrooms were soiled, stained

and offensive smelling. For example, toilet seats in communal toilets and people's own bedrooms were covered with faeces. We found that some practices in the home needed to be improved to protect against the spread of infection. The toilets within the home, which were frequently used, were not being cleansed to an acceptable standard; most did not have toilet paper, paper handtowels, hand soap or hand sanitizer in situ for people to use. We noted a number of dirty and cracked toilet seats in people's bedrooms and bathrooms. We found offensive odours throughout the home. We spoke with the registered provider and registered manager and they agreed that some of the communal bathrooms were soiled, stained and offensive smelling. The registered manager informed us that the domestic worker was on leave but had cleaned the previous week. However, poor standards of cleanliness we saw indicated the home had not been thoroughly cleaned for some time.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care and support including the detecting and controlling the spread of infection which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

One person told us, "There's enough staff to help me." However, from our observations sufficient staff were not always deployed to meet people's needs. The registered manager advised that people's dependency levels had not been reviewed or calculated. They confirmed there were no systems or tools in place to determine the number of staff required to meet people's needs. We saw that service users were left for periods of time with no interaction from staff as they were undertaking other duties. During our inspection there were no dedicated staff available to carry out domestic duties which contributed to the poor cleanliness of the environment. We reviewed staff rota's which confirmed domestic staff work 08.30 – 14.00 Monday to Friday. Any domestic duties outside of these days and hours and carried out by staff who are responsible for care duties. A member of staff said, "Cleaning is not good, we can't do both jobs. Caring should be 100%." In addition, there was no dedicated catering staff after 14.00 Monday to Friday and no catering staff weekends. This meant staff responsible for other duties had been taken of the staffing rota to undertake catering duties. No risk assessments or related actions had been taken into consider the impact of this on the staff team and their roles and responsibilities.

The registered provider had failed to ensure there were sufficient numbers of staff deployed to meet people's care and treatment needs. This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We looked at the way in which staff were recruited and found that the provider carried out pre-employment checks prior to offering them a job. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people.

Following our last inspection in January 2017 the service had improved their systems to ensure medication was disposed of correctly. People were happy with how their medicines were managed. One person told us, "They [senior staff] ask me if I want some pain tablets." The arrangements for the storage, recording and administration of medication was satisfactory. The controlled drugs were securely stored and administered with the controlled drug register being correctly maintained. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Staff who administered medicines had undertaken medicine training and whilst one staff member told us they had received observational competencies, these had not been recorded.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2017 we rated the registered provider as 'Requires Improvement' in this key question. We found people were not supported by staff who had knowledge and skills to protect the rights of people. The needs of people living with dementia were not taken into account in the design and decoration of the home. At this inspection in October 2018 there had been no improvement. We found the service had deteriorated and was now in breach of Regulations.

People told us that in their opinion staff had the skills and right experience to meet their needs. One person told us, "Staff know what they are doing." However, we saw that some staff did not have the skills or knowledge required to support people safely and promote their wellbeing. Whilst we were told staff had received moving and handling training we observed a number of examples where staff did not display an understanding of how to use safe manual handling techniques and as a result placed people at risk of injury. Whilst the staff we spoke with told us they received sufficient training we found they did not always have the skills or time to work effectively with people living with dementia. People we met were at differing stages of their dementia and there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. This meant that people were at risk of being supported by staff who may find it difficult to understand their specific care needs. Training records we reviewed confirmed staff had received key training in 2018. However, the registered manager was not able to demonstrate they had checked the competency of care staff to ensure they were equipped with the skills needed and were applying these into practice.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified,competent, skilled and experienced persons to meet people's care and treatment needs. This was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

We found that the environment supported the physical needs of people with the use of handrails and raised toilet seats. However, other areas of the building were not well maintained. For example, some of the furniture was very worn in the communal areas. Carpets were worn and threadbare on stairs which may have put people at risk of tripping. Within communal bathrooms we found baths were broken and in need of repair. Within people's bedrooms we saw examples of poor maintenance such as broken shower doors, missing light shades and broken furniture. One bedroom had a large step down into it and there was no warning sign to make people aware of it and a risk assessment was not in place to identify that the person's mobility had been considered. There were some uneven flooring and low lighting in some areas of the home. Whilst there were no reported incidences surrounding these hazards, people were potentially at risk of injury. The environment was not to a consistent standard to meet people's needs and well-being.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. During this inspection we reviewed if the registered provider was complying with the MCA. Staff we

spoke with had limited understanding of the MCA, although we observed that generally they sought people's consent before providing care. We saw one person was being supported and cared for from their bed. We saw their bed had been lowered to the floor and crash mats had been put in place. When we checked the persons' care plan, the person had not consented to the use of the equipment and there was no evidence that this decision needed to be made in the person's best interests. This meant that consent to care and support was not always sought in line with legislation and guidance.

