The Abbeyfield Kent Society

Abbeyfield - Stangrove Lodge

Inspection report

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Date of inspection visit: 12 and 13 May 2015
Date of publication: 10/07/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 12 & 13 May 2015 and was unannounced.

Abbeyfield Stangrove Lodge provides accommodation for up to 56 people who need support with their personal care. The service provides support for older people and people living with dementia. The service provides accommodation on one level arranged into separate units. The service has single bedrooms. There were 37 people living at the service at the time of our inspection.

The registered manager of the service had left in April 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager for the service had been appointed and had been in post for one month. We had not yet received an application for their registration.

We last inspected Abbeyfield Stangrove Lodge in July 2014. At this time we found that the registered provider

Summary of findings

was not compliant with the regulations. There were shortfalls in the safety, availability and suitability of equipment and in the provision of suitable staffing. At this inspection we found that the registered provider continued to breach the regulations relating to staffing and the provision of equipment. They had not ensured that sufficient numbers of suitably qualified, skilled and competent staff had been deployed to meet people's needs. They had not taken appropriate action to ensure that suitable equipment was provided to meet people's needs.

In addition we found a number of other breaches of regulations at this inspection.

People were not kept safe from abuse and harm and the risks to their health, safety and wellbeing had not been properly assessed and managed. In particular people were at risk of unsafe practices to help them move around the service. People had not had their mobility needs properly assessed to ensure they were provided with the equipment they needed to move around safely.

Staff had not identified concerns about people's health to ensure that appropriate action was taken.

People were not protected from the risks of the spread of infection in the service.

Staff had not been trained properly to ensure they could meet peoples' needs and care for them in a safe way. Staff did not understand how to support people living with dementia.

People were not consistently asked for their consent before care and treatment was provided. Where people could not give their consent the Mental Capacity Act had not been followed to ensure their rights were protected.

Some staff were not caring and kind in their approach to supporting people and did not demonstrate compassion.

Staff did not treat people with respect and did not listen to them. Staff did not know how to deal with people who were distressed and they were not able to provide support that reassured and comforted them.

Staff did not always respect people's privacy. They shared personal information about people in front of others using the service.

People did not receive a personalised service. People had not been supported to maintain their hobbies and lifestyle choices. People were bored and some were isolated. People did not have a say in many areas of their daily routines.

The service was not well led. The manager had been in post for a month. They did not know people's names and they did not demonstrate that they promoted the rights of people living with dementia. The manager did not have a good understanding of the needs of the people using the service or how to ensure people received a personalised service. The registered provider had not adequately monitored the service to ensure it was safe and they had not identified the areas of poor practice that we found during our inspection. The registered provider had not identified that the manager lacked the skills and qualifications to effectively lead a service for people living with dementia.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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.

We are currently taking enforcement action against the registered provider in respect of this service.

Summary of findings

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.

People were not protected from the risk of harm or abuse.

People were not protected from the risk of the spread of infection in the service.

The risks to people's safety and welfare were not assessed and managed effectively.

People were not supported to take their prescribed medicines safely.

People were supported by sufficient numbers of staff.

Is the service effective?

Inadequate

The service was not effective.

People did not receive effective care from staff who had the necessary skills and knowledge to meet their needs.

People were not always asked for their consent before care and treatment was provided.

The provider did not follow legal requirements of the Mental Capacity Act (2005).

People were not supported to maintain good health.

The provider had not ensured the premises was suitable for people living with dementia.

People were provided with enough to eat and drink.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect and their privacy was not upheld.

Staff had not developed positive caring relationships with people.

People were not involved in the planning of their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that met their individual needs and preferences.

People knew how to make a complaint and most people felt their complaints were listened to.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not promoted a culture that focused on people.

The manager had not demonstrated good leadership.

Summary of findings

The provider had not ensured people received high quality care.

There were no quality assurance systems in place to identify how the service could improve.

Abbeyfield - Stangrove 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 12 and 13 May 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist professional advisor, whose specialism was in Occupational Therapy.

We gathered and reviewed information about the service before the inspection, including information from the local authority and previous reports. We spoke with the safeguarding team and the commissioners of the service to gather their views of the care and service. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about.

During our inspection we spoke with two people, three people's relatives and seven staff. We observed the support provided to people on both days of our inspection. We used the Short Observational Framework for Inspection (SOFI) because many of the people were living with dementia and could not tell us about their experiences of using the service. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care and support that people received. We looked around the premises. We looked at care records and associated risk assessments for seven people. We observed medicines being administered and inspected medicine administration records (MAR). We looked at management records including two staff recruitment records and records of staff training and support.

Inadequate

Is the service safe?

Our findings

People who were able to talk with us told us that they felt safe in the service. However, our observations found that people were at risk due to unsafe practices for helping them to move around the service. We found that people were not protected against the risks of injury from others who were in distress and risks around people's mobility had not been properly managed.

