Vijay Odedra and Partners

Abbey Lodge Care Home - Wolverhampton

Inspection report

Cranmere Avenue
Tettenhall
Wolverhampton
West Midlands
WV6 8TW

Tel: 01902745181

Date of inspection visit:
11 May 2016
12 May 2016

Date of publication:
17 August 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Our inspection took place on 11 and 12 May 2016 and was unannounced. We last inspected the service on 6 May 2014. At the last inspection on 14 May 2014 we found the provider was meeting the regulations. This inspection was brought forward due to safeguarding concerns that were brought to our attention by Wolverhampton City Council.

Abbey Lodge provides personal care and accommodation for up to 25 older people, some who live with dementia. There were 22 people living at the service when we carried out our inspection.

The service had a registered manager at the time of our inspection. 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 2008 and associated Regulations about how the service is run.

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 and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. 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.

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.

The provider had not met a number of regulations, and systems to monitor the service had not ensured risks to people were minimised. Potential risks to people were not always assessed, and staff had not consistently provided care to people in a way that was safe. Staff were aware of what abuse looked like and how to report allegations but this had not led to consistent reporting of allegations of abuse to the correct agencies. In addition, we had not always been notified of these as the law required. The provider had not ensured safe staff recruitment practices were in place. The provider had not always people's rights were considered when decisions were made on their behalf.

People were not always supported in a timely way and many told us they waited for assistance from staff. The provider did not have systems in place to review staffing levels to ensure these reflected people's needs.

People expressed satisfaction with how their medicines were managed and we saw staff gave these to people in a safe way.

Some people expressed confidence in the staff who cared for them, but this view was not consistent. We saw occasions where the lack of staff knowledge and skill was seen to impact on the effectiveness of the care provided to people. People had sufficient food and drink, but were not always offered a choice of meal. People's health care needs were promoted although communication so that people were up to date with referrals to other health care professionals could at times be better.

People told us they thought staff were caring. We saw occasions however where staff were not consistently kind and caring. People's privacy and dignity was not consistently promoted by staff and some staff had a poor understanding of how this would be promoted. People were able to be independent and could maintain relationships with their families though.

People were not always supported to occupy their time with the leisure pursuits they enjoyed. People said they were able complain, most confident their complaints would be addressed. Systems for recording people's complaints were not however robust. People or/and significant others said they had involvement in planning people's care, but some said they were not always kept up to date with important changes. Staff were able to tell us what people's likes and preferences, as detailed in their records, were, although these were not always met.

People said they were able to approach the registered manager and share their views or concerns, although some told us the registered manager was not always accessible. Staff said they received supervision but had mixed views about whether they were consistently well supported. Staff were not always confident their views or concerns would be responded to. The provider's systems for monitoring the service had not identified some significant shortfalls, including risks to people's well-being.

The provider was not meeting the requirements of the law in a number of areas. People were not safeguarded people from abuse and improper treatment. People did not always receive safe care. Systems were not in place to ensure fit and proper staff were employed. People's consent was not always sought in accordance with the law. Staff were not always supported with appropriate training. The provider had not always notified use of incidents they were required to. Systems were not in place to ensure the provider complied with the law. 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 safe

Potential risks to people's health and welfare were not always managed. While staff could identify signs of abuse and knew how to report these; they were not always escalated appropriately to the correct agencies. The provider had not ensured staff recruitment checks were in place. People may have to wait for assistance from staff on some occasions. People were satisfied with how they received their medicines.

Is the service effective?

Inadequate

The service was not effective

The provider had not always ensured that people's rights were protected in respect of how they were supported to make specific decisions. People expressed confidence in staff but we saw staff skill and knowledge could be better. People were not always offered a choice of food and drink. People's health care needs were promoted, but systems for communicating changes in people's well-being were not always effective.

Is the service caring?

Requires Improvement

The service was not consistently caring

People and visitors told us some staff were caring, but there were occasions where staff provided care in a way that was not respectful or kind. People were not consistently offered choice. There were occasions where people's privacy and dignity were not respected. People were able to be independent and maintain relationships with friends and families.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were not always able to follow person centred activities of their choice. People felt able to complain and most were confident any issues they raised would be addressed to their satisfaction, although systems for capturing complaints needed

to be more robust. People and significant others were involved in planning the care they received, but were not consistently kept up to date with significant changes. Staff demonstrated they were knowledgeable about people's likes and preferences, but these were not always considered.

