Abbey Grange Residential Home

Abbey Grange Residential Home

Inspection report

47 Venns Lane
Hereford
Herefordshire
HR1 1DT

Tel: 01432271519

Date of inspection visit:
22 June 2017

Date of publication:
07 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 9 and 16 February 2017. Breaches of legal requirements were found, and we issued a Warning Notice, which the provider was told they had to comply with by 22 June 2017. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this inspection to check that they had followed their plan and to confirm whether they now met legal requirements.

This inspection took place on 22 June 2017 and was unannounced.

At this inspection, we found the registered provider was still in breach of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we identified during the last inspection. These shortfalls in the service are described throughout all sections of this report.

Abbey Grange Residential Home provides accommodation and personal care for up to 29 people, some of whom are living with dementia. At the time of our inspection, there were 20 people living at the home.

There was a registered manager in post, who was also the registered provider. 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 and associated regulations about how the service is run.

People were exposed to harm, both in terms of their physical environment as well as the care they received. Action had not been taken when a significant safety issue had been identified, which resulted in the local authority and Care Quality Commission having to intervene to ensure people's immediate safety. The provider failed to take action to address a gas leak for two weeks until we inspected the service. At this point the provider contacted the emergency gas service and people were evacuated from the home for their safety whilst the matter was dealt with.

People's risk assessments were not followed, which resulted in unsafe care and treatment. People's skin health was compromised due to the fact their specialist equipment had not been used.

The provider was carrying out building works, which resulted in a hazardous living environment. Although the provider had risk assessed the situation, they did not follow their own risk assessment to ensure people's safety.

Staffing levels were not sufficient to keep people safe, with the local authority having to request the provider arrange for additional staff to be on duty.

The provider had not taken action where risks had been identified by staff and brought to their attention. The provider had not identified the concerns we highlighted during the course of our inspection.

People felt lonely, bored and isolated. They were unable to enjoy their individual hobbies and interests.Professional and medical guidance was not followed, which meant people's health needs were not always met.

The principles of the Mental Capacity Act were not followed, resulting in inappropriate applications to deprive people of their liberty.

The provider's website contained a link to an outdated CQC inspection report and rating, which was misleading and did not demonstrate transparency.

People and their relatives were positive about the approach and attitude of staff. People's independence was promoted as much as possible. Staff training had improved, which had resulted in some positive improvements in their daily practice.

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

Services in special measures will be kept under review; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

People were exposed to harm and were living in an unsafe and hazardous environment. People's specialist equipment was not used, resulting in compromised skin health. Risk assessments were not followed, both in relation to people's care needs and the physical environment.

Is the service effective?

Requires Improvement

The service is not very effective.

Professional and medical guidance was not always followed, which meant people's needs were not met effectively. The principles of the Mental Capacity Act were not adhered to.

There was a choice and variety in the food and drinks provided. There was an increased focus on staff training and development.

Is the service caring?

Requires Improvement

The service is not very caring.

People's views were not routinely taken into account. People had been exposed to a harmful situation, which did not demonstrate a caring approach.

People's independence was promoted as much as possible. People and relatives were positive about staff and their approach.

Is the service responsive?

Requires Improvement

The service is not very responsive.

People were not able to enjoy their individual hobbies and interests. Although staff did know about people's preferences, these were not always taken into account. Staff did not always respond promptly to people's needs.

There was a system in place for capturing complaints and feedback.

Is the service well-led?

Inadequate

The service is not well-led.

The provider had not acted on significant risks to people's health, safety and welfare. The provider did not have their own system in place for monitoring the quality of care people received, with audits only being carried out when requested by the local authority.

Although staff had approached the provider with concerns about people's safety, no action was taken.

Abbey Grange Residential Home

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.

We made an unannounced inspection on 22 June 2017. The inspection team consisted of two Inspectors and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had knowledge and experience of care for older people.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

We asked the local authority if they had any information to share with us about the care provided by the service. Due to ongoing concerns regarding the care people receive, there was a local authority action plan in place with the provider. This set what concerns the local authority had, and what action they expected the provider to take.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with eight people who lived at the home, and three relatives . We spoke with the manager, the deputy manager, the provider, and three members of staff. We also spoke with five health professionals.

which included two district nurses, a social worker, a mental health professional, and a best interest assessor. We looked at one capacity assessment and Deprivation of Liberty Safeguard; a weight loss care plan; two skin integrity risk assessments; and one mobility risk assessment. We also looked at the provider's risk assessment for the premises, and two quality assurance audits.