Staff had received training in safeguarding people from abuse. They knew how to recognise the signs of abuse and understood the procedure for reporting safeguarding concerns. One person appeared frequently distressed and grabbed out at staff and other people living in the home. A recent incident had resulted in a person being bruised on their hand from this person grabbing them as they went past. Staff had reported the incident appropriately to the local authority safeguarding team. However, the risk assessment and care plan for the person around managing behaviours that could challenge had not been updated to include guidance for staff on keeping other people safe. The accident and incident report showed the only measure to be taken by staff was to advise people to stay away from the person that had harmed them and no further guidance was in place. Advice had been sought from healthcare professionals about the person's needs and their medicines had been reviewed. Staff told us that people remained at risk of harm despite the person's medicines having been changed. Following our inspection we received notification of a further incident where another person was harmed by the person. The action that had been taken was to advise people to stay away from the person. A person had a care plan in place titled 'retaliation when other residents show aggression/hit out causing injury'. This stated "I would like carers to try and divert and calm the situation and to complete all incidents and behaviour charts if needed", but it did not give staff direction on how to do this. This meant that people were not kept safe by staff as there was not sufficient and appropriate guidance for staff to reduce specific risks of harm.

People were able to deposit their personal money with the staff which was then stored securely on their behalf. However, people's personal belongings were not always safeguarded. Relatives of a person told us they had found that their relative's hearing aids had gone missing a few weeks after moving into the service. The person had not had a property list completed on admission to document the belongings they arrived with. The relatives had raised the matter with staff, but the manager told us they had not been made aware of the missing hearing aids until the day of our inspection.

People were not safeguarded from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were not effectively managed. People did not have clear assessments of their mobility needs. An assessment of people's mobility across a range of areas, such as sitting to standing and getting in and out of bed, had been completed on admission, however it had not been used to inform their care plan. There was conflicting information about the equipment some people required to help them move around safely. A person had a 'falls care plan' that stated they used a walking stick and a 'mobility plan' that stated they used a Zimmer frame. Staff said that the person usually used the Zimmer frame, but they were unclear what the care plan directed them to do. Assessments of people's mobility needs did not take into account factors such as their cognitive ability to understand what staff were asking them to do whilst assisting them to move. Staff did not have the guidance they needed or the understanding of safe practices to assist people who had a cognitive impairment to move safely therefore staff and people were at risk during these times.

Most people who had been identified as requiring physical help to move were being helped by staff who used a standing hoist. There was no evidence that other manual handling solutions had been considered such as transfer belts, turntables or transfer boards. This meant that the equipment provided may have been in excess of people's needs and may reduce their independence. Where people used a hoist there had not been an assessment of the size of sling they required or the loop position they required for attaching to the hoist. A staff member told us that there were glide sheets and other manual handling items available however they did not know where the equipment was stored and were unable to locate it upon request.

We saw practices during the inspection which placed people and staff at risk of injury. A staff member positioned a dining chair at right angles to the table then hoisted a person into it and dragged the weight of the chair and the person around to face the table. This placed both the staff

member and the person at risk and did not promote the person's comfort during the transfer. Another person was being assisted by two staff to transfer out of a wheelchair into a chair. The staff did not give prompts to the person to help them position themselves into the chair and we saw the person fall backward into their chair. whilst holding onto their walking frame.

Staff moving people using the hoist did not do so safely. For example, staff moved people whilst they were raised up in a hoist to position them over a chair before lowering them down, rather than bringing the chair to them. This placed staff at risk of injury, placed the person at risk of falling and was not a comfortable experience for the person being moved.

Staff had found a person sitting on the floor. There was no handling plan in place to manage the incident and the staff appeared to be alarmed and unsure about how to proceed. Staff did not know which size sling to use, which caused a delay of approximately 10 minutes whilst the correct size sling was agreed upon and located. The person was hoisted into a wheelchair using a full electric hoist so that they could then be transferred to an armchair using a standing hoist. However, another person had sat in the chair that the staff were planning to use and there were no other chairs available in the room. The person sat in the wheelchair with the sling on and experienced further delay while staff arranged suitable seating for them.

We saw other examples of poor practice when staff were assisting people to move which posed a risk of harm or injury to staff and people and caused disorientation or discomfort to people who were living with dementia. This included staff pushing people backwards in wheelchairs and using the same size sling for everyone who was helped using a hoist. In one instance this was clearly the wrong size and the material was cutting up tightly under the person's shoulders. Another person was being assisted to move using a standing hoist, but they appeared unable to hold their weight so they slipped down in the sling, which meant they were at risk of injury or of falling.

Risk assessments relating to falls contained conflicting information. A risk assessment had been completed for a person which identified that they were at high risk of falls, however this risk had not been reflected in their care plan. When the person had fallen the records showed that the risk assessment and care plans had not been reviewed to reduce the risk of recurrence. Staff said that some people had been referred to a falls clinic, but we found that people's care plans had not been updated with any evidence to show that appointments had taken place..

The staff handover records showed that a person who had recently fallen needed to be kept under observation with checks being made every 30 minutes for the next 24 hours. This was also recorded on the handover whiteboard in the care staff office. No checks had been made and staff were unaware of the requirement to do so. The manager checked the records for the person and told us that "The system for observing people after a fall had failed in this instance".

We observed a person being supported to walk around the home by staff who held onto their arm. They were also moved around the service using a wheelchair. We looked at the person's mobility assessment and care plan. There was no indication in their care records that the person required any support with their mobility or needed any equipment. This meant that the person's care records did not reflect their current needs. A member of the administrative team supported a person to walk around. The staff member had not received any training in safe moving and handling techniques to enable them to do this safely.

