Abbeyfield North Northumberland Extra Care Society Limited

Abbeyfield House - Alnwick

Inspection report

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Alnwick
Northumberland
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23 May 2017
25 May 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in November 2016. A breach of legal requirements was found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this unannounced focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. The inspection was also prompted in part by the receipt of a notification of an incident following which a person using the service sustained a serious injury. This report only covers our findings in relation to those requirements and this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbeyfield House – Alnwick on our website at www.cqc.org.uk.

At our previous inspection we identified a repeated breach of regulation 17, good governance. We found shortfalls in the maintenance of records which had not been identified through routine audits of the service. At this inspection, we found further shortfalls and omissions.

There was a registered manager in post she had commenced employment at the end of September 2016. She had become registered with the Care Quality Commission in January 2017. 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.

We identified omissions and shortfalls relating to one person's care following an accident. The registered manager told us that she had arranged further training for the staff involved.

Risk assessments had been completed following an assessment of people's care. We noted that roller blinds with pull cords were fitted in some people's rooms. This risk had not been fully assessed, monitored and mitigated to ensure the health and safety of people.

There were safeguarding policies and procedures in place. However, some staff raised concerns of a safeguarding nature. We found that one specific allegation had not been fully investigated.

A monthly accident analysis had been completed to ascertain whether any trends or themes were identified. It was not always clear whether the actions taken to minimise accidents or incidents were effective.

We found shortfalls in the maintenance of records. Observation charts were not completed following one person's accident. There were two falls risk assessments in people's care files. These sometimes assessed people's risk of falls differently. One person's falls risk assessment rated them at medium risk of falls, the other rated them as high risk. We considered that this could lead to confusion.

Deprivation of Liberty Safeguards [DoLS] assessments had been completed. However, these had not been updated following the Supreme Court judgement in March 2014. This meant that DoLS assessments may not accurately assess whether people's plan of care amounted to a deprivation of liberty.

A quality assurance system was in place. We noted however, that this had not highlighted the areas of concern which we had found.

We checked whether the provider was meeting the conditions of their registration and notifying us of all changes and events at the service in line with legal requirements. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns within the service.

At our previous inspection we found that the provider had not notified the Commission of two events at the home in line with legal requirements. At this inspection we identified that the provider had not notified the Commission of four safeguarding incidents. These omissions meant an effective system was not in place to ensure that all notifiable incidents were reported to ensure the Commission had oversight of all safeguarding allegations to make sure that appropriate action had been taken to safeguard people.

We have carried out three inspections including this inspection since the provider registered with CQC in 2015. We rated the service as requires improvement at our inspections in 2015 and 2016 and identified two breaches in 2015 relating to safe care and treatment and good governance and one breach in 2016 which related to good governance. At this inspection we identified further concerns and shortfalls and breaches of regulations. This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

Despite our findings and identified shortfalls, people and relatives were positive about the care home.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, safeguarding people from abuse and improper treatment and good governance. We also identified a breach of the Registration Regulations 2009 which related to the notification of other incidents.

Full information about CQC's regulatory response to any 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?

Requires Improvement

The service was not always safe.

We identified omissions and shortfalls relating to one person's care following an accident.

We noted that roller blinds with pull cords were fitted in some people's rooms. This risk had not been fully assessed, monitored and mitigated to ensure the health and safety of people.

There were safeguarding policies and procedures in place. However, some staff raised concerns of a safeguarding nature. We found that one specific safeguarding allegation had not been fully investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found shortfalls in the maintenance of records relating to people and the management of the service.

A monthly accident analysis was undertaken to ascertain whether there were any trends or themes. It was not always clear whether the actions taken to minimise accidents or incidents were effective and not all accidents were analysed.

A quality assurance system was in place. We noted however, that this had not highlighted the areas of concern which we had found.

The provider had not notified the Commission of all safeguarding events at the home. The submission of notifications is a requirement of the law.

Abbeyfield House - Alnwick

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 checked 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.

We undertook an unannounced focused inspection of Abbeyfield House - Alnwick on 23 May 2017. This meant the provider and staff did not know we were coming. A second announced visit was undertaken on 25 May 2017 to complete the inspection. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in November 2016 had been made. The inspection was also prompted in part by a notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of accidents and falls. This inspection examined those risks.

The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one adult social care inspector and a specialist advisor in dementia care.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We did not request a provider information return (PIR) due to the late scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

We contacted Northumberland local authority safeguarding and contracts and commissioning teams prior to our inspection. We also contacted Healthwatch. 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 their feedback to inform the planning of this inspection.

We spoke with six people and two relatives on the day of the inspection. We conferred with a nurse specialist from the local NHS trust.

We spoke with the registered manager, two members of the board, three senior care workers, two care workers, a member of the domestic team and a member of hospitality team.