Inadequate

Is the service safe?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not always assessed the risks to the health and safety of people living at Abbey Grange, nor had they taken steps to reduce risks to people where these were known. Where risk assessments were in place, these were not followed. We asked the provider to complete an action plan to tell us what action they would take to ensure they complied with this regulation. Their action plan told us they would update people's risk assessments and communicate this information to staff; improve their accident and incident reporting; and ensure staff had refresher training on safe moving and handling techniques.

At this inspection, we found some improvements had been made, but we identified further concerns during the course of this inspection. For example, people had been living in a potentially dangerous situation for two weeks. A smell of gas was apparent. Staff told us they had noticed the smell for the last two weeks and had informed the provider. However, action had not been taken to identify the possible cause. We asked the manager to contact the gas emergency helpline immediately, who advised the people living in the home would need to be evacuated until the source of the leak could be identified and the environment made safe. Consequently, people were evacuated until the leak was isolated and all rooms had been checked for any presence of gas.

We also had concerns about the construction work taking place at the home. These concerns were shared by health professionals we spoke with. One told us, "It is dangerous and is affecting people's daily care." Although the provider had risk assessed the environment, they were not following this to ensure people's safety. For example, the risk assessment said the main stairwell would be closed off for people so they could not access this work area. However, there was just plastic tape across the stairwell. This had been taken down by the provider when they accessed the stairwell and not been replaced.This meant people could access an unsafe area. The risk assessment also stated work areas would be kept clear and free from hazards. We found work tools on the floor, including a claw hammer, nails and drills. We alerted the provider to this, who told us they were at fault as the tools should not have been left out and they would secure them.

The provider had placed plastic protective sheeting on stairs leading up to three bedrooms and one bathroom. The sheeting was slippery and not a safe surface for people to walk on, particularly people with mobility issues. Staff told us they were worried about this sheeting and people slipping on it. We spoke with the provider, who told us it was to protect the carpet from dust and dirt during the building works, and that one person whose bedroom was in that area used the stair lift. However, we saw another person attempting to walk up these stairs and re-directed them from doing so due to it being unsafe for them.

Due to the building works, the living environment was very dusty for people. We asked the provider and the manager if anyone at the home had respiratory problems, and were told no one did. However, we later saw a person's inhaler in the office. We asked staff if anyone living at the home had asthma, and they told us one person did. One member of staff told us, "[person's name] has breathing difficulties. Their breathing has

been more difficult for them recently because of all the dust." The provider's risk assessment said that the home would be cleaned daily to remove the dust. However, thick dust remained present, including on the carpet when people had trod in dust.

We looked at how the risks associated with people's individual care and support needs were managed. Before our inspection, we received two safeguarding concerns about the quality of pressure area care provided by staff. The concern was in relation to moisture lesions and skin tears. We looked at one person's risk assessment regarding their skin health. The person had been assessed as being very high risk of pressure sores. Their risk assessment said the person was to use a prescribed pressure relieving cushion and mattress to minimise this risk. The district nurses had noticed the person's prescribed equipment was not being used, which had compromised the person's skin health and resulted in painful and broken skin. We spoke with the manager about these concerns, who confirmed the person's prescribed equipment had not been used for a period of a minimum of six months. When we asked why this was, we were told there had been a change in supplier of the equipment, which had resulted in difficulties in identifying to whom each pressure cushion belonged. The manager told us they had been in contact with the new supplier to resolve this issue. We checked this with the district nurses the following day, who told us there had been no change in supplier in the last three years. Therefore, there was no identifiable reason as to why people's prescribed equipment was not being used.

Another person's risk assessment said there was to be a pressure mat outside their bedroom door due to alert staff to when they had left their bedroom door and needed assistance. This person's mat was not in place. We asked staff why, and we were told it had been moved "due to the building work". Staff could not tell us what other measures had been put in place for the person's safety in the absence of the mat.

Prior to our inspection, we had been notified by the provider of a person falling in the lounge area and the paramedics being called. The notification told us the person had complained of back pain after the fall, and staff had placed them in the recovery position whilst they waited for the paramedics. The recovery position is used when a person is unconscious but breathing. We spoke with the provider about this incident, who told us they had been unaware the recovery position had been used. They told us the recovery position should not have been used in this instance, and this had put the person at risk of further injury. They could not explain to us why staff would have used this technique.