A person was observed independently using a self-propelling wheelchair without footplates, thereby presenting a possible risk of entrapment and damage to their feet. Staff were not able to give clear information about who was responsible for mobility assessments, reviews, or the provision of mobility aids and demonstration of their correct use. Two people were using their walking sticks the wrong way round, creating a potential fall hazard as the weight was not being supported by the handle. Staff were present at the time and did not correct this.

A range of chairs of varying heights were available in communal areas and people's bedrooms, however two of the armchairs had a long seat base sloping backwards. A person was observed struggling to position themselves to stand from one of these chairs. A person who was hoisted into a standard dining chair was unable to maintain a good sitting posture and was slumped as the chair did not provide adequate support. They were therefore not in the appropriate position to eat their meal and appeared uncomfortable.

Inadequate

Is the service safe?

Three people who used a hoist to be transferred had beds equipped with adjustable height settings. However these were positioned against the wall preventing staff to access either side to hoist the person in a safe way. Other equipment such as toilet frames designed to support people and reduce risks were incorrectly placed or used.

Risks within the premises had not been effectively assessed and managed. Some areas of the floor were slippery such as the hallway on the ground floor. One of the housekeepers explained to us that the reason for the slippery surface was because someone may have accidentally sprayed the floor with polish instead of bleach. They explained that they were in similar bottles and said "Unless you really looked you may not be able to tell the difference". They told us that it had happened before and that it had caused them to fall over and be bruised. The floor coverings in some of the corridors were slippery, presenting a potential falls hazard to residents, especially in the event of spillage.

A shower door in one bathroom was broken which meant that water could not be easily contained within the tray. This placed staff and people at risk of slipping when the floor became wet. We saw that the manager had requested the provider review the bathroom facilities to increase the provision of level floor showers. However they had not yet been advised of a schedule of works to make these improvements.

The door to the hot water boiler was unlocked and easily accessible. It was in the same area as two bathrooms and due to the lack of identifiable signage on the doors, it could have easily been accessed by a person who used the service. There was a laundry trolley blocking the entrance to one of the bedrooms in the unit for people living with dementia which meant that a person would not be able to get out of their bedroom. There was a brick on the floor by one fire exit. We asked the manager what it was for were told it was likely to have been used by staff to prop the internal fire door open. The manager removed the brick immediately.

People's care plans did not promote positive risk taking. There was limited planning to support people's independence. We asked staff if people could make their own drinks or help prepare meals, but were told that "It would be too dangerous for them".

Risks to the health and safety of people using the service and staff were not assessed and appropriate action had not been taken to mitigate the risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the procedure for evacuating the building in the event of a fire or other emergency. There was an emergency safe accommodation plan in place. Fire safety equipment, including alarm system emergency lighting and extinguishers had been checked and serviced at regular intervals. There was an up to date fire risk assessment in place. Equipment such as hoists and bath lifts had been regularly serviced. There was a system in place for visual checks of wheelchairs, walking frames and height adjustable beds.

The manager had arranged for additional pagers to be supplied in response to staff concerns about not being able to hear the call bells in all areas of the building. This meant that staff could respond to people more quickly when they requested help

The provider had not ensured that people were kept safe from the risk of infection. Some areas of the premises were not clean, including three of the four sluice rooms. The sluice rooms were cluttered and untidy making it difficult for staff to use safely and hygienically. The sinks were heavily stained and there was a dirty sponge on the sink of one of the sluice rooms. Some toilets were dirty. There were two commode pan sterilising machines in the building and the care coordinator told us the service's policy instructed staff to use these However the staff we spoke with gave inconsistent responses about the procedure to follow for cleaning and sterilising commode pans.

Some rails in the bathrooms designed to help people with their mobility were rusty and corroded. This placed people at risk of injury and made them difficult to keep clean resulting in a risk of infection. Wheelchairs were being stored in one bathroom in front of a clinical waste bin used to dispose of products containing bodily fluids. This made it difficult for staff to safely access the bin and created a risk of cross infection if the wheelchairs were to become contaminated with clinical waste. One bathroom had a bin for disposing of clinical waste but there was no basin for staff to wash their hands afterwards.

Inadequate

Is the service safe?

Hoist slings, including those used to help people on and off the toilet, were shared amongst people. We saw the same sling was used to move people into the dining room before lunch. This was then taken with the hoist to move people to the toilet after their meal. Slings were stored in a room that contained a range of equipment. One sling was draped over a foot spa. This increased the risk of spreading infection in the service.

These practices increased the risk of infection to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and ensure that staff employed are of good character. Staff were interviewed by the manager to ensure they were suitable for the role and were issued with a contract of employment that outlined the requirements of the role. The provider had a disciplinary procedure in place to respond to any poor practice.

The provider had a system for assessing people's needs in order to determine the required staffing numbers for the service. The staffing levels had recently been increased to seven care staff plus a senior care staff during the day. The manager told us that this needed further review as the layout of the building made it difficult to ensure that staff were able to supervise all areas at all times, however this had been managed by providing staff with more pagers to call for assistance. There were vacancies for staff and the manager told us they were not planning on admitting any new people until they had recruited to the posts.

