Amesbury Abbey Limited

Amesbury Abbey Care Home

Inspection report

Church Street
Amesbury
Salisbury
Wiltshire
SP4 7EX

Tel: 01980622957
Website: www.amesburyabbey.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Amesbury Abbey Care Home provides accommodation which includes nursing and personal care for up to 45 older people, some of whom are living with dementia. At the time of our visit 32 people were living at the service.

People's experience of using this service:
People were not safeguarded from the risks of scalding. This was because the hot water temperatures from hand wash basins in 21 people's rooms and communal bathrooms were excessively high.

Excessively high-water temperatures were identified at the last inspection, but insufficient action had been taken to ensure safety.

The Health and Safety Executive states water temperatures above 44 degrees centigrade, creates a scalding risk to vulnerable people who use care services. The temperature of the water identified during this inspection was above this and ranged from 46.3 to 79.4 degrees centigrade.

The temperature of the hot water was being monitored but action had not always been taken when excessive temperatures were identified.

The provider did not ensure they were informed of the results of the water temperature checks. This did not give the checks high profile, reinforce the importance of the task or ensure risks were satisfactorily addressed.

Assessments to identify each person's risk of scalding, had been undertaken. The precautionary measures in place did not effectively minimise the risks of scalding to people.

Thermostatic valves to control the safe temperature of the water were in the process of being fitted. However, the provider or manager were not aware of the order in which they were being fitted, or by when. This did not ensure risks were being managed in a strategic or timely manner.

Rating at last inspection: At the last inspection on 14 and 16 January 2019, the service was rated as Good. The report of this inspection was published on 06 April 2019. At this inspection, the rating dropped to Requires Improvement.

Why we inspected: This was a focused inspection to check the provider had met the breach of Regulation 17, which was identified at the last inspection. We issued the breach, as water from some of the hand wash basins, was very hot which increased the risk of people scalding themselves.

Follow up: We will monitor all intelligence about the service and complete another inspection in line with this and our frequency of inspection guidance.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Amesbury Abbey Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was undertaken by one inspector.

Service and service type: Amesbury Abbey Care Home is registered to provide accommodation and nursing care for up to 45 older people.

The service does not have a manager registered with the Care Quality Commission. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

There was a new manager who started employment at the home on 28 April 2019. The manager said they were in the process of registering with the Care Quality Commission to become the registered manager.

Notice of inspection:

This was an unannounced responsive inspection, so no notice was given. The inspection was prompted to check on the safety of the hot water, as excessive temperatures had been previously identified.

What we did:
Before the inspection, we reviewed information we had received and held about the service. This included statutory notifications sent to us about events and incidents that had occurred at the service. A notification

is information about important events which the service is required to send us by law.

During the inspection, we accompanied a member of staff to test the temperature of the hot water from 31 hand wash basins. We looked at monthly water temperature monitoring records and 8 assessments which identified the risks to people's safety. We spoke with the manager and provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

- The provider told us they took the risks of scalding very seriously. They said they did not want any harm to be sustained to any person living at the home. However, insufficient action had been taken to minimise the risks associated with the hot water.
- People had been assessed in relation to their risk of scalding but the precautions in place for each person were the same. This did not reflect each person's individuality.
- The precautionary measures identified, did not always minimise the risk of scalding. For example, within one assessment it was stated, "[Person] is aware of the appropriate temperature suitable for her" and, "[Person] has access to a call bell and a pendant that she always wears.] Another assessment stated, "[Person] has a loss of sight and therefore is unable to access the basin or the taps. [Person] is able to recognise if the water is too hot." These were not effective control measures and did not minimise risk.
- All assessments showed the risks to people from the hot water were "acceptable". This was despite one person being relatively mobile, with water of 79.4 degrees centigrade from their handwash basin.
- Some of the information within the assessments, which related to the risk of scalding, showed the person's ability to summon assistance if an injury was sustained. This was not a precautionary measure, which minimised risk.
- The water within an unoccupied room was 56.3 degrees centigrade. There was a risk this excessive temperature would be overlooked, if the room was used for an emergency admission.
- The provider told us people had capacity and were aware of the risks of the hot water. This was not a satisfactory response, as the excessive temperature, would only be identified once it touched the person's skin.

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

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI:□Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection, the provider and registered manager had failed to identify and address the risks associated with the hot water in people's bedrooms. This was a breach of Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection, some action had been taken to address the risks associated with the hot water. However, this action was insufficient, and the risk of scalding remained.
- The Health and Safety Executive states, "High water temperatures (particularly temperatures over 44 degrees centigrade) can create a scalding risk to vulnerable people who use care services."
- There were 21 en-suite facilities and three communal bathrooms, which had hot water above the Health and Safety Executive's recommended safe temperature. The hot water tested ranged between 46.3 and 79.4 degrees centigrade.
- Thermostatic valves to regulate the temperature of the water from hand wash basins, were being fitted. However, the provider or manager were not aware of the order in which they would be fitted or by when. This did not ensure a safe programme to regulate the water would be managed in a strategic or timely manner.
- Thermostatic valves to control the water at a safe temperature had been installed to eight hand wash basins. However, four of these had been installed in unoccupied rooms. This did not minimise the risk to people living at the home.
- Communal bathrooms and toilets were not included in the record that showed which hand wash basins had been fitted with thermostatic valves. This did not ensure all outlets were appropriately considered.
- Records showed the temperature of the hot water was being monitored. However, action had not always been taken when excessive temperatures were identified. For example, hot water in one person's bedroom was 79.4 degrees centigrade. Records showed earlier in the month it had been 78.4 degrees and in April 2019 it was 60.7 degrees centigrade. No action had been taken to reduce the excessively high temperature.
- The provider did not ensure they were informed of the results of the water temperature checks. This did not give the checks high profile, reinforce the importance of the task or ensure risks were satisfactorily addressed.

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

After the inspection, the manager sent the Care Quality Commission an action plan, which showed a

structural assessment of the building would take place, to ensure thermostatic valves would be effective. The information showed the provider had met with the maintenance team to discuss how they would ensure the water was of a consistently safe temperature.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with excessively high-water temperatures had not been effectively identified. Regulation 12(1)(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Insufficient action had been taken to mitigate the risk of people scalding themselves from the hot water in their room and communal bathrooms. Regulation 17(1)(2)(b).