Abbeville RCH Limited

Abbeville Lodge

Inspection report

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16 November 2016

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9 and 16 November 2016 and was unannounced. Our previous inspection carried out on 21 and 26 May 2016 had found that there were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were wide ranging and had a considerable impact or the potential to impact upon the people living in the home.

This October 2016 inspection found that the service was still in breach of three of the same four regulations. The regulations still in breach related to safe care and treatment, staff training and the governance arrangements of the service. The service was now in breach of the regulation relating to safeguarding, but was no longer in breach of the regulation for person-centred care.

Abbeville Lodge provides accommodation and care for up to 20 older people, some of whom may be living with dementia. At the time of our inspection 15 people were living in the home.

A registered manager was in post. 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.

This November 2016 inspection found considerable concerns in relation to the safety of the service. Some people were not receiving the standard of care that they had been assessed as needing by healthcare professionals. Some risks to people's well-being had not been identified or adequately mitigated. This had put people's welfare at risk.

There were enough staff to meet people's care needs. However, there was little time for staff to support people socially. The manager was recruiting for an activities staff member to carry out this function.

Some improvements had been made to ensure that people were supported by staff that had up to date training. However, there were still some significant gaps in the staff training programme. We were satisfied that there plans to rectify this.

Staff were caring and knew the people they were supporting well. People felt cared for and cared about.

The provider had over-relied on the auditing tools supplied with the new computerised care records system and were over reliant on a management consultant they had engaged for one day a week.
We have ongoing concerns about the provider's oversight of this service and their capacity to implement and sustain improvements.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two

consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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 or 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.

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 consistently safe.

Some risks specific to individuals had not been identified or appropriately managed. Hazardous substances were not always secured and some cleanliness and infection control risks were found.

When concerns had been raised they had not been identified as requiring a referral to the local authority's safeguarding team.

There were enough staff to ensure that people's needs were met and safe staff recruitment processes were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was still progress to be made to ensure that staff had received suitable and timely training.

People received a choice of food and drink in sufficient quantities.

People had access to health professionals.

Is the service caring?

Good

The service was caring.

Staff were polite and friendly in their approach.

There was clear emphasis on promoting people's independence and dignity and staff were respectful of people's wishes and preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst improvements had been made, there was still further improvement needed to ensure that people's needs were fully

assessed and planned for.

People received few opportunities to participate in meaningful activities.

There was a system in place to manage people's complaints.

Is the service well-led?

Inadequate

The service was not well led.

The service audits were not always effective in identifying where improvements needed to be made.

The provider was over-reliant upon a management consultant who was engaged for one day a week to oversee their three services and support three managers.

Abbeville Lodge

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 inspection took place on 9 and 16 November 2016 and was unannounced. The inspection team comprised of two inspectors.

Prior to this inspection we reviewed information we held about the service. Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During the inspection we spoke with four people living in the home. We made general observations of the care and support people received at the service throughout the day. We also spoke with the manager, two care staff and the cook.

We reviewed seven people's care records and the medication records of five people. We viewed records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our last inspection in April 2016 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's welfare in were not always identified or mitigated.

This October 2016 inspection found that whilst improvements had been made in relation to the management of people's medicines, other risks remained.

One person had been assessed by a speech and language therapist (SALT). This assessment stated that spouted beakers should be avoided. However, we saw that the person was in the dining room throughout one morning with a drink in a spouted beaker. Staff had not followed the health professional's advice in order to help ensure the person's safety.

The same person's care plan stated that the person was at high risk of developing a pressure area. It stated that the person was to use a pressure relieving mattress and cushion. However, the person was not sitting on a cushion and we saw no pressure relieving cushion in their room. The manager told us that they would look into this. We also observed that the person spent up to four hours at a time in the same seat, whether it was their wheelchair or an armchair, without the pressure cushion they had been assessed as needing. Staff had not ensured all necessary actions had been taken to reduce the risk of this person developing pressure areas.

A risk assessment in place for one person related to their use of a portable electric heater. The manager told us that hired portable heaters had been used for a short period when the home's heating wasn't fully working. Different types of electric heaters pose different risks. The risk assessment didn't say what type of heater this had been. This person had been diagnosed as living with dementia. There was no consideration in the risk assessment about the person's ability to understand any risks presented by the heater or how this risk might be managed.

