Cumbria County Council

The Abbey

Inspection report

Main Street
Staveley
Kendal
Cumbria
LA8 9LU

Tel: 01539821342

Date of inspection visit:
05 January 2016
22 January 2016

Date of publication:
17 May 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 5 and 27 January 2016 and both visits were unannounced. We last inspected The Abbey in October 2014 and we rated the service as good.

The Abbey is registered to provide accommodation and care for up to 28 older people. The home is situated in the centre of the village of Staveley near to the town of Kendal. There is a passenger lift to assist peopel to access the first floor of the home. There are adapted bathrooms and toilets close to all the areas used by people who use the service. There are four separate units each with bedrooms, lounges and dining areas.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was on phased return to work due to a period of time off with illness. During that time the registered provider had given reassurances to CQC about how the home would be supported.

During this inspection we found a number of breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They were Regulation 9 Person centred care, 11 Need for consent, 12 Safe care and treatment, Regulation 18 Staffing and Regulation 17 Good governance.

When accidents and incidents had occurred these had not always been reported to the appropriate authorities. Incidents requiring notifications to be made to CQC had not always been done. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their

registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

The number of care staff available to people during the night was not always sufficient to ensure people's needs could be safely met. There had been inconsistencies with the numbers of staff on shifts and that there was no process in place to determine the numbers of care staff required to meet people's individual needs.

The storage arrangements for some medicines in the home were not always in line with current national guidance.

Information held about people's care and support was routinely recorded in four different types of records. The information recorded was not always consistent or accurate within these four types of records. The reviews of care plans and records made were not always accurate about the changing needs of people's health and support required.

Where risks relating to falls and weight loss had been identified we did not see that appropriate actions had always been taken to address them.

Staff had completed initial training that enabled them to deliver care and support safely. However some staff required some elements of training to be updated to refresh their skills and knowledge.

Where the need for consent was required it was not always obtained from the appropriate person.

People living in the home spoke highly of the staff and were happy with their care and support.

The recruitment procedures demonstrated that the provider operated a safe recruitment procedure to ensure that fit and proper persons had been employed.

We have made a recommendation that the provider look at the temperature control for where medications were stored in the home.

We have made a recommendation that the complaints procedures identified in the home are followed for all complaints raised.

'You can see what action we told the provider to take at the back of the full version of the report.'

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 always safe.

Prescribed medicines were not always stored correctly.

Staffing levels at night were not sufficient. Staffing levels during the day had been inconsistent and not based on people's individual needs.

Risks identified were not always managed safely.

All the required checks of suitability had been completed when staff had been employed.

People told us they felt safe and very well cared for in this home.

Is the service effective?

Inadequate

The service was not always effective.

Consents had not always been obtained from the appropriate person.

Staff training records showed refreshers in training had not been completed by some staff.

People had their nutritional needs assessed and met.

Is the service caring?

Good

The service was caring.

People told us that they were being well cared for and we saw that the staff were respectful and friendly in their approaches.

We saw that staff maintained people's personal dignity when assisting them. Staff also offered explanation and reassurance about what they were doing.

People's preferences for care at their end of life had identified

and recorded.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints system in place but not all complaints had been recognised and dealt with using the provider's procedures.

Information in people's care records was fragmented and did not always accurately reflect people's needs.

We saw there were activities which people took part in.

Is the service well-led?

Inadequate

The service was not always well led.

The consistency of management had not been effective.

Where staffing shortfalls had been identified to the provider action had not been taken.

Not all processes in place to monitor the quality of the service were effective.

The Abbey

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 was 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.

Before the inspection we reviewed the information we held about the service. This included concerns relating to a specific incident that had occurred in the home. Based on our collective information we brought forward the date of the inspection of this service.

This unannounced inspection took place on 5 January 2016 and we revisited the home on 22 January to ensure that the provider took immediate action to protect people from the risk of potential harm.

The inspection team consisted of an Inspection Manager and a lead adult social care inspector.

We did not have a Provider Information Return (PIR) when we visited. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider had not received the request for a Provider Information Return (PIR) before our inspection. This was the first inspection following the registered provider's recent reregistration with CQC in October 2015.

During the inspection we spoke with the registered manager who had recently returned to work following a period of absence, the operations manager, four members of care staff, the cook, people who used the service and two relatives. We observed how care staff supported people who used the service and looked at the care records for 11 people. We also observed how people were supported by the staff during the day.

We looked at the staff files for staff most recently recruited, four in total. These included details of recruitment, induction, training and personal development. We looked at the overall training record for all staff. We also looked at records of maintenance and repair and other quality monitoring documents.

Inadequate

Is the service safe?

Our findings

People living at The Abbey that we spoke with told us they felt safe and did not have any concerns about the care they received. One person said "I definitely feel safe here, it's a good place to be.'' Relatives we spoke with told us they had no concerns about the safety of people at the home. One person told us ''I have no concerns and would say so if I had.''