Is the service well-led?

Inadequate

The service was not well led

The provider had not always met legal requirements, and systems to monitor the service were not always robust enough to ensure risks to people were minimised. People felt able to approach the registered manager to share their views when they were available, and some were confident these would be listened to and changes made. Staff said they received supervision but did not always feel well supported. Staff were not always confident their views or concerns would be responded to.

Abbey Lodge Care Home - Wolverhampton

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.

The inspection took place on 11 and 12 May 2016 and was unannounced. The inspection team consisted of three inspectors. This inspection was brought forward due to safeguarding concerns that were brought to our attention by Wolverhampton City Council.

We reviewed the information we held about the service before the inspection, including statutory notifications the provider had sent us since the last inspection. These are events that the provider is required to tell us about in respect of certain types of incidents that may occur like serious injuries to people who live at the service. We also spoke with other agencies, for example commissioners and the local safeguarding authority. We considered this information when we planned our inspection.

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

We spoke with eight people who used the service and twelve relatives. We also spoke with the registered provider, registered manager, two senior carers, four carers and one cook. We observed how staff interacted with the people who used the service throughout the inspection.

We looked at six people's care records to see if these records were accurate, up to date and supported what we were told and saw during the inspection. We looked at three staff recruitment files and records relating to the management of the service. These included minutes of meetings with people and staff, service improvement plans, complaints records, stakeholder survey records and the provider's self-audit records.

Inadequate

Is the service safe?

Our findings

A relative told us, "One staff is using the hoist when it's a two person job; they have not got the staff". They also said that the person had received marks on their hands and legs with staff not able to offer explanation. A health care professional who visited the service before our inspection told us people were seen sliding down off chairs and staff did not respond to the risk of them injuring themselves.

We found the provider had not ensured staff always took the necessary action to ensure people's risk assessments were followed and people were safe. For example, we saw staff using unsafe practices when transferring people with hoists. We saw one person was lifted with equipment to the point they had to support themselves on the tips of their toes. Health and Safety Executive (HSE) guidance on hoisting people states, 'The person must be able to consistently and reliably bear weight through their legs'. Lifting a person on to their tip toes would have reduced their ability to weight bear and put them at greater risk of injury due to instability. This was in addition to staff operating hoists on their own, when people's risk assessments clearly stated two staff should be available to operate the hoist. HSE guidance states 'In many cases, assessment will show that two handlers are required: one to operate the hoist; the other to help steady things and, where needed, support the person's lower legs to keep them in a safe position when moving from one place to another'. We asked the registered manager about what we saw and they confirmed staff should have followed the person's moving and handling risk assessment, namely to ensure two staff operated the hoist.

We saw some risk assessments were not sufficiently detailed to set out risks to people and how these should be minimised. For example, we saw people were assessed as needing the assistance of hoists and slings for transfers with no reference to use of manufacturer's guidance to ensure equipment was used correctly. The HSE state hoists and slings are to be used in accordance with manufacturer's guidance. This guidance would tell staff how to use the equipment safely. We asked the registered manager to show us copies of the manufacturer's guidance for the equipment the provider used, and they were unable to locate this. We found one person's risk assessment stated they needed a full body lifting sling. We saw the hoist, in the person's room was equipped with a toileting sling that would have been unsafe for the person. HSE guidance states, 'Access/toileting slings give a great degree of access but very little support and their use should therefore be restricted to toileting purposes, where appropriate'. We asked the registered manager where the correct sling was, but they were not able to locate it. The person's relative confirmed staff consistently used the toileting sling to transfer the person. The use of the incorrect lifting sling may result in inadequate support and therefore present an increased risk of the person sustaining an injury. We also found some pressure relieving equipment used for people assessed at risk of developing pressure ulcers were not maintained at the settings consistent with the person's weight. This meant there was a risk this equipment may not be effective. These issues showed people's care was not always provided in a safe way that prevented potential risk to people, and steps had not been taken to reduce the risk to people from use of equipment.

