Hinckley Care Limited

Abbey House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:

Abbey House is a care home that was providing personal and nursing care to 25 people aged 65 and over at the time of the inspection. The service was registered to provide support for up to 73 people. At the time of the inspection the service was being operated under the name of Ridgeway Rise. Hinckley Care Limited were asked to submit documentation to change the location name on their statement of purpose to Ridgeway Rise. At the time of the inspection this had not been received by CQC.

People's experience of using this service:

People were not protected from risks associated with their care and support. Medicines were not always managed safely.

The provider did not ensure there were always enough staff deployed to enable people's needs to be met safely. Systems to manage accidents and incidents were not always effective.

Systems to monitor and improve the service were not always effective. The provider did not ensure that records were accurate and up to date.

Relatives and staff were not always confident the service was well managed. Staff did not always feel supported, valued or listened to.

People were supported by staff who were kind and compassionate. Staff used their knowledge and understanding of people to form positive relationships that valued them as individuals.

People enjoyed a varied diet that met their individual dietary requirements. People had the opportunity to participate in a range of activities.

Staff referred people to health and social care professionals when they required specialist support. Health and social care professionals were positive about the skills and knowledge of staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Rating at last inspection: This was the first inspection following the location being registered with the provider Hinckley Care Limited.

Why we inspected: This inspection was prompted in part by concerns CQC received. We looked at staffing levels and how risks were managed as these were areas of concerns raised.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will continue to monitor the service closely. We have asked the provider to send us an action plan to identify the action they are taking to meet the regulations. We will inspect the service in line with our inspection methodology where a domain is rated inadequate.

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?

The service was not safe

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was effective

Details are in our Effective findings below.

Good

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement

Abbey House

Detailed findings

Background to this inspection

The 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.

The inspection was prompted in part by information shared with the Care Quality Commission (CQC). The information indicated concerns about staffing levels and the management of risk of falls. This inspection examined those risks.

Inspection team:
The inspection was carried out by two inspectors, a medicines inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Abbey House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The registered provider is currently Hinckley Care Limited, with the location named as Abbey House. At the time of the inspection a new provider, Ridgeway Rise Care Limited, had submitted an application to register with the Care Quality Commission, to operate the location of Ridgeway Rise.

Abbey House accommodates up to 73 people in one purpose-built building. The building is divided into six units over three floors. At the time of the inspection there were people accommodated in three units.

The service did not have a manager registered with the CQC. A registered manager, along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in post who had submitted an application to register with the CQC under a new provider,

Ridgeway Rise Care Limited.

What we did:

Prior to the inspection we looked at information we held about the service. This included notifications we had received from the service. Notifications are specific events the provider is required to notify us about by law. We spoke to the local authority safeguarding team and commissioners of the service.

During the inspection we spoke with five people, nine relatives and one visitor. We also spoke with the area operations manager, the home manager, three nurses, eight care staff, the dementia expert, the lead housekeeper and the chef.

We observed care practice and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records, medicine administration records, three staff files and a range of other records relating to the management of the service.

Following the inspection, we received feedback from two health and social care professionals. We also received some additional information from the area operations manager regarding compliments and the introduction of a newsletter.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• Our inspection was prompted, in part, by concerns raised regarding the management of risk of falls. During the inspection we found these risks were not managed safely. Risk assessments and care plans were not always updated following incidents to ensure risks were managed and people's needs were met. One person was at high risk of falls. The person had experienced a fall resulting in a hospital admission. Following discharge from hospital the care plan had not been reviewed or updated to reflect changes to the person's needs and ensure risks were reduced.
• Risks to people were not always managed effectively. One person could become anxious and their anxiety could result in behaviour that posed a risk to themselves and others. There was no risk assessment or care plan guiding staff how to support the person to manage their anxiety and behaviours. The registered manager did not always take action, following incidents where people had harmed staff, to reduce the risk of incidents re-occurring. • Staff did not always follow assessments and care plans to ensure risks to people were minimised. One person's sleep care plan identified the person required hourly checks through the night. On one occasion the person had left the building unaccompanied during the night and was not safe to do so. Records showed the person had not been checked hourly through the night on that occasion. There had been no review of the person's care following the incident.