The manager told us that risk assessments in relation to people's rooms were sometimes kept on the inside of wardrobe doors. When we opened one person's wardrobe door we saw that there were five bottles of spirits on their wardrobe shelf. A staff member told us that the person didn't drink this and that it had been brought in as gifts by the person's family. There was no risk assessment in place in relation to the person consuming alcohol. The risks of a large quantity of alcohol being unsecured in the home had not been assessed or mitigated.

We observed that one person was having an alcoholic drink with their lunch. However, no risk assessment had been carried out to determine whether there were any risks to the person from this, and if so, how these could be mitigated. For example, alcohol can adversely interact with some medicines.

Other substances that could be hazardous to people's health were unsecured in the home. The bathroom that was used as a sluice room was unlocked. It contained steradent, multi-surface cleaners, anti-bacterial

spray, urine neutraliser and a large bottle of bleach. This room had also been unlocked on our April 2016 inspection.

Our April 2016 inspection identified that one person sometimes went out shopping and returned with tools. Whilst the manager hadn't felt that this presented a risk to other people, they told us that the person had threatened to self-harm in the past. During this November 2016 inspection the person told us, "If I buy anything dangerous they take it off me. We discuss these things." However, whilst the person's care records stated that the person liked to bring back items to put in their room, there was still no risk assessment or plan of how staff were to respond to this behaviour.

Whilst most of the cleanliness and infection control concerns found during our April 2016 had been rectified, we found that the lounge chair backs had still not been cleaned. We saw that one person's mattress overlay, the cover of which had significant amounts of debris and staining, had been laid over their armchair. This meant that any germs or bacteria had been transferred to a previously clean armchair. We observed a yellow stained urine bottle on the sink surround in one person's room. Another stained urine bottle was on the floor behind one of the communal toilets.

These concerns meant that the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we viewed the complaints received by the service in the last 12 months we found that two of the complaints received in recent months should have been referred to the local authority as safeguarding referrals. The complaints had been relation to similar concerns raised by one person. As this had not been done the local authority had not been able to independently investigate if necessary or provide support and guidance to staff to help reduce risks to people. Instead the manager had looked in to the concerns themselves when this may not have been appropriate.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Guidance was in place for staff to help them determine when to administer medicines that had been prescribed for people on an 'as required' basis. There was also clear guidance for staff on where people's topical creams needed to be applied. A medicines communications book was in use to aid communications between staff on different shifts administering people's medicines. We checked stock levels of people's medicines available in the home against the records kept and found no discrepancies. We were satisfied that people were receiving their medicines as prescribed.

One person told us, "Sometimes I have to wait a long time for staff to come." However, three other people told us that they didn't have to wait very long for staff assistance. One of these had said, "We don't have to wait very long for staff here." We found that there were enough staff to meet people's needs. During the day there were three care staff members on duty with two care staff available overnight. Staff told us that there were enough of them to meet people's needs, but they would like to be able to send more time chatting with people.

Safe and suitable recruitment processes were in place. We saw that the manager made all necessary checks to establish that people were suitable for the role they had applied for. This included ensuring references and criminal records checks had been carried out and the results were satisfactory before staff commenced duties in the home.

People told us that they felt safe. One person said, "I feel safe for the first time in my life." They gave us an example of how staff warned them if a floor was wet. Staff we spoke with understood their responsibilities in relation to safeguarding people from abuse, what might constitute abuse and told us what action they would take if they had any concerns. The vast majority of staff had received up to date training in safeguarding.

Requires Improvement

Is the service effective?

Our findings

Our last inspection in April 2016 identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received sufficient training to carry out their roles and responsibilities.

Our April 2016 inspection had found most of the staff training had expired in October 2015. At this November 2016 inspection we found that only medicines administration training was up to date for all staff members who administered medicines to people.

Nine staff required training in fire safety and thirteen staff needed training in health and safety. Twelve staff were waiting for training in mental capacity. Seven staff required training in first aid and five required training in moving and handling. This was a small service with shifts operating with two or three care staff. Consequently, some shifts may have been operating with few, or sometimes, no staff on duty with up to date training in some areas. This put people at risk of receiving care that was unsafe or inappropriate.