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

The registered manager and staff were able to tell us what potential abuse looked like, and what should be escalated to other statutory bodies to protect people from the risk of harm. However, we found there had been occasions when this had not happened. For example, a member of staff shared an allegation with us about another member of staff who they alleged had abused people who lived at the home. They said they reported this to the registered manager verbally and in writing. We asked the registered manager how they had responded to these allegations at the time they happened and they confirmed they had taken no action, even though they understood they should have on reflection. They told us the person alleged to have abused people was later suspended due to other allegations, not related to those raised by this member of staff. We also became aware of a person sustaining an unexplained injury. We spoke with staff and the registered manager and they were not able to give an account as to how this injury occurred. The registered manager had again not raised this as a safeguarding alert to the local authority, the lead agency for investigating allegations of abuse. The registered manager did report these events as safeguarding alerts, but only after we had raised concerns with them about the lack of escalation. This meant there was a risk the local safeguarding authority would not be able to protect people as the provider had not made them aware of allegations of abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place for recruitment of staff were not robust and did not ensure people living at the home were protected. We looked at the files for three recently employed staff and none had a Disclosure and Barring checks (DBS) carried out before they began work at the service. Two staff had a DBS completed some weeks after they were first employed during which time they were providing care to people. There was no evidence of update checks or baring list checks for any of these staff prior to employment. DBS checks include criminal record and baring list checks for persons whose role is to provide any form of care or supervision. We saw that the DBS checks for the newly recruited staff, while delayed, did not raise any concerns about their ability to work at the home however. We also found other pre-employment checks had not always been carried out. For example one of the staff had not provided any references and another had only one reference.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with had mixed views about the availability of staff. We received concerns from relatives prior to our inspection that people sometimes had to wait for assistance. A person told us, "Sometimes if [staff] are busy you have to wait, there should be more staff they are always busy". One visitor we spoke with said, "I believe they are short staffed" and when, "Two staff have taken one person to the toilet; there are no staff to take anyone else. They [people] have to wait so long for attendance, I worry when (the person) needs the toilet". Another relative said, "Sometimes not enough staff. Sometimes no cleaner. Sometimes no bin emptied as they have reduced the cleaners' hours".

On the first day of our inspection we were told a member of staff had phoned in ill and the provider had been unable to organise cover. A member of staff told us, "When people call in sick there is no cover". The registered manager confirmed they did not use agency staff and they were unable to cover for the staff member off ill. We saw occasions where the staff response to people's requests for assistance was delayed. We saw staff called away when assisting people when they were hoisted a number of times. Staff had mixed views; one telling us, "I think there is always enough staff on duty" whereas others said they needed more. A member of the night staff and the registered manager told us there were up to six people who needed the assistance of two staff which meant if staff were busy with one person they may not be able to respond to

anyone else. We asked the registered manager about how they had made a judgement about night staffing based on how often more than two staff may be required at night to meet people's needs. They told us they did not have a staffing tool to show how many staff were needed based on people's dependency. In addition they had not considered if times of accidents showed trends indicative of staff deployment issues. This showed the provider did not have systems in place to review staffing levels and could not demonstrate there were sufficient staff available who were deployed in such a way to ensure people's needs were met, and they were safe.

We found the provider ensured people's medicines were managed safely and people received medicines as prescribed. People told us they had their medicines at the times they needed them. One person said, "Staff always give you your medicines on time" and "Staff tell you what you medicine is for". A visitor told us they were satisfied their relative was getting their medicines as needed, this including painkillers when required. They also said that these were provided in liquid form that was easier for the person to take. We saw staff administer medicines and found this was carried out in a safe way. We found medicines were stored securely and recording in medicines administration records (MARs) was completed appropriately .However, where people took 'as required' medicines, protocols to tell staff how these should be given were not always available. The staff member we spoke with was able to verbally explain how they administered these, and records showed they were given as prescribed. We did see the senior, when administering medicines and wearing a do not disturb tabard was frequently interrupted due to requests for assistance from people or staff. We did not see this had impacted on how safely medicines were given. The senior did say this was a common occurrence though, and there was potential for errors.