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. The application procedures for this in care homes are 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 were being met. The registered manager advised us that five applications for DoLS had been made to the authorising authority. However, a mental capacity assessment had not been completed before the DoLS referrals had been made. This meant that the person's capacity to consent to the restriction that was being referred had not been assessed and consideration to the fact that they may be able to consent to the decision had not been made. In addition, we saw people were restricted from accessing the garden as all the doors were locked and could only be opened by staff. A member of staff told us, "People can't go out on their own." The registered manager advised that some people went outside on their own, but the majority of people were unsafe to walk into the garden on their own. This meant the provider had failed to identify that practices in the home were not always in accordance with principles of MCA and had not considered this to be potentially restrictive practice.

Some of the staff we spoke with did not always know which people were subject to authorised DoLS and three staff had no knowledge of what DoLS meant for people living at the home. One member of staff said, "Nobody is on a DoLS." Another member of staff told us, "There are only three people here who are not on a DoLS." Another staff member said, "I don't know what it means." The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

Staff who were new to the service completed an induction to the home and had the opportunity to shadow more experienced staff members. The registered provider had ensured their induction processes were in-line with the principles of the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.

People told us they were supported to have enough to eat and drink. One person told us, "The food is nice, I get a choice." A relative said, "The food is wholesome." We saw the food looked appetising and assistance was provided to people where necessary. People told us they had the opportunity to see healthcare professionals such as their GP, dentist and optician to maintain their health and receive ongoing healthcare support. One person told us, "A lady has been about my [continent aids] today." A hospital transfer form was used to support people when they were admitted into hospital. The information within these documents included, what professionals should know about the person in respect of their medical conditions.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2017 we rated the registered provider as 'Good' in this key question. At this inspection the service had not sustained this rating. The service has now been rated 'Requires improvement' in this key question and was now in breach of Regulations.

We received positive feedback from people about the caring attitude and behaviours of individual staff. However, we also found that the providers systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report. For example; people did not enjoy a clean home and were not protected from the prevention and control of infection and people did not consistently receive personalised care from staff as they were not always aware of or responsive to people's individual care, emotional and support needs. This did not demonstrate a caring and compassionate approach to people's care.

One person told us, "All staff are pretty good." A relative told us, "Staff are friendly and caring." Staff did not always recognise and intervene where people needed support. People were not always treated with dignity and respect. A lot of people living at the home needed support and/or prompting from staff to ensure they had their personal care needs met. We saw this was not always being provided. For example, on the day of our inspection we saw people whose attire was soiled and odorous due to their unmet continence needs. We saw people sitting with clothes on that were covered with spillage from food. We saw people's appearance was unkempt and their personal hygiene not maintained. Staff did not pay sufficient regard or priority to maintaining people's dignity and self-respect and did not recognise their responsibilities to maintain and promote people's dignity.

We found that people living with dementia had a poor quality of care. Despite our previous inspections identifying the need for improvement in the environment and the need to improve social and emotional outcomes for people this had not been addressed or improved. There was little for people to find to enable them to engage in independent activity and a lack of signage to help people orient to time and place. There were some pictorial signs on doors to denote bathrooms and toilets, for example, but no signage to help people locate these independently. We saw that people who were living with dementia were left alone, unsupervised with little or no social interaction.

Staff did not have the time to build relationships with people; opportunities for staff to spend time with people were limited. We saw numerous occasions where people were sat in the lounge areas of the home without any interaction from staff. We saw staff were more focused on tasks than people and their well-being.

Failing to treat people with dignity and respect is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 10.

At the time of our inspection the registered manager advised us there was no-one living at the home who required advocacy support. Advocates are trained professionals who support, enable and empower people

to speak up. There was no information on display within the home which informed people about local advocacy services available to them.