We looked at the staffing rotas for the two weeks prior to the inspection and found that staffing levels through the day had been inconsistent in the numbers of staff on duty for each shift. Care staff numbers varied on a variety of shifts during the day. Although the provider told us they used a dependency tool to calculate staffing levels we did not see any evidence of this being used to provide a consistent level of staffing. We were told by the registered manager that recruitment of care staff was ongoing and the provider had been aware of the low availability of care staff since the summer of last year. We saw that bank staff had been used on a regular basis to support the staffing numbers. Audits taken in the home identified that staff morale had been low due to the low numbers of care staff.

At the first inspection visit we raised concerns with the registered manager about the number of staff available at night to adequately meet people's needs. The registered manager told us at that night time staffing levels were based on the provider's dependency tool. We saw that the dependency tool used did not identify the level of support required by individuals during the night. We found that two members of care staff on duty at night were not adequate to safely meet the needs of the people living in the home at the time of the inspection visits.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not sufficient numbers of care staff to adequately meet the needs of people safely.

The home was divided into four separate units, two on the upper floor and two on the ground floor. These were divided by fire safety doors and staircases. Where people were known to have fallen at night causing injury they had been frequently left unsupported by staff at times during the night. This was because the two care staff had been required to support other people elsewhere in the home. On our second visit to the home we looked at the logistics of the building and the fire evacuation support needs of individual people and found that the needs of some people had changed since their initial assessment. This meant they would require more physical support from staff should they ever need to be moved in an emergency.

We saw that where someone who moved around often during the night and had frequently fallen actions identified to reduce the risk of injury and to alert staff to their movements had not been taken. We also saw that two people had been identified as at risk of weight loss. However we could not see what actions had been taken to reduce further risks.

We also saw that a person who had demonstrated behaviours that might challenge the service did not have any risk assessment or management plans in place for those behaviours.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because actions identified relating to the risks associated with people's health and safety had not always been taken to prevent them.

We looked at the records of medicines and their management. We also looked at care plans relating to the use of medicines. We found that the storage for some medications did not have the temperature monitored on a regular basis to ensure the safe storage of them.

We made a recommendation that the provider look at the temperature control for the environment where medications were stored.

We looked at four staff files for recruitment and saw that the necessary checks on employment had been completed. References had been sought and we noted that they were usually from the most recent previous employer in accordance with the homes recruitment policy. Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had been conducted.

Inadequate

Is the service effective?

Our findings

Most of the people who lived in the home told us that they enjoyed the meals provided. One person told us, "The food is very good and there's plenty of it." Another person we spoke with told us, ''The food is very good and we always get a choice.'' However another person who had very specific dietary requirements told us that despite making complaints the presentation of their food was still unpleasant. We saw that when their food was presented it did not look appetising. We discussed this with the registered manager and operations manager who told us they would look into the matter.

We saw that people had nutritional assessments completed to identify their needs and any risks they may have when eating. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well. Where people had been identified as at risk of malnutrition and weight loss had occurred we did not see that actions identified were sufficient to prevent further risks occurring.

We looked at the staff training records which showed what training had been done and what was required. We saw that staff had completed induction training when they started working at the home but some staff had not received regular updates on important aspects of their work such as first aid and moving and handling. We saw that not all the training of staff was up to date and that only member of the team of staff who worked nights had up to date training in first aid. We also noted that the majority of the staff team had not received any training about the Mental Capacity Act 2005 (MCA) or on the Deprivation of Liberty Safeguards (DoLS)

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there was not sufficient numbers of suitably qualified staff.

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 are called DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was no one living at The Abbey that was subject to DoLS at the time of the inspection.

We looked at care plans to see how decisions had been made and recorded around 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. We noted that some forms stated that they had been completed in the best interests of people who used the service.

Guidance on how to act in people's 'best interests' is outlined in the Mental Capacity Act 2005. The act states people's levels of capacity to make important medical decisions must be measured and documented. We found that the process for best interest decisions had not always been formally noted in the written records. We also noted that some DNACPR decisions had not been reviewed in the time frame identified on the DNACPR record or when changes in people's medical conditions had occurred. We asked the care staff on duty if they knew which people they were caring for had these recorded decisions in place. None of the four care staff we spoke with knew which people they were caring for had these recorded decisions in place.

We also noted that where two people lacked capacity to consent to care and treatment that the consent had been obtained from a relative who did not have the legal authority to do so

This was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment must only be provided with the consent of the relevant person.

Where people were living with dementia there was some signage to show people what different areas were for. This was to help people with memory problems to be able to move around their home more easily and more independently. We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. Bedrooms we saw had been personalised with people's own furniture and ornaments to help people to feel at home and people were able to spend time in private if they wished to.

Good

Is the service caring?

Our findings

We spent time visiting the different units in the home observing how staff supported and interacted with people living at The Abbey. We spoke with relatives and they told us they had no concerns about the care their relative received. We saw examples of a caring approach by staff during daily interactions. For example we saw that care staff offered people reassurance when they showed signs of distress and allowed them time to express themselves. We saw care staff interacting and engaging people with activities such as puzzles. People we spoke with also told us, '' The staff are very kind and friendly.''