Visitors to the service told us "There seem to be enough staff around to call on".

We observed a staff member administering medicines at lunchtime. They followed safe procedures and completed the medicine administration records (MAR) charts once the person had taken the medicine. We observed them talking to people and explaining what they were giving them. They were patient and made sure that people had a drink with their medicines. The staff member offered people their prescribed pain relief and as required 'PRN' medicines and recorded if people did not need these. Supplements were given to people who needed them and recorded on the MAR charts.

The senior care staff on each shift was responsible for giving medicines. The person giving the medicines wore a red 'do not disturb' tabard. The senior staff told us that "It was effective most of the time, but was difficult in the dementia areas of the home". Staff told us that they had received medicines training at the home.

There were appropriate facilities for hand washing and waste disposal in the medicines area. Medicines were kept securely and in appropriate storage for the type of medicine. The temperature of the storage area had been checked and was between the recommended temperatures. Some prescribed topical medicines were on display in people's bedrooms which placed people at risk as we saw people going in and out of others bedrooms.

There were two first aid kits in the clinical room which contained dressings and first aid equipment which had passed the expiry date, however a third box was found in which everything was within the expiry date. Staff we spoke with were unaware that the first aid equipment was out of date and would therefore not have known not to use it.

Not all front sheets in the MAR folder contained photographs to identify people, this meant that any temporary staff may not know who they should be giving medicines too and increased the risk of a medicines error. Handwritten MAR charts did not always have two signatures as directed in the MAR chart folder.

People were not consistently protected by safe systems for managing their medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The people who were able to directly tell us about their experience said they were happy with the service they were receiving. A relative told us that they did not feel that the service was meeting their family member's needs. They were concerned that their relative had become more disorientated since moving to the service. They were also concerned that their relative did not have their health needs met and were not supported to be engaged in social activities. Our observations of the care provided found that staff were not delivering effective care or supporting people to maintain their health or engaging with people living with dementia. People told us they enjoyed the food. One person said "The food is quite good" and another said "I am happy with what they give us".

New staff joining the service were required to complete an induction. We saw completed induction workbooks that met the standards of the national training organisation 'Skills for Care'. A member of staff was working on the care certificate, which is the new entry level qualification for care staff.

There was a programme of training for staff to complete. There were gaps in the completion of the required courses. Not all staff had completed training in first aid, falls prevention, responding to behaviours that challenge, risk assessment and safe moving and handling of people. A member of staff helping a person to walk had not received training in safe moving and handling of people. We saw that where staff had completed these courses they were not always using the skills or training to deliver safe or effective care.

The manager said that staff were not regularly receiving one to one supervision to support them in their role. We asked to see the most recent supervision records, but these were not made available. The Care coordinator said that staff had not received an appraisal for over a year, but that these were to be booked within the next six weeks. The manager confirmed this. The manager said that they had not arranged any team meetings or senior staff meetings since they had been in post.

Staff were not appropriately trained in caring for people living with dementia. Records showed that some care staff had completed a basic awareness level of training. However, our observations showed that staff did not understand how to support people living with dementia. A senior care staff said they had completed dementia training in a previous role, but not in their current post. They said they had requested more in depth dementia training, but that this had not yet been arranged. The manager had completed the same one day dementia awareness course as care staff. They had not completed advanced training in caring for people living with dementia. The manager did not have a good understanding of the needs of people living with dementia or how to provide a service that would meet their needs. The manager held a level 5 qualification in leadership and management.

Staff told us they were happy with the training provided. One said "If I needed more training there would be no problem getting it".

Staff were not suitably qualified, competent and skilled. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not always been asked to give their consent to care and treatment. Where people were unable to make decisions themselves the correct procedure had not been followed to protect their rights under the Mental Capacity Act 2005 (MCA). People's wishes regarding resuscitation were recorded for some people. One person's document about resuscitation had been signed on their behalf by a doctor, as it was stated they did not have the capacity to make the relevant decision. However, there had been no assessment of the person's mental capacity to make this decision. The decision had been made in 2013 and had not been reviewed since to ensure it was still relevant.

A MCA form had been completed in March 2014 for two people. The staff completing the document had assessed that person did not have the capacity to make decisions, but the assessment was not in relation to a specific decision as set out in the MCA. This meant that whilst the people may not have had capacity to make decisions in some areas of their lives, their capacity to make other decisions may be overlooked.

Staff weighed people using a seated weighing scale in one of the lounges. People were not asked for their consent and two people were heard to tell the staff that they did not want to be weighed. The staff member ignored their comments, failed to respect their wishes and continued to move them onto the weighing scales.

Inadequate

Is the service effective?

The manager told us that they had purchased a pressure alarm mat for a person to alert staff when they were moving around their bedroom so that staff could be aware in case they fell. The person had not been asked for their consent to use this monitoring equipment. The manager said that they would not be able to make a decision about this, but no assessment of their capacity or a decision to take this action in the persons best interests had been carried out.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS applications were being made for people who used the service to ensure that they were not deprived of their liberty unnecessarily.