Consequently, the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received supervisions approximately every six weeks. Sometimes these were themed around specific areas, for example around how to encourage people's independence or they tested staff knowledge and understanding. Staff also had the opportunity to discuss their performance and training needs or requests.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff we spoke with understood about people's rights to make their own decisions. Where necessary staff supported people to make their own decisions. Staff were also clear about the circumstances when they might need to make a decision in a person's best interests.

We noted that a mental capacity assessment had been carried out in relation to a habit one person had that could put them at risk. It had been determined that the person did not have the mental capacity to make a decision in relation to this habit. The manager had then taken decisions in the person's best interests. They

had also judged that their actions might be a restriction on the person's freedoms and had applied to the local authority for a DoLS authorisation.

One person told us, "I have choices about what food to eat." Another person said, "They always make sure I have a cup of tea at 6am when I wake up." During our inspection we observed that people received regular drinks and snacks and those who needed assistance with meals received this. When people changed their minds about what to have to eat we saw that staff offered them alternatives. We heard one person saying that they weren't feeling well and were not hungry. Later on we saw that staff had brought them a plate of cold snacks so they had something to eat if they felt like it.

The cook on duty was able to tell us about people's individual dietary needs. They had up to date information about people's preferences in the kitchen. We saw records showing that people were offered choices. The cook had an understanding of specialised diets and had supporting information and guidance available to them about this. The kitchen was available to staff throughout the night, so that people could be made snacks if necessary.

People told us that their health needs were being met. Two people told us that staff helped them monitor their blood glucose levels. If people became unwell they told us that the GP would be contacted straight away. For more routine concerns the person would be seen when the GP carried out their weekly visit to the home. People's care records showed that they were supported to receive visits or attend appointments for routine health matters, such as the optician or chiropodist as well as specialist appointments. The manager told us that they had an arrangement whereby they were able to make direct referrals to the falls team. We saw that this had been done recently when one person had experienced a spate of falls. This referral had been discussed and agreed with the person's GP first.

Good

Is the service caring?

Our findings

People we spoke with were positive about the staff. One person told us, "On the whole they're kind and caring." Another person said, "They are good to me. I do feel a bit spoiled." A third person stated, "Staff here are highly commendable."

Staff supported people in a kind and patient manner. People were comfortable and contented in the presence of staff. Staff approached people in a warm and friendly way whilst being respectful. They were clear about their approach to supporting people. One staff member told us that they strove to provide person-centred care and were careful to ensure that people were involved in their care and had choices. Another staff member told us how important they felt it was that they had got to know the people living in the home.

One person told us, "Staff don't take over. They encourage me to do what I can for myself. And they chat with me about things." Staff members understood the importance of people maintaining as much independence as possible for as long as possible. People's care plans detailed what the person could do for themselves and what support they actually needed.

People's dignity and respect was maintained by staff. One person told us "They are respectful, like knocking on my door before coming in." Throughout the day staff supported people with their personal care. Staff discreetly prompted and supported people with this. We observed staff knocking on people's bedroom doors before entering. A staff member told us how they maintained people's privacy and dignity when assisting them to wash.

People's care plans were written in a way that reflected their likes and dislikes. For example, one person's care plan stated how they liked their bed made up. We saw that this had been done according to the person's preferences. Staff were aware of how people liked to spend their time and had built positive relationships with people.

We observed positive interactions between people and staff. One member of staff escorted a person to their room. Progress was quite slow, but the staff member was patient and reassuring throughout.

A residents meeting had recently been held in the form of a tea and coffee morning. The manager had told us that some people didn't want to be involved in group meetings so they had tried to make it a little less formal. However, approximately half of the people living in the home declined to attend. People's views were sought and there had been discussions about potting up some flowers. Some people had expressed an interest in doing some cooking which the manager had said they would arrange.

Where people were able to participate they were involved in discussions about their care. Some people told us that they discussed the way things were done with staff and staff took their wishes and views on board. Staff consulted with people's relatives if people were not able to participate in these discussions. Relatives had stated that they were made to feel welcome in the home and were positive about the appearance and

attitudes of staff supporting their family members.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection in April 2016 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not assessed people's needs on an individual basis.