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

We looked at the provider's staffing levels and deployment of staff. We saw that one person did have a pressure mat outside their bedroom. Their risk assessment said staff were to respond immediately to this when it was activated. We activated the alarm whilst the person was in their bedroom to see how quick the staff response time was; a member of staff did not respond to this for a period of 10 minutes, despite two members of staff walking past the person's bedroom on two separate occasions. We mentioned this to the manager, who told us there should have been a quicker response time, but could not explain to us why there had been such a delay. The manager told us their dependency tool suggested three carers for 20 people, which was the ratio used. The manager told us their observations were that this staff ratio was sufficient to meet people's needs. However, the provider's risk assessment specified that during the building works, "management is to ensure one member of staff is in the communal area at all times." Our observations throughout demonstrated that staff were not deployed in this manner, with people routinely in the communal area without a member of staff present. One person we spoke with told us people were usually in the communal area by themselves. They told us, "[person] had a bad fall recently and there was no one (staff) about, so we had to call out for help. They did come." This was confirmed in the statutory

notification the provider sent to us regarding the fall. Following the concerns we identified on the day of our inspection, the local authority ensured the provider immediately brought additional staffing to ensure people's safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether people received their medicines safely and as prescribed. People told us they got their medicines when they needed them. One person told us, "I have my usual tablets, and I can ask for pain relief as well if I need it." A health professional we spoke with told us they were satisfied with the management of people's medicines and had no concerns in that regard. Senior staff carried out monthly medication audits to make sure people continued to receive their medicines safely, and as prescribed, and to ensure there was no overstock of medicines. A recent medication error had been investigated internally and measures put in place to prevent a reoccurrence.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we identified that medical and professional advice and guidance was not always followed. This was in relation to physiotherapist guidance. At this inspection, we found action had been taken to ensure staff were familiar with the guidance and it was being implemented. However, we found further examples where medical and professional guidance not being followed. For example, district nurses told us their guidance about pressure care was not followed, which we found evidence of during our inspection. This meant that people's healthcare needs were not being met in relation to their skin health.

We asked people whether they saw health professionals when they needed to. People told us, and we saw in their care plans, they saw doctors, nurses and other health professionals as required, including mental health professionals and physiotherapists. However, one person was trying to read a magazine and they told us they were unable to see it properly as they could not find their glasses. They told us staff did arrange optician appointments for them, but their glasses had been missing for a period of three weeks and they had told staff, but nothing had been done. We told a member of staff, who was aware the person's glasses were missing. They checked the person's bedroom and were also unable to find them. We informed the manager, who ordered a new pair for the person that day. However, the person had been without their glasses for a period of three weeks with no action taken.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. We spoke with the manager about a person who had been offered a choice of a different bedroom whilst the building works were completed, but had chosen to stay in their current room. The manager told us the person had capacity and was able to make this decision. We saw a capacity assessment had been carried out, and the person's choice had been recorded. However, this person's care plan contained a DoLS. A DoLS should not be applied for where a person has capacity; applying for a DoLS demonstrated a lack of understanding of the principles of the MCA. Wwe saw that MCA and DoLS training had been provided to all staff. However, we spoke with a senior carer about this application, who was unable to tell us why a DoLS would have been applied for. Other staff members were spoke with were equally unclear as to what the restrictions were for, and why this had been applied for. Staff were not aware that a DoLS should not be applied for where people have capacity. We asked the manager to review people's DoLS and capacity assessments to make sure DoLS had not been applied for incorrectly, and that people were not being deprived of their liberty where it was unlawful to do so. The manager

reviewed these and later informed us this had been the only error.

At our previous inspection, staff told us they did not feel they had adequate or suitable training for their roles, which was reflected in our observations. At this inspection, staff told us they felt this had improved. Training had been arranged, or had already taken place, in the areas staff had highlighted. On the day of our inspection, an external assessor was present and was assessing staff for a nationally recognised care qualification they were in the process of completing. We saw some improvements in staff's knowledge and practice. For example, at the previous inspection, we saw unsafe moving and handling techniques used. We had no such concerns at this inspection. However, we did have concerns over staff's understanding of pressure area care, as well as the principles of the Mental Capacity Act. This included incorrect pressure equipment being used for people and a lack of understanding of the significance of this, as well as a lack of understanding of capacity and its relationship to DoLS. We brought this to the attention of the manager.

At our previous inspection, people told us they were not happy with the lack of choice and variety of food and drink provided. At this inspection, one person we spoke with told us, "It's alright (the food). I had cornflakes and toast for breakfast". None of the people we spoke with could tell us if meals had improved recently. However, a relative we spoke with told us they had seen some improvements in this area. Throughout our inspection, we saw people were offered a choice of drinks and snacks as well as a choice of two different lunchtime options. Picture cards were used to show people what the meals were and to help aid them in their decision-making. The cook was aware of people's specialist dietary needs and how to cater for these.