Using medicines safely
• Risks associated with medicines were not always managed effectively. One person was at risk of holding medicines in their mouth. This had been reported by the person's relative to a nurse. However, there was no review of the person's care plan to guide staff to monitor that the person had taken their medicines.
• People were at risk of their pain not being managed effectively and in line with their care plans. Three people's medicine care plans stated that a pain assessment tool should be completed to assess whether they required pain relief as they were unable to verbalise when they were in pain. The pain assessment tools had not been completed for all administrations of pain relief.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager had effective systems in place to ensure the safe maintenance of the environment and equipment.
• Medicine administration records (MAR) were accurately completed. Medicines were stored safely. Staff responsible for the administration of medicines had completed training and their competencies were assessed.

Learning lessons when things go wrong

• The provider did not have effective systems in place to investigate and monitor incidents and accidents.
• Two incidents had inconsistent details on the records relating to the incident. The manager's investigation had not identified the discrepancies. In the absence of accurate records the manager could not analyse the facts and prevent future re occurrence.
• There was no system in place to analyse accidents and incidents for trends and patterns. Staff told us there had been an increase in the number of falls. An accident and incident log showed that between 25 March 2019 to 28 April 2019 (a four-week period) there were three reported falls. From 29 April 2019 to 13 May 2019 (a two-week period) there had been 13 reported falls. We spoke with the manager who had not done an analysis of the falls to look for any trends. The manager told us that when people had a fall nurses tested for urinary tract infections which they told us was the reason for the falls. However, the incident records showed only four of the 13 falls identified the person had a urinary tract infection.
• There was no accident and incident policy in place. We asked the manager for the accident and incident policy. They told us the accident and incident policy formed part of the health and safety policy which was under development by the provider.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
• The provider did not have arrangements in place to make sure there were enough staff deployed across the service to meet people's needs. People were left alone in communal areas of the service with no staff available to meet their needs. One person was anxious and required support with personal care. There was no staff present to support the person until the inspector located a member of staff and asked them to help the person.
• At lunchtime two people, who required support to eat and drink waited 55 minutes for staff to be available to support them with their meal.
• There were two care staff and a nurse on each unit during the day. The manager had completed a dependency assessment tool that calculated this was sufficient staff to meet people's needs. However, nurses were not always available to help with personal care as they were carrying out nursing tasks. This meant that if the two-care staff on the unit were supporting people who required two staff to meet their personal care needs there were no staff available to respond to other people's needs.
• Relatives told us there were not sufficient staff to meet people's needs. Relatives comments included, "There is a severe shortage of staff" and "My concern is that carer (care staff) numbers have gone down. I am worried about their being no-one about when they are helping with doubles (people who require two staff to support them)." One relative told us they had to wait too long for support for their loved one. This resulted in distress for both the person and their relative. The relative said, "I can't find anyone. I ring the bell, and no-one comes. It results in [person] becoming distressed".
• Staff were concerned about the staffing levels, with some becoming distressed when they spoke about the impact this had on people. Staff comments included: "I feel like I am not a good carer as I have to rush all the time. We are not meeting people's needs because we don't have enough time"; 'We're at breaking point. It's too dangerous. We can't do our jobs properly" and "There's no time to sit and make them smile.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment
• The provider had systems in place to enable them to make safer recruitment decisions. This included pre-employment checks.

Systems and processes to safeguard people from the risk of abuse

• Staff we spoke with had clear understanding of their responsibilities to identify and report concerns relating to harm and abuse. Some staff knew where they could raise concerns outside of the organisation. One member of staff told us, "I could call safeguarding at Swindon." Some staff told us the manager was the only person who could report to the local authority. The manager was aware of this and was working with the local authority to source additional training for staff to ensure they were clear about reporting outside of the organisation.
• The provider had systems in place to investigate and report concerns. The systems were being developed to improve effectiveness as not all concerns had been raised with the local authority safeguarding team when they initially happened.

Preventing and controlling infection
• The service was clean, well maintained and free from malodours.
• There was a lead housekeeper who monitored the quality of the cleaning to ensure all areas of the service were cleaned regularly and risks of infection minimised.
• Staff had access to personal protective equipment (PPE) and used it effectively.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments were completed prior to people moving into the service. Assessments were used to develop care plans to ensure people's needs were met in line with current guidance. This included ensuring support was delivered in line with National Institute for Health and Care Excellence (NICE) standards.

Staff support: induction, training, skills and experience
• Staff had completed a range of training to ensure they had the skills and knowledge to meet people's needs. This included training in how to support people with specific conditions. The manager was developing a training matrix to ensure staff had completed all training appropriate to their role.
• Staff told us they were being supported to access development opportunities which included access to national qualifications in health and social care.
• Not all staff had received supervision. However, the manager had developed a matrix for supervisions and appraisal which was being implemented. This identified who was responsible for completing staff supervision and when they should happen.