We viewed six people's care plans. We also looked at information relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection, the provider submitted a serious injury notification. We examined records relating to the accident and subsequent injury. We identified omissions and shortfalls relating to the person's care. The registered manager told us that she had arranged further training for the staff involved.

Risk assessments had been completed following an assessment of people's care. We read one person's care file and noted there was a specific risk assessment in place following a behavioural incident which related to their environment. We noted that roller blinds with pull cords were fitted in some people's rooms. This risk had not been fully assessed, monitored and mitigated to ensure the health and safety of people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Safe care and treatment.

There were safeguarding policies and procedures in place. However, some staff raised concerns of a safeguarding nature. We found that one specific allegation had not been fully investigated.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Safeguarding people from the risk of abuse and improper treatment.

People told us they felt safe at the home. This was confirmed by relatives. Comments included, "I do feel safe" and "We feel safe knowing she is here."

Staff had appropriately referred other safeguarding incidents which had occurred between people who lived at the service to the local authority safeguarding adults team. We found however, that they had not notified the Commission of four safeguarding incidents in line with legal requirements. These omissions meant that the Commission did not have oversight of all safeguarding allegations to make sure that appropriate action had been taken.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we identified a repeated breach of Regulation 17, Good governance. We found shortfalls in the maintenance of records.

At this inspection we found that some improvements had been made with regards to the maintenance of records, however we identified further shortfalls with the governance of the service and record keeping.

One person had fallen at the home. The registered manager told us that staff had not completed observation charts following the accident in line with procedures. We read the minutes of a recent staff meeting. The registered manager had stated, "All observation visits and times must be documented to back up any actions and decisions taken." We considered that staff had not fully assessed, monitored and mitigated the risks relating to the health, safety and welfare of this individual.

The registered manager carried out a monthly accident analysis to ascertain whether any trends or themes were identified. It was not always clear whether the actions taken to minimise accidents or incidents were effective. We read that one person had fallen on four occasions in April 2017. We noted that the registered manager had recorded by the 'actions taken to minimise any reoccurrence' that staff reminded the individual to request support if they wished to mobilise. We read in another document however, that this person was suffering an acute confusional episode. It was therefore unclear whether they would understand these instructions. Another person's fall had not been included in the accident analysis. This omission meant that the analysis of accidents and incidents was not always accurate.

There were two falls risk assessments in people's care files. These sometimes assessed people's risk of falls differently. One person's falls risk assessment rated them at medium risk of falls, the other rated them as high risk. We considered that this could lead to confusion.

We found that one specific allegation which had been reported to the registered manager had not been fully investigated. We concluded that although safeguarding procedures were in place; these were not always operated effectively to protect people from the risk of abuse.

A quality assurance system was in place. We noted however, that this had not highlighted the areas of concern which we had found at the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Good governance.

At our previous inspection we found that the provider had not notified the Commission of two events at the home in line with legal requirements. At this inspection we identified that the provider had not notified the Commission of four safeguarding incidents. These omissions meant an effective system was not in place to ensure that all notifiable incidents were reported to ensure the Commission had oversight of all safeguarding allegations to make sure that appropriate action had been taken to safeguard people.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

We read the home's statement of purpose which had been reviewed in May 2017. We noted that it had not been updated with the new registered manager's details and information about dementia care was not included. The chairman of the board told us that this would be addressed. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. These omissions meant that an effective system was not in place to ensure that legally required information was kept up to date and submitted to the Commission.

The home opened in 1985. The provider was a registered charity and was overseen by an executive committee consisting of nine trustees. They had a wide depth and breadth of experience from the public and commercial sectors. They took an active role in the running of the service. There was a manager in place who commenced employment at the service at the end of September 2016 and registered with CQC in January 2017.

Despite our findings and identified shortfalls, people and relatives were positive about the care home. Comments included, "It's a happy home," "I think that it's everything we would want [a home] to be" and "We're more than happy." Staff were also positive about working at the home. Comments included, "The residents - I love them to bits. Everyone just works together as a team" and "I love my job."

We have carried out three inspections including this inspection since the provider registered with CQC in 2015. We rated the service as requires improvement at our inspections in 2015 and 2016 and identified two breaches in 2015 relating to safe care and treatment and good governance and one breach in 2016 which related to good governance. At this inspection we identified further concerns and shortfalls and breaches of regulations. This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not been provided safely following one person's accident. Risks relating to the environment had not been fully assessed. Regulation 12 (1)(2)(a)(b)(d)

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 fully protected from the risk of abuse because allegations of abuse were not always investigated. Regulation 13 (1)(2)(3)(6)(b)

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 17 HSCA RA Regulations 2014 Good governance Effective systems were not fully in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. Records relating to people and the management of the service were not always well maintained. Feedback was not always acted upon to ensure the safety and welfare of people. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(e)(f).

The enforcement action we took:

We issued a warning notice to be met by 1 August 2017.