We looked at what action was taken where there were concerns about people's weight. Where people had been identified as being at risk of malnutrition, referrals had been made to the relevant health professionals and the weight monitored on a weekly basis. Staff we spoke with were able to tell us who was at risk of malnutrition, and what was being done to try to keep their weight within a healthy range.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, although people were asked for their views and opinions, these were not always valued and acted on. At this inspection, we had similar concerns. For example, the home was being re-decorated. We asked the manager if people had been consulted on this and asked for their opinions on colour schemes and so forth. We were told they had been, but people we spoke with were not able to confirm this, nor were we able to find where this had been documented. One relative we spoke with told us, "I think it (the renovations) just happened."

People we spoke with told us they thought staff were caring. One person told us, "They're (staff) very good. I'm deaf but I manage and get by; I lip read". We saw that staff spoke particularly clearly to this person and positioned themselves so that their faces could be seen when they did so. Another person told us about a particular member of staff, "They are my best, best friend." Relatives we spoke with were also positive about the caring approach of staff. We observed staff knew people well as individuals, and their preferred communication styles. For example, staff knew how to reassure and explain to each person why they had to evacuate the home. Staff tailored their approach to the needs of each individual person to help minimise their distress and concern.

Staff told us, and we saw that, they helped people try to retain some independence. We saw staff helped people to a standing position so they could take hold of their walking frames or sit down in a wheelchair, either by operating the powered armchairs or by encouraging people to stand by pushing themselves up from their chairs . One member of staff told us, "We try to preserve their independence". In both cases, staff offered guidance and reassurance throughout so that people did not become concerned or frightened.

We looked at whether people were treated with dignity and respect. One relative we spoke with told us their relative was always, "Clean and tidy and as I would want to see them." They told us they knew their relative was treated with respect as they would tell them if that was not the case. We saw that where people needed assistance with personal care, this was offered discreetly and in a dignified manner. At the time of our inspection, the provider had built a wet room in a communal lounge. We asked staff and the manager about this, who told us it was to increase dignity for people so they could be taken in there in the case of any personal care emergency. However, we raised the point that people who chose to sit in the other communal lounge would have to walk through from there to the wet room, which meant people would see. As the wet room was new and was not yet in use, we were unable to determine whether this enhanced or compromised people's dignity, nor were we able to ask people whether they felt comfortable using it.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, people told us they were not able to pursue their individual hobbies and interests and their preferences were not always taken into account. At this inspection, people told us this had not improved. One person told us, "I love reading, but I haven't been able to recently because my glasses are lost. I get very bored." Another person told us they would like to do gardening as this had always been their interest. They told us, "All this lovely weather we've had and I've been stuck indoors. I haven't even gone into the garden." We mentioned this to staff, who told us the garden was not currently available to people due to the ongoing building works. No consideration had been given to taking this person, or other people out as an alternative to being able to use the garden.

People we spoke with told us they felt socially isolated and lonely. We asked one person if they were happy living at the home and they replied, "No, not really. I am fed up." Another person told us, "I am very, very lonely." One person chose to spend their time in their bedroom. We asked staff how they ensured they respected this person's wishes, whilst also preventing them from feeling isolated. They told us, and the care plan recorded, the person was checked every two hours by staff and staff spent one to one time with them. We did not see staff check on this person during our inspection, nor was there a system in place to make sure these checks were carried out.

Although staff did demonstrate knowledge of people's likes, dislikes and preferences, we saw examples of where people's preferences were not taken into account. For example, we saw a member of staff hand a person a magazine on World War One to read. The person did not appear interested in this. We asked them if they wanted to read it and they said no, and put the magazine back down. The member of staff also gave another person a magazine, which was upside down and the person struggled to read it. Staff put the television on for one person so they could watch a tennis match. The person told us they used to love playing tennis, which staff were aware of. However, the person told us they could not see the ball due to the fact their glasses were lost and therefore, were unable to fully enjoy watching.

A relative we spoke with expressed concern about the over-reliance of the television for people as stimulation. We saw the television was on throughout the day, although people rarely appeared to be watching or enjoying it. The relative told us since watching a certain programme on the television, their relative had expressed concern that, "a man is going to come and shoot us." The relative was concerned about this negative stimulation.