Supporting people to eat and drink enough to maintain a balanced diet
• People and relatives were complimentary about the food. Comments included; "What I've seen of the food looks lovely. The cakes are lush. We had cakes and coffee when [person] moved in, delicious" and "It's tasty food."
• Care plans detailed people's dietary needs and we saw that people received food and drink to meet dietary needs.
• People were supported to eat and drink where this was required. People were supported at a pace suitable to them. However, one person had their mealtime interrupted as the member of staff had to leave them to answer a call bell.
• The chef was knowledgeable about people's dietary needs and visited people to get feedback about the food. The chef ensured peoples' preferences were being catered for. One person told us, "The food is fine. The Chef comes in to see me every day. Just to see if I'm happy with my meal. I like cold for lunch and hot for the evening, so I had roast lamb last night. I tell him my preferences".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Records showed that people, had access to health professionals when needed. This included, speech and language therapy, dieticians, later life team and G.P.
• Care plans showed that where advice and guidance had been given this was followed.
• Health professionals told us people were referred appropriately to them. One health professional told us, "I

feel that the nursing staff are very receptive to my advice and patients are being appropriately referred."

Adapting service, design, decoration to meet people's needs
• The service was spacious and bright. People's rooms were personalised with their own belongings. One person was pleased to show us their family photographs displayed in their room.
• There was clear signage to enable people to orientate themselves around the service.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Staff had completed training in MCA and had a clear understanding in how to support people in line with the principles of the act. One member of staff told us, "In everything we do we need to consider if people have capacity. We cannot think just because someone makes an unwise decision that it means they lack capacity."
• Throughout the inspection we saw staff offering people choice and ensuring their choices were respected. Where people were assessed as lacking capacity to make decisions staff explained and ensured people were given choice and their rights protected.
• Care plans contained capacity assessments where there were indications the person lacked capacity to make a decision. All decisions were made in people's best interest.
• Where people had a legal representative appointed to make decisions on their behalf this was recorded in care plans. • Where people were assessed as lacking capacity to consent to support that may restrict their liberty, applications had been made to the supervisory body to ensure restrictions were applied lawfully.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and relatives were complimentary about the caring nature of staff. A relative told us, "The staff are kind. They look after her very well".
• Staff showed kindness and compassion when supporting people. Staff reacted promptly to signs of people's distress and were reassuring in their approach.
• Staff knew people well and used this information to support people in a way that respected their individuality.
• Staff spoke with genuine affection when speaking about people and were clearly committed to supporting people. One member of staff told us, "I'd rather put them first than us [when speaking about not taking breaks]."

Supporting people to express their views and be involved in making decisions about their care
• Throughout the inspection staff involved people in their care. Staff checked people understood what was happening and explained all aspects of their care to them.
• People and relatives were involved in reviewing care plans through the 'resident of the day' programme. Relatives who had been involved in reviews were positive about the experience and felt involved.

Respecting and promoting people's privacy, dignity and independence
• People were treated with dignity and respect. One person told us, "Goodness me. They're so respectful and kind. They always treat me with dignity."
• Care plans identified people's needs regarding respect and dignity. One person's care plan stated the person became frustrated if staff entered their room without knocking and that routine and privacy were important to them. We saw staff knocking on the person's door and waiting for a response before entering.
• People were supported with dignity and respect when requiring support with personal care in communal areas. Staff supported people in a discreet way and encouraged them to go to a more private area for support.
• Staff supported people to maintain their independence. Staff encouraged people to mobilise using walking aids. Staff also encouraged people to eat and drink independently where they were able.
• People's confidential information was stored securely. Where information was available electronically this was password protected to ensure information could only be accessed by those authorised to do so.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans did not always contain consistent, accurate information relating to people's support needs. A nurse told us that care plans were updated following reviews when people's needs had changed. However, one person's nutritional care plan stated, "fork mashable diet and thickener fluid". A review document, following an assessment by speech and language therapist (SALT), within the care plan identified the person required a pureed diet. The care plan had not been updated. We carried out checks to ensure this person was receiving the correct consistency of food and we were satisfied that they were, and this concern related to poor record keeping.
• Another person required regular repositioning as they were at risk of pressure damage. The person's mobility care plan stated the person required repositioning every two hours. The sleep needs care plan stated the person required four hourly repositioning. We carried out checks to ensure this person was receiving appropriate pressure care and we were satisfied that they were, and this concern related to poor record keeping.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans contained details of people's life histories, their likes and dislikes and what was important to them.
• Staff knew people well and supported people in a way that respected them as individuals. People had developed positive relationships that enabled them to feel cared for. One person living with dementia had a strong bond with one member of staff. The member of staff linked arms with the person and took them around as they carried out some of their duties. It was clear the person was comfortable and relaxed.
• The service employed two activity staff who arranged a variety of activities for people to enjoy. We saw people being supported to walk in the garden and a group enjoyed preparing fruit. One relative told us, "[Person] enjoyed the sofa football and loves singing and dancing".