The service had implemented a computerised care records system two months prior to this November 2016 inspection. This inspection found that people's care needs had been assessed. However, some care plans required further development. One person's diabetes care plan referred to national guidance for blood glucose levels but no information had been obtained from health professionals about whether this was appropriate for this person. The person's blood glucose levels had been increasing over the last two months. However, no action had been taken to determine whether this was a cause for concern or not.

We noted personalised guidance for staff on how as a result of a health condition another person was living with, their night time routine varied considerably. Guidance was in place about how staff needed to support the person depending on the circumstances.

Care plans described people's individual care and support needs, decision making capabilities and things they enjoyed or disliked. We found that care plans were regularly reviewed and updated to reflect changes in people's needs or preferences.

We judged that whilst there was room for improvement that the provider was no longer in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the care they received, but some people told us that there wasn't much to do in the home. The manager told us that they were advertising for activities staff. At the time of our inspection care staff needed to fit this in when they could. Staff told us that this was proving difficult to do at times. This meant that some people who would have benefitted from staff support with social engagement were not receiving this.

There was a wide range of people in terms of age and interests living in the home. Some were very independent and came and went as they pleased or were able to pursue their interests independently in the home. Others were more reliant on staff support for social engagement.
The manager told us that group activities hadn't worked very well in the past. They were anticipating that most activities provision in the future would need to be on a one to one basis.

Information about how to make a complaint was available for people and visitors to the home in communal areas. People were confident who they could raise any concerns with and felt that any concerns would be dealt with in a sensitive and fair manner. One person told us, "I've never needed to make a complaint here. But I know I'd speak with the manager."

The last resident meeting showed that people had been encouraged to raise concerns or make observations

or comments. We saw that where people had raised issues the manager had treated these like complaints, looked into the concern and discussed their findings with the person who made the complaint.

Four concerns had been raised with the manager since our last inspection in April 2016. We saw that comprehensive investigations had been carried out in a timely manner and reasonable conclusions reached. However, two of these issues should have been referred to the local authority's safeguarding team.

Inadequate

Is the service well-led?

Our findings

Our last inspection in April 2016 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance arrangements in the service were poor.

The manager in post at the April 2016 inspection had subsequently registered with CQC. However, no applications to remove two previous registered managers had been received from the two individuals concerned. Neither had the provider been in contact with CQC in relation to this. Consequently, there were three registered managers for the service although two have not been employed for some time.

The service was using the audits that were built in to the computerised care system. These were all up to date. However, these audits were mainly based on procedures and contained no sampling to evidence the assertions in the audits that all was in order. For example, the infection control audit did not query the cleanliness of the home. The care overview audit was not effective at identifying when people were not receiving care in line with their care plan. For example, it had not identified that one person didn't have a pressure relief cushion or that another person was drinking from a beaker that they were not supposed to use which could have placed them at risk of harm.

Some of the issues we found in relation to the environment during the April 2016 had not been fully addressed. For example hazardous chemicals were still unsecured and we observed some issues in relation to cleanliness. The provider and manager had not taken suitable steps to ensure that the day to day operation of the home and the care people received reduced risks to their wellbeing.

One person had made two allegations of theft of money. These were serious allegations that had not been reported to the local authority's safeguarding team or to CQC. The manager had failed to identify that these were issues that needed reporting.

These concerns meant that the provider remained in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person told us, "The manager is very nice, very approachable and manages the home pretty well." Staff were supportive of the manager. One said, "The manager is never too busy to make time to speak with people living in the home and staff. Suggestions and comments are welcomed and acted upon." We saw that the manager held regular minuted meetings with staff.

The provider had engaged the services of a management consultant for one day a week. This meant that there had been an improvement in support that the manager had access to, albeit for one day a week only. The consultant's main duties were to support and supervise the managers of all three of the provider's services, facilitate service manager meetings, to conduct service visits and carry out reviews on behalf of the provider.

This was the third of the provider's three services we have inspected since 6 October 2016. From records we have seen at all three services, the provider has minimal direct oversight and is heavily reliant upon the management consultant. However, the provider remains legally responsible, along with their registered managers, to ensure that regulations are complied with. We remain concerned about the ability of this provider to make and sustain improvements.