Inadequate

Is the service effective?

Our findings

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. We looked at people's records and found there were no assessments in respect of people's mental capacity and ability to consent to specific decisions. The registered manager told us they had not assessed people's mental capacity, and there was no confirmation to show how people could be supported to make specific decisions, or to show when they may be unable to. The registered manager said they were aware people must be assumed to have capacity unless it was established otherwise. However a number of people we met presented as lacking some capacity, as confirmed by staff. We found staff and the registered manager were making decisions on their behalf. For example, some people had bedrails and while some people had capacity and had consented to the use of these, we were told other people were not able to make this decision. We saw some decisions had been made in respect of bedrails, by the person's relative, although it was not always clear that the relative had the legal right to make this decision. The registered manager said, after one person having a fall out of bed they had made a best interest decision, with their relative. They told us the basis for this was the person could not make any decisions, although there was no assessment to demonstrate how this was decided or whether they had considered the least restrictive options. Some relatives we spoke with did tell us they had legal authority to make decisions on behalf of the person but the staff team had no record of this. Some staff we spoke with did not have a good understanding of the MCA however and told us they had not received any training in this subject and would not know what their responsibilities were. The registered manager confirmed staff needed training in the MCA and this was planned for the near future. This showed that while staff did consider people's consent to care some staff needed training to ensure they knew what their responsibilities were in line with the MCA. This showed the principles of the MCA had not been followed and people's rights had not always been considered when making decisions on their behalf.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff asked people for their consent before helping them, for instance, before assisting people with personal care or medicines. One person told us, "If they [staff] have to do anything they always ask is it ok?" Relatives told us staff asked people about day to day decisions one telling us, "Staff do ask, they do oblige". Staff understood they should ask people about their day to decisions, for example one person told us, "I wouldn't force them to do anything they don't want to do for example, eating".

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 the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they were aware they should refer people to the local authority when people without capacity were restricted and they had made an application for one person. We were told this DoLS request was yet to be authorised by the local authority.

We heard mixed views from people and their relatives about the competence of staff. One person told us, "I think they [staff] are well trained. They do the job well and they look after me well". One relative told us, "Staff know what they are doing", another that, "I can't fault the staff". A number of staff told us they had not received training in care of people living with dementia, this despite a number of people living with dementia. A visitor told us from their observations staff needed training in responding to people appropriately when they became anxious. During our inspection we saw examples of poor or inappropriate practices due to the lack of staff training. For example, we saw occasions were staff did not respond appropriately to people living with dementia. One person was told not to do something as opposed to staff using appropriate diversion techniques. We also saw staff using hoists to move people in an unsafe way. We spoke with staff using this equipment and they told us they had not received training in how to use the hoist or sling safely, or other training in the principals of moving and handling people safely. This presented a significant risk to people as staff had not been trained in how to safely support them with their mobility.

Staff gave us mixed views about the training they received one saying, "I have asked for more training but not had it yet". Another said, "Did not have a lot of training with old manager, but the [registered manager] has arranged this training". The registered manager told us they had identified staff needed further training system when appointed last year. The registered manager showed us the staff training record which they confirmed was accurate. This showed a number of staff required training in a number of areas, for example moving and handling people, MCA, and caring for people with dementia, which the registered manager agreed staff needed. This meant the provider had not ensured staff had sufficient skills and knowledge to consistently provide people with effective care that reflected their specific needs.

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

We saw staff had access to a brief induction gave them an introduction to the home. This included senior staff signing off when staff had demonstrated learning but was seen to be completed within a two week period. The registered manager was unable to show us how the induction related to fundamental standards care workers would be expected to learn as covered by the care certificate. This certificate covers what staff need to know so they have a good basis from which they can develop their knowledge and skills. The expectation from Skills for Care (a national organisation that helps provide guidance on adult social care workforce training) is that new staff would be expected to complete an induction over a 12 week period to allow for appropriate assessment of their skills, and sufficient time to learn. This indicated new staff may not have an appropriate induction to nationally recognised standards that would allow them to deliver high quality care.