People's right to confidentiality was respected and protected appropriately. Care plans were locked in a secure cupboard and only staff with appropriate authority were able to access them. Relatives we spoke with told us they could visit at any time. One relative told us, "I can visit anytime I like. This meant people were supported to maintain their relationships with those close to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2017 we rated the registered provider as 'Requires Improvement' in this key question. This was because people did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. People were not engaged in meaningful activities. People were not involved in the planning and reviewing of their care. At this inspection in October 2018 we found that the issues had not been addressed and the service had deteriorated. The provider had failed to ensure people received consistently good, responsive care that was compliant with the legal regulations and were now in breach of regulations.

People did not always receive personalised care that was responsive to their needs. One person told us, "They [the staff] don't know me or what I want." Personal preferences for people were not consistently recorded in their care records. During our inspection we found that staff followed a routine when providing care, which was not personalised. Staff advised us that, where possible people were given choices around when they would like to get up and we saw a few more independent people in the dining room for breakfast. However, we observed and staff described a general routine in place whereby staff were focused on tasks. Staff told us and we saw that drinks were served at set times and we observed set times to assist people with personal care needs. We did not see people being supported out of these times.

Where people's preferences had been assessed these did not always translate into personalised care. For example, we saw information within one person's care records to show that prior to living at the home they were in contact with their family who lived in a different country via telephone. This was very important to them. However, there was no information to demonstrate they had been supported to keep this contact. This meant we were unable to demonstrate staff had supported, respected and met this person's individualised need. Staff were not provided with comprehensive information to enable them to deliver personalised care. We looked at people's care plans to see what their social interests were. Most of the care plans we sampled identified the same information; such as that people enjoyed 'singing, colouring and reading'. One person told us that they enjoyed shopping but we found the service had not supported people to follow their interests.

Staff did not support people to maintain choice, control and involvement in their care and treatment. people were not consistently involved in decisions about their care, treatment and support. Where they were included, it was not always in a meaningful way. Care records did not demonstrate that staff discussed care plans consistently with people and their relatives to ensure people's opinions were taken into consideration for the development and reviewing of their plans. One person told us, "I don't attend care plan meetings." Care records were standardised with no evidence of individualised or person-centred care. People's care plan reviews were ineffective and did not always reflect the changes in people's care needs. Some care plans were out of date and did not sufficiently guide staff on people's current care and support needs. Many of the people living at the service would be unable to share this information if asked by the staff.

Improvements had not been made since our previous inspection in January 2017 to how people were

supported to engage in social occupation or things that interested them. The service did not always support people to follow their interests or encourage them to take part in social activities relevant to their interests, or maintain personal or community relationships. One person told us they did not like living at the home because they had nothing to do. Staff we spoke with told us they shared responsibility for providing activities and we saw there were limited opportunities for people to get involved with social occupation until after lunchtime. After lunchtime we saw staff supported some people to participate in colouring and singing. Our observations identified there was not much available in the home that would provide people with items to focus on. For example, tactile objects that people may be able to pick up and use. While we saw an activity schedule on the wall there was limited variety in the choices. For example, chair aerobics, hand massage, skittles, puzzles and colouring. On the day of our inspection the activity schedule identified chair aerobics, but this did not happen. There was no evidence that people had contributed to the choices of what social occupation they would prefer to do.

We saw there were missed opportunities for staff to interact with people because they did not have the time to spend with people. Staff had not considered how people would like to or wished to spend their time. For example, one person told us how they would like to go out and have some books to read. Their care plan provided no information for staff about how this person wished to be supported with this goal and there was no reference in their daily care notes with regard to this. We saw little evidence of staff encouraging people to get involved with daily life tasks. Only one person was seen to be encouraged to lay the table for lunch.

People were not encouraged to access and integrate with the local community with support from staff to reduce social isolation, and maintain skills and independence where appropriate. People and staff told us there were no regular or planned trips out. One person told us, "I would love to be able to go out." There were no activities in place to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation. Relatives we spoke with told us they had not seen any meaningful activities. One relative said, "I'm pretty sure there are not many activities." People were able to decorate their room with their personal possessions. One family member told us their relation had some personal possessions in their room and said, "Feels more like a home."

We observed a member of staff in the communal areas of the home walking around asking people to hold out their hands to see if their nails required cutting. This appeared to be common practice as people held their hands out without questioning why. The staff member carried one nail clipper and one towel to be used for everybody. This was undignified, unhygienic and did not demonstrate people received person-centred care.