People had not always been asked for their consent before care and treatment was provided. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with sufficient qualities of food and drink to meet their needs, however they were not consistently provided with the help they needed to eat their meals. One person was given their meal, but was only given a knife. Staff said there were "no forks around" and that they would go and find one. They were gone for five minutes during which time the person had begun eating from their knife.

People told us that they enjoyed the food provided. We saw that people were offered fresh fruit in the afternoon of one of our inspection days. People were offered drinks regularly throughout the day.

People did not have their health needs met. A person who required hearing aids did not have these fitted during our inspection. Staff said that these had been lost. Records showed that the person had been without them for three weeks. No action had been taken to replace the lost hearing aids and the person's care plan had not been updated to reflect the difficulties they would have with their hearing as a result. The manager was unaware of this until the day of our inspection when the relatives spoke with them to raise a complaint about the matter. The person's care plan stated "I require my hearing aids in as cannot hear without them." The manager said that an audiologist appointment would be made to replace the hearing aids.

A person had been seen by a specialist nurse regarding a suspected diagnosis of diabetes. The diabetes nurse had asked that the person's blood sugar levels be taken four times a day, before meals, and recorded to provide more information to help the diagnosis. A care plan had been written for this detailing the requirement. This stated that staff must be aware how to use the blood testing machine, but there were no records to show that staff had been trained to do this. Staff we spoke with said that they were shown by other staff. The records showed that the testing had not been carried out as requested by the nurse. On five out of nine days the person's blood sugar levels had not been tested four times. On two occasions the testing was carried out after a meal instead of before.

A person had been assessed as being at risk of constipation. The care plan also identified that the person's mobility was affected if they became constipated. Their care plan instructed staff to monitor the person's needs regarding digestion and to report any concerns to senior staff. The plan did not specify what was normal for the person so that staff knew when to be concerned. The person's records showed that they had become constipated for a period of ten days. We asked a senior care staff what action had been taken about this. After checking the records they confirmed that no action had been taken and told us that this should have been reported as a concern after a couple of days. The person was prescribed a medicine to be used if they became constipated. The medicine record showed this had not been given during this time. The person had had a fall during this time. The records for the person during this period of time showed frequent episodes of distress and agitation. The person's keyworker had reviewed their continence care plan during this time and had not identified the problem.

A person's care plan for their dental care had not been updated to reflect their family's request for a dental appointment.

A person had a care plan that stated that their catheter bag must be changed weekly to avoid the risk of infection, however this had not been changed for a period of two months. They were in hospital for part of this time; however staff did not identify on their return that the bag had not been changed and they did not change this for a further two weeks. Staff told us that there was not a system in place to ensure that the person's catheter bag was changed

weekly. The person's care plan for their continence and the risk assessment for their catheter bag had both been reviewed during this period of time and staff had not identified that the bag had not been changed.

A person's relatives told us that they did not think their relative had their own dentures in. We saw that the dentures kept falling out of the person's mouth during their meal. Staff said they did not have a way to check that the person had the correct dentures.

A person's care plan gave staff conflicting information about their eyesight. In one part of the plan it stated that they wore glasses, but in another part it said they did not.

The examples above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment did not meet the needs of people living with dementia. Some adjustments had been made to provide a dementia friendly environment, including contrasting coloured toilet seats and signs on bathroom doors. However, the layout of the premises was confusing as it was organised into different wings with a lack of signs to help people find their way. All the corridors looked the same and there was nothing in place to help people living with dementia identify their own bedroom. Two staff we spoke with said that people often found it difficult to find their way around and that there were often occasions where people went into others' bedrooms. A relative told us that they often saw people going into others' bedrooms.

There was a handwritten 'out of order' sign on a toilet door which was difficult to read and may not have been understood by a person living with dementia. There were two other toilets in the home which had 'men at work' health and safety signs outside them restricting access to the toilets. We checked both toilets and found that whilst other toilets in the premises were dirty these were not particularly dirty or in the process of being cleaned. This meant that there was a limited number of toilets available to be used. We asked staff why the signs were there and they did not know. The manager removed the signs so that the toilets were made available again.

Light switches were located on the outside of the toilets and were turned off. This may be confusing for people living with dementia if they went into a dark toilet and could not locate a light switch.

There were some historical pictures of the local area, which staff said were to be used as a memory aid for people living with dementia. However, these were in a corridor at the front of the home that was not used by people living with dementia.

The premises were not suitable for the needs of people living with dementia. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to safe and suitable outdoor space. They were able to access the courtyard garden through doors in the lounge and dining areas.

Inadequate

Is the service caring?

Our findings

People and their relatives told us that they liked the staff that worked in the service and that they treated people kindly and with respect. People told us "The staff have been lovely" and "They are always really friendly". The practices we observed during the inspection did not match people's views of the service. We found that although some staff demonstrated a caring and compassionate attitude others did not and people were not always treated with respect.

We saw that during a mealtime a person complained to staff several times that they were cold. The window near to them was open, but staff in the room did not acknowledge the person's comments or attempt to resolve the problem. Staff did not listen to the person.

People were left waiting 35 minutes for their meal to be served after being helped to sit at the table. Two people were seated alone at their own meal tables facing away from the rest of the room. This isolated them from others and did not demonstrate respect and compassion.