People expressed some mixed views about how they were supported with their health. One person said, "If you have a complaint with your health they get the doctor to come. Dentists and chiropodists also visit". A visitor told us staff ensured their relatives saw the doctor and other health professionals when needed. They also told us staff followed recommendations made by a visiting health care professional. People's records showed there was follow up in respect of identified health care issues, for example the doctor was called when people had infections and we saw their treatment commenced quickly. However, one person complained to us about their swollen ankles telling us they were painful. We told staff and they said they would inform the person's doctor. We asked later in the day and staff had not called the doctor about this person's concerns, and the information was not shared on handover with other staff. We saw that people had regular routine health care checks with for example opticians, chiropodists and dentists. This showed people's heath was promoted in partnership with community healthcare professionals, but staff needed to ensure people's health concerns were consistently escalated.

We asked people their views about food and drink. One person said, "We have a lot of mashed potatoes, we should ask for some new little potatoes". Another person said, "The food is alright but we don't get a choice, we would like more variation in the food". A third person said, "I would like a few more greens on the plate, and I don't know what the meal is until I get it". We saw displayed menus but these did not show what day set meals were to be served. People's preferences and individual requirements as to food they liked had been recorded and the cook was aware of these. People's preferences were not always provided however, for example we saw one person's likes and dislikes had been assessed by a dietician with a record of their preferred foods. This was so the person's diet would be encouraged with foods they liked as they had lost weight. We found the service had little of these foods available despite having had a food delivery the same morning; this meaning staff would have been unable to give the person their preferred foods. In addition when we saw staff assisting people living with dementia with their meals, they did not talk to them about the meal they had, or show them the meal before they ate it so they could make a choice. People told us when able to express a preference they could decide where they had their meals. One person told us when having breakfast, "I could have it in my room if I want ". At lunch time we saw staff focussed on serving the meals as a task, and did not use the opportunity to create an enjoyable social occasion for people. We saw one person sat alone on a table, with no interaction from other people or staff. We saw people did not have drinks and when we asked staff these were brought in, but no choice of drink was offered. We heard one person say, "One would like a sherry, not had one since I have lived here". This showed people were not actively supported to, or offered a choice of foods or drink and the dining experience was not promoted as a social occasion that would encourage people to enjoy their food.

Where there were identified risks to people due to poor diet or fluid intake we saw staff monitored people's weight, diet and fluid intake. When there was weight loss we saw the person's doctor was informed. A relative told us, "[The persons] weight is checked monthly, I ask how it is and now it's relatively stable". We saw staff identified a safe daily minimum fluid intake for people, but we saw, based on records, some people were not drinking these amounts. These concerns had been escalated appropriately. We asked staff how they would know if a person was dehydrated and they were unsure. The registered manager agreed that more specific information should be added to people's records so staff knew what the signs of dehydration may be.

Requires Improvement

Is the service caring?

Our findings

We saw the approach of some staff showed there was a warm and affectionate relationship between them and the people they cared for; however this approach was not consistent. We saw one person spoken to by staff in their preferred language and they presented as happy during the conversation. We saw another time where staff gave a person a hug when anxious which made them seem happier. There were other occasions where staff responses were not appropriate. For example, we saw when a person spilt their drink, the member of staff presented as annoyed due to their tone of voice and mannerisms. The approach of some staff was also very focussed on completing the specific tasks that were involved in caring for a person and not always the caring and social aspects, for example maintaining a dialogue with people during their care. For example we saw occasions where staff helped people with their meals and there was at times little communication. We saw they were trying to attend to the needs of more than one person which impacted on their approach. A relative said, "I can't fault the staff" but expressed concern that it took time to look after some people properly and this impacted on the staff approach, as they felt staff rushed people's care. We also saw only four people used the dining room at lunch time and a member of staff told us, "Just walkers and self-carers eat in dining room". Another member of staff was heard to refer to people that needed assistance with their meals as, "Feeders". Use of such terms showed some staff presented a lack of respect for people.

People who used the service told us staff were caring. One person said, "Staff are not too bad, they are very polite" another that, "The staff are nice, If they didn't treat me properly they would know about it". One visitor said, "Girls are lovely, very caring and helpful" and, "Staff are very caring". Another visitor said, "The way they treat [the person] when we are here, the staff are respectful". They said staff could be very caring but, "Staff get quite stressed at times, lose patience (with person) who is too anxious, then it carries on with another person, it's a training issue". They said people were not unsafe, but it was clear on occasions where staff were annoyed this was not conducive to fostering a positive relationship with people. This mirrored some occasions where we saw some staff could have responded more appropriately to people. For example we saw one instance where a member of staff responded to a person saying, "No, no, no you can't do that", when the person was touching a person sat next to them. The visitor said, "It can be a highly charged environment". This showed that the approach of staff was not always kind and caring.

People told us they were given some choices by staff, for example when they wanted to get up and go to bed but this was not consistent. People were not encouraged to make a choice at meal times, and people who we saw staff assist with meals were not offered a choice, by for example staff describing what the meal was. We saw occasions where people had food protectors put on and again while some staff did ask before putting them on, this choice was not given consistently by staff. People were offered assistance on occasions and we saw staff did not always interact with people. This contrasted to other occasions where staff talked through what they were doing through the time they were supporting the person.

People's privacy and dignity was not always respected. We saw occasions where people were assisted with equipment with the use of a hoist, this compromising people's dignity on a number of occasions. For example we saw one person's trousers were falling down during transfers. We also saw staff assist to lift

person's leg at which point their skirt rose up, this compromising their dignity. We also saw a person had a visit from a health professional during the inspection, and they had their consultation in the lounge, rather than in private. We saw staff did knock on people's bedroom doors before entry. People were also able to spend time in private in their rooms if this was their wish. We saw one person had a key to their bedroom door. Staff we spoke with had a mixed understanding of how to promote people's privacy and dignity, some able to describe very clearly how they would do so, others having a limited understanding of what this meant in respect of their practice.

People told us their independence was promoted by staff. One person said, "I do all my own personal care, staff allow me to be independent where I can". We saw where people were able they could move freely around the building and we saw occasions where staff encouraged people to do tasks for themselves for example eating or drinking with encouragement. A member of staff told us the registered manager encouraged staff to ensure people's ability to be independent was promoted.

People told us their relatives were able to visit at any time, this confirmed by visitors. Visitors also told us they were always made welcome. One visitor told us, "I come and go any time" another telling us that they were always offered hospitality and made welcome. Visitors told us that they were able to have privacy with people when visiting, either in the visitor's room or the person's own room. Relatives told us the visitor's room had been redecorated and this they thought made this a more pleasant environment to meet people. This showed people were encouraged to maintain important relationships with their friends and families.

Requires Improvement

Is the service responsive?

Our findings

We asked people how they spent their time. One person said, "I spend my day talking, I get bored. We think we are having events but nothing has happened yet, I would like things to do as we sit a lot". Another person said, "I am a little bit bored. We have had the odd game of bingo, could do with more activities", a third, "I spend the day just sitting here" and another, "I just sit around all day". A visitor said, "We feel [the person] needs more interaction", another telling us the service, "Could do with an activities co-ordinator". One visitor said the registered manager had made some improvements in respect of the activities available to people. They said there was a visiting singer, although they had not been recently. They told us a vicar visited and their relative enjoyed these visits. They also said caged birds recently provided were of interest to some people. We saw there was a programme of planned activities displayed, although we did not see staff spend much time on individual activities with people, apart from some limited occasions where staff sat and spoke with people or played games. We saw some people were actively watching an old movie on one occasion with subtitles. Staff told us they did try to arrange activities for example a music man, bingo and throwing a ball about but said people did not like getting involved. We discussed the importance of people having appropriate opportunities for occupation, and how this should reflect the needs of people living with dementia with the registered manager. They said they would arrange training for staff in dementia care, this with the intent it would give staff greater awareness of how to promote people's opportunities for occupation. This showed that people were not routinely occupied or supported to spend their time involved in chosen hobbies or interests.

People told us they were involved in planning their care. One person told us, "They ask what I want; They ask if they change anything is it working. We discuss my care". Visitors told us they were involved in reviews about their relative's care, and said these commenced shortly after the registered manager took up their post. One visitor who was able to make decisions for the person told us, "When [the manager] came they had a meeting with them and asked why is [the person] in room all the time. They said there is no reason and then ensured the person was sitting in lounge". The visitor said this was better for their relative as they could see more happening around them. Another visitor said they had discussed the person's care and, "They have tried everything we have suggested". Some relatives told us they had seen that information they had raised had been recorded in people's care plans and these reflected what some people and visitors told us was important for people in terms of their likes and dislikes. There were mixed views expressed about how well the service kept relatives up to date however. One visitor said, "If something is wrong staff will tell us" and another visitor said "Staff keep us up to date". Other visitors said they had not been made aware of changes to their relative's health and felt there was scope for improvement in this area. One visitor said the person had, "The person fell a couple of times and they did not tell us". Relative communication records did not carry a record of any communication of these falls. This indicated that people and their relatives were involved in planning people's care but were not consistently kept up to date with any significant changes in people's health.

We looked at people's care plans and saw things that were important for the individual were recorded. The registered manager and staff were able to tell us about people's needs and preferences. The registered manager said they ensured they under took assessments prior to people's admission to ensure they were

able to meet their needs, and we saw that people's care records contained supporting information from services people used before they came to Abbey Lodge. They also told us about one person who had been reassessed by commissioners. We were told the person was to move to a service that was better able to meet their needs in the near future. The registered manager told us they were arranging reassessment by commissioners of some other people due to their complex needs. This was confirmed by staff we spoke with who said the overall dependency of people living at the service had decreased, although there was still a number with complex needs. This indicated the registered manager was aware that the service had difficulty meeting some of the complex needs of people that had, and were still living at the home.

The registered manager said the views of people and their relatives were sought in a number of ways. The registered manager said they had planned meetings with relatives although attendance had been low. Relatives confirmed awareness of these meetings but some said they did not attend, one saying they did and no other relatives turned up. They said the meeting arranged for the next day was cancelled as the registered manager was not available. People told us they could talk to staff. A relative said, "I can talk to the [staff]" and they listened to what they said. One person told us however, "We don't have resident's meetings and they don't send me any questionnaires". Another person said, "They don't ask us any questions about living here". We saw completed questionnaires received by the provider in March 2016. These showed systems for gaining people's views were developing, but based on people's views not everyone felt involved.

People we spoke with said they could talk to staff and said they had no complaints. We saw information about how to complain was available within the service although the information within this was out of date. One person told us, "I can complain, I haven't needed to complain, I would talk to the manager or staff, and I would feel confident". A relative told us, "I ask at one level, if this does not work I go to the next level", but said the service had responded to comments and they were confident when they complained "Everything was acted upon". The registered manager said they had not received any complaints in the last 12 months but said any concerns raised would be investigated and outcomes fully documented. The registered manger had investigated some concerns people raised and we had seen investigation reports the provider sent to us, although these were not logged with the provider's complaints record, and there was no copies of feedback to the complainant recorded. Staff were aware of the importance of escalating any complaints made to them to the registered manager or provider. The registered manager said complaints could be verbal or written although there were no records of verbal complaints a relative told us they had raised one recently. This indicated there was not robust systems for ensuring people's concerns were monitored, with outcomes consistently fed back to them.

Inadequate

Is the service well-led?

Our findings

The registered manager had an understanding of some of their responsibilities in terms of the law, but there were occasions when they had not met these. For example, they had not consistently met their legal obligations around submitting notifications to CQC and the local safeguarding authority. The provider is required to notify us certain significant events by law, but had not always done so. For example we had not been notified of allegations of abuse until we identified these at the inspection and made the registered manager aware of the requirement to formally notify us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw the provider's auditing systems had not consistently ensured risks to people's safety were identified and actioned. We saw accidents were recorded with these monitored monthly for trends and patterns. We saw some actions identified in response to these, for example the use of bed rails. However, the times accidents occurred were not considered meaning trends that were time specific would not be evident. While we saw the number of accidents had reduced recently there was still a significant number of unwitnessed falls between October 2015 and March 2016. One accident report stated a person was injured due to an exposed screw on their bedside locker. The registered manager said this record was incorrect but was unable to explain why. There was no exposed screw on the locker when we saw it but we found risks not identified by a recent room audit. For example there was other furniture with exposed screws and a trailing electrical cable that could be a trip hazard. We found other risks, these not identified by the provider's audits. For example we saw dirty bed bases and falls mats used on the floor kept on top of beds when not in use, which may present infection risks. A relative told us, "The [person's bed] room is awful I think they [staff] turn a blind eye". This showed the provider's systems for monitoring accidents, and environmental risks were not always effective.

We found there was a need for review of staffing levels and asked the registered manager if they had a system to identify safe staffing levels based on people's dependency. A commissioner's visit report in September 2015 had asked the service to introduce a dependency tool to ensure there was effective staffing throughout the day and night. The registered manager was aware of this report but said they had not introduced a system for identifying what were safe staffing levels based on people's dependency. This meant the provider did not have a system to ensure there was sufficient staffing that was responsive to people's changing dependency levels.

In addition we found systems to ensure checks of new staff took place had not been effective. This had led to employment of staff that had not been appropriately checked at the time they commenced employed. We saw records of provider visits, the last dated February 2016 that had not identified the significant shortfalls in the way the service was led, as found at this inspection. We also found other areas in addition to those detailed above that further evidenced the ineffectiveness of the provider's quality monitoring. This included ensuring staff not having received sufficient training and not ensuring people's right to consent was consistently promoted. This showed system to ensure the provider complied with regulations was not always effective.

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

Some people and relatives said there had been some improvements recently. One relative said, "In general much better than it was" another that, "Its 100% better since the registered manager took over, "We feel [the registered manager] keeps staff on their toes". They said there had been redecoration of some rooms, some new furniture and better involvement in planning their or their relative's care. We saw positive comments from people about the care they received in recent survey forms the provider had sent out. People did comment about the registered manager not always been available. One person said, "The manager is not here much". Staff had mixed views about the availability of the registered manager who was usually said to be at the other care home they managed. Staff said most of their support came from the deputy manager who they were positive about. We spoke with the registered manager about having sufficient time to manage the home and they said as they were the registered manager for two care homes that were a distance apart this did present challenges. This indicated the management arrangements for the home would benefit from review.

Staff said they had regular one to one meetings with the registered manager or deputy where they could discuss their work which they felt were useful. One member of staff said, "We get regular supervisions. I feel I can say what I want" another that, "We have staff meetings, we can all say our opinion I like that it's a good thing". A third member of staff said they were, "Very supported by manager" although said staff teamwork needed improvement. Staff had mixed views as to whether the registered manager and provider would act on what they said. One member of staff said, "I want it to be better but I don't think it is". Other members of staff said the registered manager did not always act on issues, for example some staff said they voiced concerns about staffing levels but these were not actioned. This showed that while staff said they were supported they were not confident issues they raised would be actioned.

Staff told us they knew how to raise concerns and contact the provider and 'whistle blow' if needed. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, dishonest, or not correct within an organization that is either private or public. We had found an allegation of abuse escalated to the registered manger was not reported to the local safeguarding authority.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not always notified CQC of other incidents when required to do so. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not followed the principles of the Mental Capacity Act 2005 and as a result people's rights to consent had not always been considered when making decisions on their behalf. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that care and treatment was always provided in a safe way to service users by consistently assessing the risks to service users and doing all that was reasonably practicable to mitigate these risks. Regulation 12(1) & (2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not always taken action to ensure allegations of abuse were investigated immediately on their becoming aware of such allegations. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not developed robust systems that would ensure risks to the health, safety and welfare of service users that would arise from carrying on the regulated activity were routinely assessed, monitored and mitigated. Regulation 17(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not operated recruitment procedures effectively to selected staff that could safely support the carrying on of the Regulated Activity. Regulation 19(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had sufficient skills and knowledge to consistently provide people with effective care that reflected their specific needs. Regulation 18 (2)