Improving care quality in response to complaints or concerns
• The provider had a complaints policy and procedure in place. This was displayed in the service.
• People and relatives knew how to complain. One relative told us, "I am more than happy to raise any concerns."
• The provider ensured that all complaints were recorded and investigated. Records showed that complaints were responded to in line with the provider's policy.

End of life care and support

• Care plans included Treatment Escalation Plans (TEP), which identified people's wishes relating to admission to hospital and where they wished to be cared for when requiring end of life care.
• At the time of the inspection there was no one being supported with end of life care.

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

• There was no registered manager in post. There was a manager in post who was responsible for the management of the service. The manager had introduced a range of systems for monitoring the quality of the service. However, the systems were not always effective as they had not identified the issues we found in relation to people's dietary requirements and repositioning charts.

• The provider had systems in place to assess, monitor and mitigate risks relating to the health and safety of people using the service and staff. These systems were not effective as risks to people and staff were not managed to mitigate the risks associated with the delivery of care and support. For example, the risks associated with medicines management.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• Feedback about the management of the service was mixed. Some people and relatives were positive. For example, one relative said, "[Manager] seems nice." However, we received many comments about a poor culture in the service and that management were not visible or available. Comments included: "The problem is the management actually"; "[Manager] reassured me they have an open-door policy, but that is not the atmosphere in the home"; "I've never seen the new manager. They don't wear badges, so you don't know who's who."

• The manager spoke about developing a person-centred service and had introduced 'resident of the day' to ensure all staff knew people well. This meant that each day one person was identified, and members of all staff teams ensured the person was reviewed. This included a deep clean of their room, a review of their care plan and a meeting with a member of the catering team.

• Following the inspection the manager sent evidence of compliments they had received about the care people experienced at Abbey House.

• The manager was aware of their responsibilities relating to duty of candour. For example, a letter had been sent to a relative following an incident. The letter included an apology and stated what action had been taken as a result of the incident. However, not all of the actions had been carried out as stated in the letter.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• Relatives told us communication with the provider and management team was poor. Comments included: "We used to get a monthly record and programme [from the previous provider], not anymore" and "It's not going fantastically. I get no response to emails [from the manager]." Following the inspection the manager provided copies of a monthly newsletter that they had commenced in May 2019. This was to be made available to all relatives and people.
• There was a relative meeting on the second day of the inspection. The manager sent the minutes of the meeting to the inspector. The minutes showed that relatives had raised their concerns and the manager and area operations manager had responded to all concerns.
• Some staff were positive about the management team. One member of staff told us, "I can definitely go to [manager] with anything and she would listen." However, some staff declined to speak with the inspection team for fear of retribution and others we spoke with were concerned that the manager would know what they said. Staff felt morale was low and that their opinions were not valued. Comments included: "[Manager] is not open and transparent. We do not see her on the floor"; "New nurses are friendly with [manager]. Feels like a real divide and lots of staff have left" and "The manager is not approachable. I'm going to get told off for this [speaking with the inspection team] but I don't care."
• The manager had held a staff meeting when they first came into post. Staff did not always feel confident to have their say and told us the meeting was to tell them how things were going to change under the new management.

Working in partnership with others
• The service was developing close links with the local community. This included visits from local schools and a nursery, volunteers helping in the garden, local carers groups holding meetings in the service and holding community lunches for people who were living alone in the local community.
• Health professionals were complimentary about improved communication with nursing staff.
• The area operations manager and manager attended regular meetings with the local authority and clinical commissioning group to review the progress the service was making in relation to the quality of care.

Continuous learning and improving care
• The manager had introduced daily meetings with heads of departments to enable a daily review of the service, identify any issues and discuss how to resolve any concerns.

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 The provider did not ensure care and treatment was provide in a safe way for service users. Medicines were not always managed effectively. Risks were not managed to mitigate the risks to service users.

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 Systems to assess, monitor and improve the quality and safety of service were not always effective. Systems had not identified the issues we found relating to management of risks, staffing and records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient staff deployed to ensure service user needs were met and risk were managed.