Meals were handed out to people with little positive interaction from staff. Staff did not engage with people more than to hand them their meal. Staff chatted amongst themselves during the mealtime about the tasks they were performing, but did not sit with people nor chat with them over their meal. There was no social interaction for people during their mealtime.

Staff did not listen to people. A person said "I don't like tuna salad" four times in the presence of staff. One staff said "just try it" and walked away. No alternatives were offered. A person was confused and began saying to a staff member "can you tell me…" but appeared to lose their train of thought and trailed off. The staff member did not respond and walked away.

Staff pushed a person backwards into the dining room in their wheelchair. This was disrespectful and disorientating for the person.

A person was singing whilst waiting for their meal. A staff member was standing in the corner of the room looking out over the room. They did not acknowledge the person or engage with them or comment in a positive way about their singing.

The manager had been in post for a month, but they did not know people's names. They referred to a person by the wrong name and were corrected by staff.

Staff said that they had some useful information about people's history in the care plan, but that this could be expanded. Information about people's past had not been used effectively to deliver their care. The biographical history section of people's care plans had not always been completed.

We observed a person who appeared distressed in the corridor of the dementia wing with their dentures in their hand. The manager had to go to their aid and take them to find a member of staff to help them. The manager did not know the person and appeared unfamiliar with how to support them.

Staff did not always support people in a kind and respectful way. A member of staff was abrupt in their manner telling someone to sit down rather than encouraging them or asking if they wanted to sit down. Whilst moving a person into the dining room in their wheelchair a staff member shouted at a person 'No' and grabbed their arm because the person was trying to grab the door frame. A member of staff banged a person's wheelchair into the door frames several times whilst moving them, but did not apologise or check the person was ok.

During the first day of our inspection a person was very distressed and kept banging on the door of one of the units to get out. Staff told us this often happened and that they helped the person walk around the building when they wanted to. However, we had to prompt staff on two occasions to respond to the person's banging.

We observed the person becoming very distressed. The person wanted to walk around the home. Staff supported the person to walk around. After approximately four loops around the building they put the person in a wheelchair and pushed them around the building. The staff member was very abrupt with the person and spoke in an aggressive tone. They said "I don't know what you want" and "Get off that". Staff did not appear to know how to respond to the person or how to manage their distress. Staff's inability to understand people meant that people's emotional wellbeing and behaviour may be affected.

Relatives visiting a person asked staff what had happened to the photos that they had brought in to furnish their room

Is the service caring?

and they were told that staff would look into it. The relatives told us that the photos had gone missing and that they were upset as these were important to the person. Staff told us they had been unable to locate them.

The manager told us that the provider would pay for replacement hearing aids for a person whose hearing aids had gone missing in the service. However, they also commented that they thought the hearing aids were very expensive "Especially for someone with dementia". We asked them to clarify what they meant. They told us that people living with dementia "Often throw them down the toilet".

There were some care plans in place which promoted independence and maintained daily living skills such as "Washing up and folding laundry". Staff we spoke with gave us examples of people who regularly undertook such household tasks.

Some staff referred to people as "Love" and "Darling". Whilst these terms were used in a caring way we found that people had not been asked if this was how they preferred to be addressed.

When helping people to move using a hoist staff did not explain to people what was to happen.

A person who was being hoisted in the dining room had their upper garments pulled up by the sling exposing part of their stomach to others in the room. Staff did not re-adjust their clothing to protect the person's dignity. Staff pushed a person backwards into the dining room in their wheelchair. This was disrespectful and disorientating for the person. A staff member was heard asking a person if they needed medicine for their "Sore bottom" in a loud manner in front of others in a communal area. People were weighed in front of others in the lounge and their weight was confirmed verbally in front of others. This was a breach of people's privacy and appeared to make people feel uncomfortable.

People were not treated with respect. Their dignity and privacy were not upheld. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff members demonstrated a caring attitude. They interacted calmly and politely with people and demonstrated genuine concern for people's wellbeing.

Inadequate

Is the service responsive?

Our findings

Care was not delivered in a personalised way to people. There were set times for tasks that staff carried out such as providing drinks and meals. After lunch everyone was helped to the toilet as part of the routine of the day. People were treated as a group rather than individuals which did not promote people's sense of identity and wellbeing.

People did not have personalised plans that ensured their individual needs were met. Their care plans did not provide staff with information about how to respond to signs of confusion, disorientation and distress associated with people's diagnosis of dementia. A person's care plan stated that they could become agitated and that staff should intervene when necessary, but the plan did not instruct staff how to do this. People's care plans did not give staff information about how to respond to them in a way that acknowledged what was important to them. People's care plans focused on their needs and difficulties and did not reflect their skills or personalities. As staff were not knowledgeable about people's individual preferences, people's needs to feel valued were overlooked.

A person's assessment asked them "What makes you upset" and they or their family had answered "When I get lost". The person did not have a plan in place to help them orientate around the building. A relative of another person told us that they were concerned their relative had become very disoriented since moving to the service. The person's care plan did not contain guidance for staff to help the person find their way around.