Some people who lived at the home their first language was not English. They were not supported by staff who reflected their diversity and culture and from our observations we saw that staff were unable to communicate in the people's preferred language. On the day of our inspection it was noted that these people were isolated and were not able to converse with staff or other people. We reviewed people's care plans and the service had not explored alternative ways to support people to express their preferences and communicate.

Prior to agreeing to people being supported at the service the registered manager completed an assessment of their needs. However, the assessments did not contain all the information they would need to care for the person comprehensively. People's assessments lacked detail around people's life histories, interests, likes, dislikes, spiritual, cultural and sexual needs. This meant that people's diverse needs had not been identified and plans put in place to ensure they would be met at the time of admission. Some staff we spoke with did not understand or recognise people's needs based on their protected equality characteristics. One staff

member told us, "All people need to be treated the same." Training and development regarding human rights and diversity had not been provided.

People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

In August 2016, all providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS). The standard aims to make sure that people are given information in a way they can understand to enable them to communicate effectively. The provider had not provided the information people needed in accessible formats. This included, easy read versions of documents such as menus and the complaints procedure. The use of pictures and photographs and technology had not been considered so that people had access to the information they needed in a way that helped them understand their care and make choices about how they lived their life. This meant that people did not always have the information they needed to make decisions about their care and support.

People and their relatives told us they felt comfortable to make a complaint. One person told us, "I would speak to [name of registered manager]." A relative said, "I would complain to the manager; she's good." The complaints procedure was displayed, however this not easy to locate as it was placed on a notice board with a lot of other information. The notice board was situated near the entrance to the home in a corridor which not all people would access. The complaints procedure had not been produced in easy to read format so may not be accessible to meet the communication needs of all people. This may restrict people's right to access a formal complaints process.

People we spoke with told us their religious needs were respected and were able to observe their religious beliefs as they wished. One person told us how important their faith was to them and we observed they were supported to access their place of worship on a daily basis. We observed that staff understood and respected people's religious practices.

Although no one was in receipt of end of life care, we found that people had been asked limited questions about their wishes at the end of their life. People could not be confident that their wishes during their final days and following death would be understood and followed by staff. Some people who lived at the home had strong faith and religious needs and may have had specific end of life wishes. However, this had not been recorded in their plan of care.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2017 we rated the registered provider as 'Requires improvement' in this key question. There were no effective systems or processes in place to ensure that the service was safe, effective, responsive or well led. At this inspection in October 2018 we found that the issues had not been addressed and the service had significantly deteriorated. We have identified seven breaches of regulations. This meant the provider had failed to improve the overall rating of the home from 'requires improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. The previous two inspections had also rated the service as 'requires improvement'. At this inspection the service had deteriorated significantly placing people at risk of exposure to harm and unsafe care and support. We found widespread and significant shortfalls in the way the service is led.

We found systems to assess, monitor and improve other aspects of the service were ineffective. The quality assurance systems were limited in their effectiveness to ensure continuous improvement. We identified widespread failings in several areas which should have been addressed through the operation of robust systems of governance, audit and monitoring. For example, we found several areas of the building were not kept in a clean, well-maintained and hygienic state. Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare.

The registered provider and registered manager had failed to ensure people received person-centred, high-quality care and good outcomes for people. There was a culture of task-centred instead of person-centred care. There were no effective systems in place to ensure that people were given choice and control over how they preferred to spend their days. People had not contributed or been involved with the planning and reviewing of their care and support needs. Quality assurance systems did not consider the impact of inadequate deployment of staff to enable person-centred care and a good quality of life. Staff told us there were not always sufficient numbers of staff to enable them to spend quality time with people. The lack of effective leadership had resulted in a lack of direction for staff and had failed to ensure that people received a service which promoted their well-being and met their individual needs and wishes.

There were inadequate safeguarding systems in place. We found people were placed at risk of harm as staff did not understand their risks and how to manage them. Staff had not reported or recognised potential safeguarding concerns or when incidents had occurred they had not taken reasonable action to protect people from avoidable harm.

The registered manager and provider did not audit the quality of records including daily contemporaneous notes, repositioning charts, and food and fluid charts; therefore, gaps in recording identified during the inspection had not been identified by the management team or measures implemented to address. People's health and well-being was not sufficiently protected. The systems in place had not ensured people received the care and support they needed. For example, we found people's fluid intake was not being recorded consistently or monitored. People's nutritional needs had not been addressed or monitored. There were no systems in place to monitor people's known skin integrity needs.