We asked people if they had been asked how they would like to spend their time. One person told us, "I would like to do something else (rather than watch television). I haven't said anything to staff. My [relative] says I ought to say something, but I don't know." The manager told us residents' meetings were held to gather people's views and feedback. However, people we spoke with were not able to recall such meetings.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how staff responded to people's health and wellbeing needs. We heard a person who was bedbound repeatedly call out, "Nurse, nurse!" Staff did not respond to this for a period of over ten minutes, when we alerted staff to the concern. We asked staff if this person was able to use an alarm buzzer, but we were told they could not, but were "checked every two hours and visited on tea-trolley rounds." However, the person had been in need of assistance at the point of calling for help. Other people we spoke with had mixed views on how responsive staff were, with one person telling us they didn't have to wait long for assistance or help, and one person telling us staff did not respond quickly enough.

We saw that handover meetings took place between staff throughout the day. A handover is a short meeting at the end of one shift and the start of another. The handovers were used to pass on information about any changes in people's needs, or any concerns staff should be vigilant to.

We looked at the system in place for capturing and responding to complaints. The complaints procedure was visibly displayed for people. People we spoke with told us how they would raise a complaint, if necessary. One person told us, "I don't care what the correct way is, I would go to [deputy manager's name]." A feedback and suggestions box had been introduced since the previous inspection, which was for people, staff, relatives and visitors. This was new initiative and as such, it was not possible at the time of our inspection to see whether feedback had been acted upon.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because information about the risks associated with people's care was not always known, recorded or shared; action was not taken by the provider when concerns were brought to their attention; and staff felt unable to approach the provider with concerns about people's health and wellbeing. We issued a Warning Notice to the provider, which informed them they must comply with this regulation by 22 June 2017.

At this inspection, we found improvements had not been made. The provider had not taken action when risks had been identified by staff and brought to their attention. For example, staff had informed the provider there was a smell of gas in the home two weeks' before the gas leak was confirmed. We asked the provider what action they had taken, and they told us they had contacted a plumber to carry out a gas safety check. The provider was aware that the gas leak had continued after the plumber had completed the gas safety check and there were no further actions identified to address this. The provider did not accept this had been the incorrect course of action to take, and told us they had "sorted it." It was later confirmed the emergency gas service should have been contacted and immediate action taken to protect people from suffering adverse effects.

Staff we spoke with told us they still did not feel listened to. One member of staff told us, "Sometimes, people are definitely at risk (from the physical environment). We did tell [provider's name] they should move the plastic sheeting from the floor. They moved it from one part of the home, but there is now some on the stairs. It just isn't safe." The manager told us they had informed the provider two new wheelchairs were required, but these had not been bought. Instead, condemned wheelchairs had been put back into use. The manager showed us they had personally ordered the wheelchairs because the provider had not taken action.

Recently, the manager had carried out an infection control audit at the request of the local authority. This audit highlighted issues regarding cleanliness in the home. Although the provider had signed the audit to confirm it had been read, action had not been taken to remedy the issues. The manager told us, "Once I do an audit and give it to [provider's name], it is then out of my control and I can't do much more." During the course of our inspection, we had concerns about cleanliness and hygiene in the home. This included faeces on handrails on bath rails and liquid soap not being available in a communal bathroom.

Where action had been taken to assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at Abbey Grange, this was as a result of other agencies and health professionals asking for action to be taken. For example, the manager had introduced a skin bundle communication tool so that staff could record and share risks regarding people's skin health. Although staff told us this new system had improved communication and helped them to be aware of concerns about people's pressure care, this system had only been introduced as a result of two recent safeguarding concerns raised by the district nurses. The manager confirmed with us it had been in place for less than two weeks. Similarly, the recent infection control audit, health and safety audit and risk assessment regarding the ongoing building

works had all been carried out at the request of the local authority.

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

Before our inspection, we checked the provider's website to ensure the most recent CQC rating was displayed. The link on the website was to a previous inspection report and a different rating. This did not provide transparency about the care and treatment provided by Abbey Grange and did not help people to make informed choices about their care. We showed the manager the website and the out of date information on there. They informed us the person who was responsible for the website no longer worked for the provider and that was how the issue had occurred. However, displaying the rating is the responsibility of the registered provider. The manager told us they would take steps to change the website.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities).

At our previous inspection, we found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because we had not been notified of safeguarding concerns, serious injuries or accidents as required as part of the provider's registration requirements. The provider's action plan told us they would now submit the necessary statutory notifications to ensure we were aware of any risks to people living in the home. Since the previous inspection, the provider had submitted the relevant statutory notifications to us, as and when necessary.