People did not have a choice of meals. People made their menu choices the previous evening. Staff said people often forgot what they had ordered or changed their mind. They told us that if there was enough left over people could have something else, or the cook could make them an omelette. However, we saw that in practice people were not offered an alternative meal if they did not like or want what they had ordered. During the inspection we saw three people refuse their meal. Staff did not offer any alternative. Some staff offered a choice of drinks to people at lunchtime, but two staff did not even though the chef had provided two different options of juice.

Staff did not encourage people to make lunch a social occasion. Two people were seated alone away from everyone else in the room and staff said that for one person this was because they were at risk of grabbing other people. However they were faced away from the room and consequently were isolated during the meal. Staff did not sit with people or chat with them. When people had finished their meal, staff removed their plates but did ask them if they had enjoyed their meals or whether they needed anything else.

Most people and their relatives had not been involved in writing their care plan. The care coordinator had identified this as an issue and had arranged to meet with some relatives to discuss the plans. One person's care plan had been reviewed with the involvement of their relative. We spoke with a person's relatives who had arranged a meeting with the manager to discuss their relative's care. They told us that their relative had been at the service for just over three weeks and they had not seen a care plan or been involved in discussing the person's needs.

People with limited mobility did not have a choice of bath or shower. There were no wheeled shower chairs available to allow people with mobility needs to safely access shower areas.

There was a 'one size fits all' approach to the provision of equipment to support people's mobility and independence. This meant that the majority of equipment was supplied for general use rather than personalised to meet the needs of individuals.

We observed a person's relative ask a staff member whether they could write things down for their relative as they couldn't hear without their missing hearing aids. The staff member replied that they already did or they "Just got a bit closer and spoke a bit louder". We looked at the person's care plan and saw that there was no guidance for staff on how best to communicate with the person. The care plans had not been reviewed to reflect that their hearing aid had gone missing and that staff would have to communicate in different ways.

A relative said they had visited and walked around the gardens with their relative and seen people doing some flower arranging. They said that their relative enjoyed that activity, but as it had not been recorded in their care plan staff did not know and had not invited them to join in. Another person's care plan said they loved flower arranging and used to have a florist shop. Their plan for social activities did not give staff guidance on how to help this

Inadequate

Is the service responsive?

person pursue their interest and there was no record of the person having been supported to do so in their activity records. No one was supported to use the outside garden space, although it was a sunny day.

Relatives told us there was little for people to do to occupy their time. We saw that people spent most of their time sitting in the lounge areas. The television or music was continuously on in the communal sitting areas making it difficult for people to hear what staff and others were saying. People were not watching the television. Staff did not encourage conversation with or between people.

There was a fortnightly church service held in the home. This covered a range of religious denominations and the advertising poster did not specify which service was being held each week. The activities record for one person showed no record of any activities being offered since November 2014. The person's care plan said that they wished to be offered the opportunity to attend the fortnightly church service in the home. The plan stated that they may need the information written down to help them understand. Their records showed that they had not been given this opportunity.

A person's assessment of their needs asked "What would you like to do whilst you are here" and they had answered gardening. Another person's care plan noted they enjoyed cooking and painting. There was no care plans in place to ensure they were supported to pursue their interest and their activity records did not show any occasions where this had happened. Staff said that they knew that one person liked to go out for walks, but there was no care plan in place for staff to follow to make this happen. There were no records to show they had been supported to go for walks. One person was being helped to build a train track and had been taken out to buy more tracks.

There was an activities worker employed in the service who worked five days a week. They showed us their activity programme which mainly consisted of group activities provided in one of the dining rooms. A Wimbledon strawberry tea was planned for June. The activities worker told us that some people chose not to join in with the group activities and that they tried to do 1-1 work with people when they could, but that their time to do so was limited.

People did not receive personalised care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives knew how to make a complaint if they needed to. They told us they felt confident to raise concerns. Most people felt that their concerns were taken seriously, but some people did not feel they were listened to. A relative told us they had complained about their relatives lost hearing aids ten days earlier. There was no record of the complaint and the manager told us they had not heard about the issue until the day of our inspection.

Inadequate

Is the service well-led?

Our findings

People told us that the service was not well managed. A relative told us it was "Chaotic" and that there were "Frequent management changes". Another said "They are useless at communicating; someone from the family is here every day so it is not like we're not here to talk to".

The manager was new in post and had been working in the service for one month. They had not yet applied to be registered with CQC. The manager referred to out of date inspection guidance and was did not understand the recent legislation changes. We signposted them to the correct guidance on the CQC website.

The provider had a set of values that they described in their statement of purpose. This included privacy, choice, dignity, independence, rights and fulfilment. We did not see that the service was managed in a way that promoted these values or reflected personalised care that met the needs of people living with dementia. The Eden alternative principles were displayed in the service. These are principles which are designed to eliminate loneliness, helplessness and boredom in people living with dementia. The manager said they were not aware of the Eden alternative and was not able to describe the principles. We did not see these principles reflected in the delivery of care. The manager was not aware of the availability of relevant guidance around the provision of care for older people and those living with dementia and we did not see that they had been advised by the provider about the availability of this.

The manager did not have a good understanding of the key risks to the delivery of a quality service at Abbeyfield Stangrove Lodge. The provider had commissioned an external auditor to audit the service in 2014. The action plan completed by the provider had been signed off to confirm compliance with a number of the regulations, which did not reflect our findings during this inspection. For example the action plan stated that all care plans and risk assessments had been reviewed and updated, with the exception of five, by 7 January 2015. Our inspection found that people did not have up to date care plans and risk assessments that reflected their current needs. The new manager had not carried out any audits or checks of the quality of the service since they had been in post and therefore had not developed an action plan for how to improve. There had not been a robust assessment of the shortfalls in the safety of the service or the risks people faced due to these shortfalls in procedures and practices.

Previous inspections dating back to 2012 have found a variety of shortfalls in the service and provision of care. During that time we have carried out further inspections to determine if actions to improve the service and care had been made. We found that any changes had not always resulted in sustained improvements and if improvements had been made we found further or different changes that were required.

We had concerns about the culture of the service, in that we saw practices that did not demonstrate that staff were caring and compassionate or that they treated people with respect. The manager had not identified these concerns. We saw a letter that the manager had written to staff in which they stated "I have been impressed with the practices so far". Staff knew how to contact agencies outside of the service to report any concerns they had about poor care practices. They were confident to do so.

There was a lack of effective systems in place for checking that people's health needs were met. It had not been identified that a person had not had their catheter bag changed as required in their care plan or that staff had not followed a person's care plan for reporting concerns about their health.

The manager did not demonstrate an overall understanding of the systems for ensuring people had the equipment they needed. When asked about equipment provision, they could not give a clear answer about the local protocol with wider stakeholders regarding responsibility for equipment provision. When asked how equipment was provided for people's needs they stated "We normally find a way to get equipment. We might cheekily ask [the local authority or NHS] for it but if they say no we will buy it ourselves. We normally already have something here that we can use".

There was a monitoring system for accidents and incidents that occurred in the service to allow the manager and the provider to monitor patterns and trends, for example the time of day of accidents or any patterns in where they occurred. We saw that the system was computer-based and gave the provider an overview of accidents and incidents in the service. Staff knew how to report accidents and

Inadequate

Is the service well-led?

incidents in the service. They completed a form which was then passed to the care coordinator for action. The manager said they did not currently see accident forms. We saw that care plans had not always been reviewed following accidents and incidents, for example after a person had fallen. The provider had not identified that people were at risk of unsafe moving and handling practices and had not followed up accidents and incidents to ensure appropriate action had been taken.

Staff were complimentary about the manager. One said "The new manager is approachable and supportive" and another said "I feel the manager is behind me". Staff also told us that "The care coordinator is fantastic, she always mucks in" and "It's a lovely place to work". Staff felt that the manager had made improvements to the handover system. The manager told us they had not held a team meeting since being in post, but they had met informally with the care coordinator on several occasions. There were no records to show how the manager had supervised and supported staff in their roles.

The manager said that the provider was supportive of any changes that needed to be made and made the required resources available as needed, such as an increase in staffing numbers.

The provider had not ensured that systems were in place or operated effectively to ensure the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Clear and accurate records were not kept to enable to provider to monitor the delivery of care. Some records, including care plans, were not easy to read.

Records of people's personal care were not completed consistently. One person's records showed they had only been supported to have two baths in 2015, despite their care plan stating they liked a weekly bath. Staff said the person often declined, but that this had not been recorded and therefore the provider could not be sure that staff were offering the person this care. Care plans and risk assessments were not always dated so it was not clear when they had been written and updated and whether they were the most recent versions for staff to follow. Where people's needs had changed, for example they were referred to a falls clinic or had a change in mobility equipment, their care plan had not been updated to reflect this.

There was a cupboard in the hallway which contained records to be archived. The records contained personal identifiable information and the cupboard was unlocked and easily accessible by anyone walking through the home.

The provider had not ensured that accurate records were maintained in respect of the care provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 **Regulation 13(1)(3) The registered provider had not taken appropriate action to prevent abuse being repeated.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1)(2)(a)(b)(e)(g)(h)** **The registered provider had not ensured that care and treatment was provided in a safe way and that risks to service users were assessed and mitigated. They had not taken appropriate action to reduce the risk of infection. They had not ensured that equipment was used in a safe way. They had not ensured the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)(2)(a)** **The registered provider had not ensured that suitable numbers of skilled, qualified and competent staff were deployed to meet people's needs. Staff had not received appropriate training supervision and appraisal necessary to carry out their duties.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1)(2)(3)**

This section is primarily information for the provider

Enforcement actions

The registered provider had not ensured that care and treatment was only provided with people's consent. They had not complied with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15(1)(c) The registered provider had not ensured that the premises were suitable for people living with dementia.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10(1)(2)(a)(b) The registered provider had not ensured that people were treated with respect or that their dignity and privacy were upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9(1)(a)(b)(c)(3)(a)(b)(i) The registered person had not ensured that people were involved in the planning of their care and that their care was delivered in the way they preferred. People did not have an appropriate choice of meals. People did not have their social needs planned for or met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Regulation 17(1)(2)(a)(b)(c)(f)

The registered provider had not ensured that effective systems were in operation to identify and manage risks to service users or to improve the quality and safety of the service. Accurate records were not maintained.