Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Abbeville Residential Care Home is a service that provides care and support for up to 38 older people and people living with dementia. At the time of our inspection there were 27 people living at Abbeville Residential Care Home.

This service requires a registered manager to be in place. 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. There is a registered manager in place at Abbeville Residential Care Home.

The inspection took place on 9, 10 and 21 December 2015 and was unannounced.

We carried out an unannounced comprehensive inspection on 28 January 2015. At that inspection we judged that the overall rating for the service was Requires Improvement due to breaches of regulations (under

Summary of findings

HSCA 2008) in medicines management and administration and also concerns that the service was not adequately protecting people from the risks of social isolation.

We carried out an unannounced focussed inspection on 15 July 2015 to check if the provider had followed their plan to improve medicines management The focussed inspection found that the required improvements had not been made. Consequently the CQC wrote to the service and told them that they had to make the necessary improvements by 7 September 2015.

A further unannounced focussed inspection was carried out on 1 October 2015 to check that the required improvements identified and highlighted by the inspection on 15 July 2015 had been made. This inspection found that the service had made improvements but that further improvements were needed with regard to the management of medicines.

Most of the people we spoke with who lived at the home with felt safe and were in the main happy with the level of care that they received. Staff had the knowledge to protect people from abuse and how to deal with any safeguarding concerns.

Some people living at the home and some relatives felt that at times there were not enough staff available to meet people's needs..

People's medicines were kept securely and safely and staff authorised to administer people's medicines had received appropriate training. However, the records for medication did not confirm that people always received their medicines as prescribed. Also supporting information was not always available alongside medication administration record charts to assist staff when administering medicines to individual people.

During our visits the lift was being replaced which was having an impact on people's livesThe equipment that people used had been serviced to make sure that it was safe.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. There was evidence that the service had assessed some people's mental capacity and had appropriately applied for DoLS where necessary.

The staff demonstrated that they understood the principles of the MCA. This protected the rights of people who lacked capacity to make their own decisions.

People received enough food and drink to meet their needs, however, people were not regularly given choices about what they ate on a daily basis. People saw health professionals as and when they needed to maintain their wellbeing.

Staff treated people with respect and kindness and worked to promote people's dignity but there were times when dignity and privacy was compromised.

People's care needs had been assessed when they first arrived at the home and that these records were mostly regularly reviewed. However, the records to monitor the care people received were not consistently completed.

The service did not always seek the views of staff and people living at the home to help them to monitor the quality of the service provided. The quality assurance system that was in place was not effective in identifying areas where improvements were needed.

There were breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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. Where necessary, another inspection will be conducted within a further six months, and if there

Summary of findings

is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

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 is not safe.

Risks to people's safety had not been regularly reviewed and updated. Records did not provide staff with adequate guidance about how to reduce risks to people.

The management of people's medicines continued to be unsafe.

The provision of staffing levels was not based on an effective dependency assessment tool

Inadequate

Is the service effective?
The service was not always effective

People received enough food and drinks to meet their needs but they had little choice about their meals.

People had regular and timely access to health professionals.

Staff received training but staff competency was not assessed to ensure that the training had been effective.

Staff understood the principles of the Mental Capacity Act 2005 to make sure that the rights of people who lacked capacity to make their own decisions were protected.

Requires improvement

Is the service caring?
The service was not always caring

Staff treated people with kindness and compassion. In general, people's privacy and dignity was respected although there were occasions when this was compromised.

People were not involved in the planning of their own care.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's care needs were not always reviewed regularly to ensure that staff were aware of people's current care needs.

The activities co-ordinator worked hard to reduce the risk of people experiencing social isolation but people still felt that there were limited activity options.

Requires improvement

Is the service well-led?
The service is not well-led

Inadequate

Summary of findings

The necessary improvements had not been made to ensure that medicines were managed safely despite the provider being advised of this previously.

The quality assurance system was not effective and did not identify the areas in need of improvement.

Staff felt supported by the manager.

The manager and provider did not always seek the views of people and staff as a means to improve the quality of the service.

Abbeville Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9, 10 and 21 December 2015 and was unannounced.

The inspection team consisted of two inspectors, one of whom was a specialist pharmacist inspector, and expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed records we hold about the provider and any statutory notifications that they had sent us. A statutory notification is information about important events which the service is required to send us by law. We also looked at the reports from the three previous inspections carried out in 2015.

On the days we visited the service, we spoke with seven people who lived at the home, three relatives, the registered manager, the cook, the deputy manager and three other members of staff. We observed how care and support was provided to people. To do this, we 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 also spoke to a visiting health professional and the local community nursing team. We spoke to the local authority quality assurance team to gain their views on the service.

The records we looked at included six care plans, three staff recruitment and training records, ten people's medicine records and records relating to how the quality of the service was monitored.

Inadequate

Is the service safe?

Our findings

During our last inspection in October 2015, we found that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because one person had been placed at risk of harm due to not receiving their medicines as the prescriber had intended.

At this inspection we found that the service was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On 21 December 2015, our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Medicines were stored safely for the protection of people who used the service and at correct temperatures. Care staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks.

However, medication records did not confirm that people were receiving their medicines as prescribed. When we compared medication records against quantities of medicines available for administration we found numerical discrepancies including records for the administration of anticoagulant medicine warfarin. Records for the receipt of medicines at the home were not always completed. There were gaps in records of medicine administration including numerous gaps in records for the administration of medicines prescribed for external application.

Supporting information was not always available alongside medication administration record charts to assist staff when administering medicines to individual people. For some people there was no personal identification to help ensure medicines were administered to the right people or information about how they preferred to have their medicines administered. Where charts were in place to record the application and removal of prescribed skin patches, there were gaps in the records. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines, however, the information had not recently been reviewed. Therefore people may not have had these medicines administered consistently and appropriately. The service had risk assessments in place for most people which could be found in their care plans. However, of the risk assessments that were present in the files some had not been reviewed recently. One person's records indicated that they were at high risk of falls but their Falls Risk Assessment had not been reviewed since 30 June 2014. This showed that people living at the home were not safe as the risks to them were not being regularly monitored as there was no clear indication as to whether this person had suffered any other falls.

We looked at the audit records for the home and saw the section on record of accidents. In this section there were details of accidents that had been suffered by people at the home. The totals of accidents suffered by individuals were completed but there was no evidence of analysis of the accidents such as what time of the day they occurred, what part of the building they occurred or if the person had any health conditions that might have contributed to the accident. This indicated that the home had not looked at possible causes of accidents in order to try to prevent repeated accidents in the future. This told us that the service did not have an oversight of managing risk to people in the home.

There was no evidence of Malnutrition Universal Screening Tool (MUST) assessments being carried out for people whose records we saw. We looked at the weight monitoring charts for six people living at the home. The service had not weighed any of these people between May 2015 and November 2015. The manager confirmed that people not been weighed during this time. We also saw that one person had lost ten per cent of their body weight during this time. We could not find evidence of a review of this person's nutritional care plan for over a year and we also could not find any plan to support this person to improve their nutritional intake.This showed us that the people's health was at potential risk because the service was not effectively monitoring people's weight and consequent nutritional needs. Nutritional intake for people considered to be at nutritional risk was recorded in their daily notes. This meant that an accurate overview of the persons nutritional intake was difficult to monitor.

There were records of Waterlow assessments of tissue viability in each person's file. These assessments are used to assess the risk of the person developing pressure areas. However, there was no indication of the date of when these assessments were carried out and no evidence that they had been reviewed. Two people's Waterlow assessments

showed that they were at high risk of developing pressure areas. However, within their care plan folders we did not find action plans to manage the risk to their skin integrity nor any records of when these people were turned in bed to reduce the risk of them developing pressure areas. The manager told us that staff made records in the daily notes of when they turned people in bed but we found that it was difficult to form an overview of how the risk of skin integrity breakdown was being monitored and managed.This meant that the service was not able to consistently identify people at risk and take action to prevent pressure areas from developing.

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

People told us they felt safe living in the home. We were given mostly positive feedback from people and their families. One person who lived at the home told us, "Yes, safe - but I wish I could lock the door. I understand why I can't but it'd be safer if I could".

We spoke to members of staff who told us that they felt confident to report any concerns about potential abuse to their manager and the relevant authorities. Staff were trained in recognising signs of abuse and avoidable harm. We saw evidence in staff files of the safeguarding training that had been provided.

Staff clearly knew the people living in the home well enough to recognise indications of abuse. However, the inconsistent and inaccurate records and monitoring of people's medicines presented a potential risk of abuse by neglect to people living in the home. This risk had not been identified by staff within the service. This showed us that people living at the home were not always safe.

On the day of our inspection we were told that the lift for the home was being replaced. This meant that people living on the first and second floors of the home would have had to use the stairs to access the ground floor and or leave the home. Some of the people living at the home had poor mobility and were unable to use the stairs so were restricted to staying on the first or second floors of the home. Also two people living at the home had moved bedrooms so that they stayed on the ground floor while the lift was being replaced. This meant that they were unable to access their own rooms for a period of time. We were told that the people involved and their families had been consulted on these temporary measures and were in agreement with them.

The views of some of the people living at the home and their relatives were variable regarding staffing levels and capabilities. People told us that that they felt that sometimes there were not enough staff on duty over weekends. One relative told us, "No, definitely not. We come every day and see and hear what goes on. Weekends are dreadful. They're supposed to have three staff on but if someone rings in sick there's only two". Another relative told us, "They leave people on the toilet for ages and that's after they've waited a long time to get help to the toilet. I try to help while I'm here; I go down and make cups of tea". One person who lived at the home told us, "I've waited an hour and a half at night. There are only three of them [care staff] on at weekends". Another person told us "We don't wait that long. There's one less [care staff] at weekends".

The registered manager told us that they did not use a formal needs assessment tool to assess staffing levels and preferred to assess staffing requirements more reactively based on their own judgement. We saw staff rotas for the time around our visits and, based on the homes own assessment of staffing required, these confirmed that there were sufficient numbers of staff working at all times in the home. However, people using the service and their relatives did not always agree with this.

The manager ensured that only suitable people were employed to work there. We saw staff files had copies of the interview checklists, evidence of police checks, references and copies of identification. There was also evidence of the training that the staff had received including: safeguarding, fire training, first aid, food hygiene, Deprivation of Liberty Safeguards (DoLS) and dementia care.

Requires improvement

Is the service effective?

Our findings

We asked relatives of people living in the home whether staff met people's complex needs and communicated with people effectively. One relative told us, "In my view, they need training in dementia. Communication is lacking". One relative told us that they were not confident that the staff would recognise the signs if their relative was unwell. They said, "No, they wouldn't pick it up. [Relative] tells me if she's not well".

The staff files that we looked at showed how staff were supported to develop their skills and there was evidence that they had received relevant training in a variety of areas of practice. We saw evidence that staff had received training in a range of topics including the Mental Capacity Act, fire training, person centred care, communication and dementia care. We saw staff putting the training into practice, for example asking for people's consent before commencing care tasks and communicating in a manner that was appropriate to the needs of the person. However, despite staff having received training regarding medecines management, this was not managed safely.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Staff we spoke to demonstrated that they understood the principles of the Mental Capacity Act (MCA) 2005 and the duty to obtain people's consent to treatment. In one person's care file we saw a record of a mental capacity assessment having been carried out and that a referral for DoLS had been made on their behalf. However, there was no record in the file as to whether this had been acknowledged by the local authority. This was raised with the registered manager who was unaware that an application had been made for DoLS in respect of this person. A letter from the local authority acknowledging the request was subsequently found amongst other paperwork in the manager's office.

We spoke to staff to enquire what impact there was on this person's liberty. We were told that this person had difficulty making choices due to problems with their memory and that staff acted in the person's best interests.

The registered manager told us that there were plans for senior staff to be trained in assessing people's mental capacity in order to improve this aspect of the service's practice.

People were supported to eat and drink enough. A relative of one person living at the home told us, "I bring in things [relative] likes such as fruit in little pots. They [residents] don't get enough drinks, often less than three times a day, so I go down and make tea for them [relative and other people]". People told us that they had choices regarding their meals. For instance, one person told us, "I have my food in my room. If I'm downstairs I come up to eat. I'm not fussy but my husband is. My daughter brings him scampi in for the chef to cook…They [care staff] bring us hot drinks. They know what I like. Oh yes we get enough to eat and drink".

We spoke to the cook who told us that they spoke to people when the first arrived at the home to find out what they liked to eat and if they had any special dietary requirements. The cook told us that special dietary requirements were recorded in the kitchen diary. People's preferences for food and drink were also recorded in their care plans. Some people had dietary care plans present in their care planning folder where details of special dietary needs were recorded.

We were told that the cook spoke to everyone at breakfast time to find out their lunch choice. The cook also told us that they knew people's preferences well and also communicated with their families to check people's likes and dislikes. We asked how the choices were managed for people who have problems with their memory. The cook was unclear about this and stated that they knew what people did and did not like. We observed that weren't offered a choice of hot meal at lunchtime. We were told that the staff knew what people liked. This showed us that people living at the home had adequate amounts to eat and drink but that they were not always given choices about what they ate on a daily basis.

People living at the home had regular access to healthcare services with a GP from a local practice visiting every week to monitor people's health. The manager told us that staff

Requires improvement

Is the service effective?

monitored people's health needs and passed on any concerns to the management team who then notified the local GP practice or community nursing team. We saw leaflets in people's care plans that gave detailed information about health problems specific to that person.

This told us that the service was providing additional information to staff to enable them to better understand and support the health needs of people. A family member of one person told us "[Relative] sees the home doctor who comes once a week or more if necessary".

Requires improvement

Is the service caring?

Our findings

We saw some care plans where people and their families had been involved in discussing their needs and how to meet them. However, in other people's care plans there was no evidence that the person or their family had been involved in discussing their care. Peoples' care plans did not include their choice of gender of carer for providing their personal care. A relative told us that their female relative was unhappy with a male carer providing her with personal care.

We asked people and their relatives about their involvement in the care planning process. We were told by one person, "Not really, they sorted me out though. I wasn't well. I was awful when I came in, but I'm getting better now. I'm a bit more aware of what's going on". Another person told us, "Yes they talked all about it when I came in on Monday". One person's relative told us, "No there's no communication, another person told us "No, I involve myself though". This showed us that people are not always involved in planning their care.

We observed how staff interacted with people living at the home. We saw several interactions between two people and staff and this was positive. The staff were attentive and polite towards people. We saw that people were treated with kindness and compassion. For instance, we observed a member of staff kneeling down by one person, who had recently sustained an injury. When the member of staff commenced their shift, they had gone straight to the person to enquire how they were. We observed staff treating people with respect by asking them for their consent to complete care tasks and knocking on people's doors before entering their room.

We were concerned that two people's dignity and privacy was at risk while the lift was been renovated. The registered manager was aware of the issues and how they might affect the people and had contacted the local authority DoLS team to clarify the situation regarding people being restricted to the upstairs of the home while the lift was unavailable. During the work on the lift some of the communal areas were being used as temporary bedrooms for two people who needed to be on the ground floor of the home. The service had put in place measures to mitigate the risk to people's dignity by using mobile screens and taking the areas out of communal use.

Requires improvement

Is the service responsive?

Our findings

During our inspection in January 2015 we found that people were at risk of social isolation due to a lack of meaningful activities being provided at the home. We recommended that the provider made improvements in this area.

During this inspection in December 2015 some people living in the home told us that there was still room for improvement in this area. One person told us, "There's nothing much. I do like to play games and cards now and then". Another person told us, "They [care staff] wanted me go and learn to cook. I know how to cook and anyway my knees and legs are too painful".

We talked with the activities co-ordinator who worked at the home on three mornings a week who described of the challenge of finding activities to interest people who lived at the home. They told us, "A group of about eight people like to play bingo. They also like to play other games. They (people) do a cooking session from time to time and one they held last week making biscuits was well received. There were six residents who joined the group but only four wanted to do it in the end so the other two watched". The activities co-ordinator told us that they raised funds by raffling donated gifts for the residents' fund, which paid for outings from time to time. The last outing had been to The Time and Tide Museum in Great Yarmouth. We saw records of people's attendance at activity sessions in their care plans. People told us that they had choices. One person told us, "Oh yes, if I don't want to do activities I don't".

The care plans were variable in respect of detailed information about people. Some had detailed information about people whereas other care plans had very little. We saw information about people's life histories under the heading 'More About Me' in some of the care plans that we viewed. We also saw information about people's choices regarding food and drink likes and dislikes and preferences for sleeping and requirements for sensory aids. This showed us that the service didn't always take account of people's individual preferences when planning care.

Most of the care plans that we saw had been reviewed recently but some had not been reviewed for over a year. This meant that the staff did not always have accurate information about how to meet people's needs.

Some people told us that they felt able to raise any complaints that they had about the service. One relative told us, "I'd speak to the manager if I had to". Complaints leaflets were available in the reception of the home for people to use and we were told that complaints leaflets were included in the welcome packs given to people when they arrived at the service. However, some people who we spoke to seemed unaware of the complaints procedures.

Inadequate

Is the service well-led?

Our findings

When we inspected the home in August 2014 we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 in respect of medicine management. The service was found to remain in breach of the same regulation at the inspections in January 2015 and July 2015. A warning notice was served as a result of the inspection in July 2015 and in September 2015 we met with the director of the company and the manager to discuss our concerns. Some improvements were made but at the inspection in October 2015 the service remained in breach of this regulation.

At this inspection we identified further concerns about the management of medicines which meant the provider remained in breach of Regulation 12. The manager told us that there were monthly checks of medicines and their records but we concluded these were ineffective at identifying and resolving medication issues.

We looked at audits for other aspects of the service and found that they were not effective and had not identified the issues we have highlighted in this report. We saw evidence of the intention to keep robust records for the service but these were mostly incomplete. For instance, assessments of risks to people's health and welfare had not been adequately completed. They were not always dated and did not contain accurate and up to date information. We looked at the quality assurance folder but there were several areas that were incomplete including the medication audit which was last completed in June 2014 and the environmental audit which had not been completed at all..

We saw evidence of the training that staff received and the manager told us that training was organised by a staff member from another service within the parent organisation. However, the manager did not have an overview of the staff training and therefore there was no plan in place to ensure that staff training was up to date.

The registered manager told us that they did not use a recognised tool to calculate staffing levels based on the needs of people using the service. Several people told us that staffing levels were not sufficient and at times their needs were not met in a timely way. The service had not identified this issue and therefore had not taken action to make improvements to the quality of care in this area.

People had mixed views regarding the visibility of the manager. Some people told us that they felt able to speak to the manager about their concerns although some were unsure of the effectiveness of doing this. One person's relative told us "I feel I can talk to the manager but I'm not sure it has an impact. Staff morale is up and down". However, staff told us that they considered staff team morale to be good.

We saw evidence of surveys for people living at the home, visiting professionals and staff but the most recent was a year old. The registered manager told us that they had been concentrating on correcting the issues with medicine management over the past year and had neglected the issue of gaining feedback from people living at the home, their families and staff. One person told us, "There's been no meetings I'm aware of". This showed that the provider was not actively involving people and staff in developing the service. A relative told us "We have never been asked for our views, been given a questionnaire and there are no meetings. Staff morale seems very wavy, up and down". This showed us that the service does not regularly seek the views of people using the service as a means of driving an improvement in quality.

Staff told us that the registered manager and their deputies were visible and accessible at all times. They felt that the registered manager was very supportive and took on board any issues and dealt with them appropriately.

The registered manager told us that staff received formal supervision at least four times per year and frequent informal supervision as they worked. Although staff confirmed that they had recieved regular supervision, there was no evidence that the manager had identified any of the areas of concern that we have identified in this inspection.

We saw that there was a record of complaints received by the service and that each complaint had been investigated and any required action had been taken by the service. However, we were not confident that the service always encouraged feedback from people living in the home and their relatives.

We concluded that the provider had a lack of effective systems in place to ensure the quality and safety of care delivered to people was good. These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

The manager and deputy manager told us that they had an open door policy and were always available to staff to discuss problems. The manager and deputy manager told us that they regularly worked with the other care staff to model good practice and identify any weaknesses in practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not being provided in a safe way because risks were not always identified and mitigated. People's medicines were not being management safely. Regulation 12(1)(2)(a)(b)(f)(g)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to or maintain accurate medicines records. Regulation 17(1)(2)(a)(b)(c)(e)