We also spoke with a family from the local community who had been provided with accommodation and support at The Abbey following recent severe weather that had caused damage to their property. This had left them unable to live in their property due to the repairs that were required. They all told us they had been really well cared for under exceptional circumstances and that the home and its staff were a credit to the local community. They told us the standard of care and support they had received was faultless.

We looked at the cards and letters of compliments that relatives of people who had used the service had sent to the home to express their appreciation of the care their loved ones had received there. These all made positive comments about the care people had received at the home.

We saw that people's privacy was being respected and that staff protected people's privacy by knocking on doors to their rooms before entering. We saw that people were asked in a discreet way if they wanted to go to the toilet and the staff made sure that the doors to toilets and bedrooms were closed when people were receiving care to protect their dignity. Staff gave explanations to people and reassured them when providing them with support to complete any tasks.

Procedures and information were in place about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

We saw that some people's treatment wishes had been made clear in their records about what their end of life preferences were. The care records contained information about the care people would like to receive at the end of their lives and who they would like to be involved in their care. This was to ensure people who could be involved with planning their end of life care were cared for in line with their wishes and beliefs at the end of life.

Requires Improvement

Is the service responsive?

Our findings

We saw that information recorded in people's care plans did not always provide staff with accurate and up to date information about how to support individuals. Information relating to people's care was recorded in different records which meant information for staff to access was fragmented.

We saw that a full assessment of people's individual needs had been completed prior to admission to the service to determine whether or not they could provide them with the right support that people required. However we noted from the reviews of care records that where some people's mobility and level of support needs had changed the plans had not been updated to reflect their current needs. For example evacuation plans in the event of emergencies and where people had lost weight. This meant that the plans for caring and supporting people's needs were not always accurate.

We also saw where someone had behaviours noted that might challenge there was no care plan available to the care staff to guide them on how to manage those behaviours.

This was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the plans for the care and treatment of people did not accurately reflect their needs.

There was a complaints process in the home and people we spoke with were aware of who they would speak to if they wanted to raise any concerns. We noted from a person's care records and by speaking with them that they had an unresolved complaint relating to the quality of their food. We also saw that a complaint received last year did not have an outcome identified as to whether the complaint had been resolved.

We recommended that the complaints procedures identified in the home were followed for all complaints raised.

On the day of the inspection there was a visiting hairdresser who regularly attended the home. During the inspection we saw that staff interacted with some individuals to engage them in activities such as jigsaws and puzzles. We were told by care staff that other meaningful activities took place on a regular basis that people could partake in if they wished to.

We could see in people's care records that the home worked with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services in order to meet people's needs.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). Although the registered provider had ensured the home had management support during the notified absence of the registered manager some evidence we found suggested that that there had been a lack of consistency in the management of the home.

People and care staff we spoke with living in the home spoke highly of the registered manager. One person said ''She (registered manager) was missed while she was off, it's good to have her back.'' Staff we spoke with said that they really enjoyed working in the home. One member of staff who had been employed at the home told us, "I've worked here over 10 years, sadly I'm leaving, I love my job but I'm returning to my previous care job."

Although there were systems in place to assess the quality and safety of the service provided in the home these had not always been effective. Some management audits on the quality and safety of the home had not been completed from August 2015 up to the date of the inspection. Where there had been previous requests for maintenance of the property to replace window restrictors this had not been pursued. The audits in place for care plans and care records had not detected where reviews had taken place and not identified the changes in people's care needs.

There had been no monitoring of the requirements for the ongoing training needs of staff in the home. This had resulted in some staff not maintaining the recommended time frames for refreshing their skills and knowledge.

The low numbers of staff available to adequately cover the service were identified to the provider by the registered manager in August 2015. This had resulted in staff regularly working extra hours. We did not see that regular staff meetings had been held to support the staff team during the period of absence of the registered manager.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (regulated activities) regulations 2014 as areas of safety and quality monitoring had been ineffective and there had been lack of consistency of management in the home. The systems and processes to ensure compliance with the Regulations were not operated effectively to identify where the quality and safety of the service may be affected.

There were systems in place for reporting incidents and accidents in the home that affected the people living there. The registered manager and registered provider had not always notified the appropriate authorities following incidents that affected the welfare and safety of the people who use the service. This also included failing to notify the CQC of incidents requiring another health professional to deal with them.

This is a breach of Regulation18 Notifications of other incidents of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration

regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This was because the plans for the care and treatment of people did not accurately reflect their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This was because care and treatment must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This was because the quality monitoring system used to help identify and assess where quality and/or safety had been compromised had not been effective.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was because actions identified relating to the risks associated with people's health and safety had not always been taken to prevent them.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of care staff to adequately meet the needs of people safely

The enforcement action we took:

Issued a warning notice