The registered manager and provider did not consistently demonstrate leadership in areas of practice such as implementation of the Mental Capacity Act 2005. This was reflected in the quality of care records, where capacity assessments were either not in place when needed and the failure to identify that practices in the home were potentially restrictive.

The ethos of honesty, learning from mistakes and admitting when things had gone wrong had not been embedded. When notifiable incidents had occurred, these had not always been reported to the relevant authorities or to CQC. We looked at how the registered manager monitored the service for patterns and trends in the event of any accident, incident or safeguarding concerns. Although information in relation to these types of incidents were recorded, there were no robust and effective systems in place to identify if there were any changes in people's needs. The registered manager and provider did not maintain oversight of such incidents, and take appropriate action, evaluate and use lessons learnt to reduce the likelihood of re-occurrence. This did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

There were no systems in place to ensure the service was adequately staffed. The registered manager advised that people's dependency levels had not been reviewed or calculated. There were no systems or tools in place to determine the number of sufficient, qualified, competent and skilled persons were required to meet people's needs. This included domestic and catering staff. Improvements were required in analysing information about people's abilities, emotional needs and dependencies to ensure staffing levels were reviewed and revised in line with increases in people's needs.

There was no clear vision and strategy for the service. At this inspection we found that despite concerns raised at our previous inspections, and the action plan we received from the provider, no significant improvements to the overall provision of the service had been made or sustained. This demonstrated the management systems at Abbey Park House were inadequate. The registered provider and registered manager had led the service for many years. The registered manager was new in this particular role they had received no formal support and supervision to ensure they were meeting the required standards. The provider did not carry out any quality monitoring of the service through visits and check and there was no action plan for continuous improvement. This meant that provider could not be sure that the service they provided met regulations and was of a good standard for people who used the service.

Whilst there were systems in place to involve people in service improvement, people's views about the quality of care they received had not been sought effectively. People we spoke with told us they were not formally asked about their views and experiences about the home. One person told us, "There are no meetings here." Monthly surveys were standardised and people were not given information in a format they understood. Some of the questions contained within the surveys would have been difficult to understand for some of the people living at the home. People had not been empowered to make suggestions that would improve their quality of life and had not been given the opportunity to shape and improve the service.

The registered provider and manager had not kept their knowledge and understanding regarding best practice, or the changes in fundamental standards and regulations up to date. There were ineffective systems in place to ensure the service continually learn and drive improvement. The service had not reviewed the delivery of care and support against current guidance. For example, they were unaware of their obligation to ensure people had access to information in a format that met their needs. In addition, a complaints procedure was in place but it referred to the now obsolete regulations dating back to 2010 rather than the current 2014 regulations. This meant leaders in the service did not have the skills and knowledge to lead staff effectively and to meet legal requirements.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events that have taken place. The provider had failed to ensure that significant events which occurred in the home were reported to the appropriate agencies such as Care Quality Commission (CQC) and the local authority safeguarding team.

The provider has a legal responsibility to inform the CQC of significant events which occur in the home. This was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents.

People told us the registered manager was approachable and supportive. One person told us, "[name of registered manager] is nice." A relative said, "[name of registered manager] is always available if I need to talk to her." Staff told us they attended meetings and had the opportunity to share their views. However, there was no evidence to demonstrate that staff had made suggestions or that they had been acted upon. One member of staff told us, "[name of registered manager] is really good and will help out on the floor [within the home]." Staff felt confident they could raise any issues with the registered manager and these would be addressed.

The registered manager told us they worked in partnership with the Local Authority safeguarding team, commissioners of the service and health professionals to support care provision. The registered manager told us how they shared appropriate information with other health professionals for the benefit of people who use the service. Following our inspection and feedback of our findings, we met with the nominated individual to discuss our concerns. As a result of this the home developed a further detailed action plan that identified the improvements they planned to make in the home. This included improving relationships with other professionals to support service development.

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 Registration Regulations 2009 Notifications of other incidents The provider failed to notify us of incidents as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of staff deployed to meet people's care and treatment 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 protected from harm due to inadequate risk management processes within the service.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration

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 People were not protected by harm due to a failure to identify, report and manage safeguarding incidents.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered 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 did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration