Abbeville RCH Limited

Abbeville Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 26 April 2016 and was unannounced.

Abbeyville Lodge provides residential care for up to 20 people, some of whom may be living with dementia. At the time of our inspection 18 people were living in the home.

The registered manager had left the service in August 2015. A new manager was in post and in the process of applying for registration. 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.

This inspection found that the provider was in breach of four regulations. These related to safe care and treatment, staff training, person centred care and governance.

Risks to people's wellbeing were not routinely identified or acted upon. A screening tool used to identify the risk of individuals developing pressure areas was not regularly reviewed. People were not weighed regularly and a nutritional screen tool was inconsistently used. This meant that the service would be unaware of ongoing risks in these areas.

There were substantial risks of infection to people from the lack of cleanliness in the home. As a result of the level of our concerns about this we alerted the local authority's public health team.

People were not always receiving the medicines, including creams, that had been prescribed for them. There was a lack of knowledge about environmental risks and what was required to ensure that the environment was safe.

Staff training was out of date. This meant that people may have been receiving care or support that was not appropriate or safe. There were enough staff to ensure that people's needs could be met.

Care planning was poor. Care records were generic and people's specific health or emotional needs had not been assessed.

The manager was new in post and they had not been adequately supported or guided by the provider. The provider did not audit the service and there were no review mechanisms in place to determine whether the content of people's care records were satisfactory.

Staff were kind and well intentioned but we found instances when people's dignity had not been respected. Staff were supportive of the manager and we reviewed positive feedback from health care professionals familiar with the service.

People living in the home had good relations with staff but there was little communication between people living in the home. There was limited staff time available to support people socially and to participate in activities in the home. However, a new activities co-ordinator had recently been employed and they had brought lots of ideas with them.

People were regularly consulted in the planning and delivery of their care. Staff demonstrated that they knew people well and people's individual preferences were respected.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's welfare were not always reviewed to ensure that any concerns could be acted upon promptly.

Some parts of the service, particularly bathrooms and people's bedding, were unclean.

People's were not always receiving their medicines as prescribed.

There were enough staff to ensure people's care needs were met.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Most staff training had expired.

People's ability to make their own decisions had not been consistently determined.

People received a choice of food and drink in sufficient quantities.

People had access to health professionals to maintain their wellbeing and act upon any concerns.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The environment was not conducive to upholding people's dignity.

Staff treated people with warmth and kindness.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual preferences had been determined but there was little information to guide staff how to support people with specific health conditions.

People were able to raise concerns with the manager and they had confidence that they would be dealt with fairly.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not provide adequate leadership or support to the manager, who was new to their role.

The provider failed to monitor the quality of the service.

The manager had the support of people in the home and the staff. However, their management of home fell short because of the lack of input from the provider.

Abbeville Lodge

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.

This inspection took place on 21 and 26 April 2016 and was unannounced.

The inspection team comprised of three inspectors, one of whom specialised in the management of medicines.

Prior to this inspection we reviewed information we held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notifiy us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters. We also reviewed information we had requested from the local authority safeguarding and quality assurance teams.

During the inspection we spoke with nine people living in the home and relatives of three people. We made general observations of the care and support people received at the service throughout the day. We also spoke with the manager, four care staff, the cook and a visiting community nurse. We reviewed four people's care records and medicines administration record (MAR) charts. We viewed two records relating to staff recruitment as well as training, induction and supervision records.

We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

This inspection found that some risks to people's wellbeing were inconsistently assessed, monitored or acted upon. Pressure area assessment tools were often undated and not reviewed regularly. People were not weighed on a regular basis. In February 2016 the service started to use a nutritional screening tool, but this had not been subsequently utilised. Whilst people's care records were reviewed monthly, nutrional screening re-assessments were not always carried out. The combination of infrequent weighing and nutritional screening meant that the service was at risk of not promptly identifying nutritional risks to people so that action could be taken. The failure to regularly update pressure area risk assessments meant that the service was not determining the ongoing risk to people of developing pressure areas.

One person who had been of a very low weight for a considerable time was only weighed seven times in 2015. They had been weighed twice since February 2016, a period in which they had lost a further 3.5 kg. However, no further nutritional screening assessments had taken place. When we looked at their food charts we found that often there was no food intake recorded for tea times and later on in the day. Sometimes the chart showed the person was asleep. There was nothing to indicate whether the person was offered food later on if they had been asleep at tea time or whether they were offered food outside of regular mealtimes. Staff told us that they did offer the person food at other times. Whilst the person had recently been referred to a dietician and a speech and language therapist, we could not determine the extent to which staff were taking action to support them nutritionally on a day to day basis.

Some people were living with health conditions that could present risks to their welfare, for example eating disorders or obsessive compulsive disorders. The service did not identify these conditions as risks to people's welfare or put plans in place to mitigate these risks.

The manager told us that one person went out shopping and often came back with tools they had purchased. They didn't feel that the person presented a risk to other people, but that they had threatened to self-harm in the past. There was nothing on their records to show this. The manager said the person agreed to staff seeing what they had bought before they took it to their room. The manager showed us a small hammer and a bradawl that they had taken from the person recently. There was no risk assessment in place for this behaviour or a plan of how staff were to respond to it.

We also found considerable environmental risks. The manager, who had joined the service in October 2015, provided documentation showing that the water system had been tested for legionella in 2010, but no subsequent water system risk assessments or routine checks had been carried out. The fire risk assessment required updating as it had been carried out in March 2015.

These findings constituted breaches of Regulation 12 (1)(2)(a)(b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people's welfare were well managed. One person who had recently moved into the home had sustained 10 falls in a four week period at a previous home they had been living in. We saw charts which

showed the person was checked upon frequently, which was confirmed by the person when we spoke with them. Another person, who was cared for in bed and was at risk of developing pressure areas, was regularly repositioned appropriately.

Parts of the service were unclean, which presented a risk of the spread of infection. Some divans were soiled. We checked the bedding in two rooms. Whilst the sheets had been laundered, stains remained on both sets of bedding. Toilets, extractor fans, pull cords, sinks, plugholes and taps were all in need of attention. Limescale debris had built up due to a slow leak under one sink. The toilet in the bathroom which was used for cleaning commodes and urine bottles was in general use. The manager told us this was kept locked, but it had been unlocked throughout both days of our inspection. We saw old and indelibly stained urine bottles on the floor of this bathroom. The lounge chairs were stained where people rested their heads. We have referred these matters to the local authority's public health team.

These findings constituted a breach of Regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Staff authorised to handle and give people their medicines had received training and had recently been assessed as competent to undertake medicine-related tasks. Medicines were stored safely for the protection of people who used the service. Records showed that medicines requiring refrigeration had been stored at correct temperatures.

However, people living in the service were not always receiving their medicines as prescribed. When we compared medication records against quantities of medicines available we found numerical discrepancies that showed that medicines had not been given as intended by prescribers. Records of medicines prescribed for external application showed that these medicines were also not always applied in line with prescriber's instructions.

There was supporting information to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies and medicine sensitivities to enable medicines to be given safely and there was written information on people's preferences about having their medicines given to them. For people prescribed painkilling medicines and who were unable to talk to staff about their pain there were pain assessment tools to enable staff to give them their painkillers consistently and appropriately. 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, when people were prescribed more than one painkiller on this basis there was insufficient information to show the order in which painkilling medicines were needed.

These findings constituted a breach of Regulation 12 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "There's just enough staff. I don't have to wait long." Another person said, "Staff answer my bell as soon as possible, but I don't ever wait too long." There were enough staff to meet people's care needs. We saw that staff were busy, but not rushed during our inspection. Three care staff were on duty during the day and two were on duty overnight. There was also a staff member in the kitchen and a domestic on duty for four hours a day, five days a week. The manager told us that care staff did the cleaning when they had time at weekends.

The staff files we reviewed for recently recruited staff members showed that robust processes were in place

to minimise the risks of recruiting unsuitable staff. The appropriate references, identity and Disclosure and Barring Service (DBS) checks had been carried out. However, when we checked some staff files for staff recruited two years ago we found that no proof of identity or staff photographs were on record.

People told us they felt safe living in the home and safe with the staff. One person said, "I was having falls before I came here. I know I'm safer now." Another person told us how staff were always with them when they mobilised with the aid of their walking frame. One person told us, "I don't feel vulnerable here." We saw that people who preferred to stay in their rooms were regularly checked upon and call bells were within reach if they needed assistance.

The staff and the manager were knowledgeable about keeping people safe and what the indicators would be for various types of abuse. They had a clear understanding of their responsibilities and the actions they would need to take if they had any concerns. The manager had reported any safeguarding issues to the appropriate authorities and taken the necessary steps to help minimise the risk of abuse to people living in the home.

Requires Improvement

Is the service effective?

Our findings

We reviewed the training records of two staff members. One had been in post since May 2013. They had last received an appraisal in February 2014 and supervision in October 2015. They had received training in areas including safeguarding, moving and handling, infection control and health and safety. However these certificates had expired in October 2015. The second staff member's training in food hygiene, fire safety, safeguarding and health and safety had also expired in October 2015.

The manager told us that most staff member's training in most areas had expired in October 2015 and confirmed that it was likely that some shifts were running with no staff member on duty having a current first aid certificate.

These failings meant that people were at risk of being supported by staff who did not have adequate or up to date training.

These findings constituted a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I'm confident that staff know what they're doing." Staff were knowledgeable and confident about how they needed to support people, but were aware that most of their training was overdue. They told us that they had undertaken an induction when they first joined the service and received training in a range of areas. If they needed training on a specific area to meet the needs of one individual, they were confident that the manager would speak with the provider to request that the training was supplied. Staff told us that they had the knowledge and skills to support people effectively, but were aware that their training needed updating.

The manager told us they had completed an initial supervision with staff since they came to manage the service in October 2015 and that they aimed to carry out supervisions with staff every two months, but this was behind at present. They also advised that a service managers meeting was to be held to organise staff training across the provider's three homes and the home care agency. A staff member who was managing the provider's home care agency had been organising training, but they had been too busy with managing their service to be able to continue to do this, so staff training had fallen behind.

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 so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was

working within the principles of the MCA.

Staff had a general understanding about supporting people to make their own decisions and gave us examples of occasions when and how they did this. We saw that several people had signed agreement to their care plans and had given consent for the service to take their photograph for their care and medicine records.

Two people had limited mental capacity to make decisions about their own care or treatment who had their medicines given to them crushed in food without their knowing (covertly). There was written guidance for staff to refer to about administering their medicines to enable them to give them consistently and appropriately, but for one person there were no records showing staff had made best interest decisions on their behalf.

The manager told us that they had completed a mental capacity assessment in respect of the removal of some belongings from one person's room. The person's safety, and that of staff, was at risk when staff were using equipment to support the person because of the obstructions caused by the amount of the person's belongings.

Some people's care records showed that they had periods of confusion or that they had health conditions that could indicate that they had variable ability to make decisions for themselves. A relative of one person told us about challenging behaviours that their family member sometimes presented and that on occasion they were unable to communicate meaningfully with them. However, the person's care records did not contain any information about the person's mental capacity. There was a general lack of information in people's records about their ability to make their own decisions.

The manager told us they had submitted DoLS applications in respect of two people living in the home and were awaiting the outcome of these referrals.

People told us that they were offered choices of food and drink and our observations over the two day inspection supported this. One person told us, "They made me a cheese and potato pie when I asked." Another person told us, "I like beans and cheese and there's plenty of it here." We were told how one person who enjoyed an English diet had been made a special fish dish from their home country on a significant day for them.

Most people preferred to take meals in their rooms and we saw that several people had cruet sets in their rooms. We found that everybody had drinks available at all times in their rooms, or when they were in the lounge. These were frequently topped up or replaced as necessary. People were also offered a variety of hot drinks and snacks throughout the day.

The cook told us that they didn't often have the time to create meals from scratch so were usually reliant upon pre-prepared food to which they added vegetables or other accompaniments. The kitchen was clean and bright. The service had been awarded the highest rating of '5' in February 2016 following their food hygiene inspection by the local council's environmental health team. This meant that food was prepared, cooked, re-heated, cooled and stored hygienically.

People told us that they had good access to health professionals. One person told us, "If I need to see the doctor, it's done promptly." A second person told us that medical appointments were arranged for them and, when necessary, transport was arranged too. The local GP visited weekly, but if required would visit people outside of this scheduled visit. With people's permission, the manager or a senior carer accompanied

the GP when visiting people in their rooms to help faciliate communication. This also meant staff could obtain guidance about how best to meet people's health needs.

We found that people had access to a wide range of health professionals. For example, podiatrists, dieticians, physiotherapists and community nurses. One person who had recently moved in to the home had been referred for a mental health assessment which was being carried out during our inspection. The service had acted promptly in ensuring that the person obtained the professional intervention they needed. Staff also had access to the professional support they required to care for the person effectively.

Requires Improvement

Is the service caring?

Our findings

The lack of cleanliness in the premises did not uphold people's dignity. From the corridor we could see that some bed divan sides were soiled. Some people's rooms were clean, but others were not. Some rooms contained chipped and broken furniture. Net curtains were sometimes ill fitting or torn.

The entrance to the building was not inviting and did not convey a good first impression of the home. A misspelt notice was sellotaped to the door and plastic flowers, that age had dulled in colour, were in containers. The grass had not been mown and shrubs were considerably overgrown. The back garden, which was a good size and quiet, was also in need of attention. This had the potential to be a really pleasant place for people to spend time in nicer weather.

Staff told us how they respected people's dignity and privacy. We saw that they knocked on people's doors and waited for permission before entering. However more discretion was required on a few occasions when staff had answered people's call bells. It was clear from what staff had said before they closed people's doors behind them that people had wanted to use the toilet.

Staff spoke with people in a polite and friendly manner and good relationships had developed. One person told us, "Staff go over and above in looking after us all here." Another person told us, "The staff are kind and friendly here, all of them." A third person told us that they felt deminished because they were not able to care for themselves anymore, but that staff supported them well and were mindful of their feelings.

People told us that staff encouraged them to maintain their independence as far as was possible. One person told us how staff encouraged them to do exercises that had been recommended by their physiotherapist. Another person told us, "I tell them what care I need, not the other way round." Care records were clear about what people could do for themselves as well as where they needed staff assistance.

Staff we spoke with knew the people they were supporting well and could tell us about people's families, what people's interests were and what things might concern them. Relatives told us that staff treated their family members well and that they were always welcomed when they came to visit.

People told us that they felt listened to. Care records showed that staff spoke with people as part of their monthly care plan reviews to determine whether they were satisfied in how their care was being provided and to discuss and agree any changes necessary. The cook also took the time to speak with people and determine whether they enjoyed the food and what changes they might like as part of the person's monthly care plan review.

Information was available on advocacy services if anyone required their support to make sure their voice was heard or act for them in situations where they may not have felt able to act for themself.

We observed that people spent a lot of time in their rooms, but people told us this was their choice. One

person told us, "I'm much happier in here on my own." Some people went out on their own unaccompanied. One person said, "I come and go as I please. They always let me out when I want to go." The home had a keypad exit system which ensured that staff were able to support those who wanted to go out but would not have been safe to do so alone.

Whilst staff were friendly and compassionate, the provider had not ensured that the cleanliness and care of the environment was supportive of their dignity.

Requires Improvement

Is the service responsive?

Our findings

We did not always find care plans to support staff in caring for people in relation to their individual health conditions, particularly those that resulted in complex behaviours or behaviours that challenged. We reviewed care plans that showed that some people were living with a variety of conditions, for example an eating disorder or obsessive compulsive disorder. One care plan queried whether the person had undiagnosed Aspergers syndrome. There were no care plans to show how these conditions, or behaviours, impacted upon people's daily lives or how staff needed to support people.

Where people had health appointments often there was nothing recorded about the outcomes of these appointments or what they were related to. Staff told us that they sometimes recorded this on the person's daily notes, but this wasn't always done. One person had recently been discharged from hospital. Since then their moving and handling care plan had been revised to show that they were now '..less mobile'. The person then had a visit from a physiotherapist but there was no information on the purpose or outcome of this visit. Consequently, we could not determine whether the service was doing all it could to meet the person's needs.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained information about their life histories, although some of these were scant in detail. Their day to day preferences were recorded, for example when they liked to get up or go to bed or whether they preferred showers or bathing.

However, most people told us they were happy with the support they received from staff and that their needs were met. One person told us, "I get everything I need here." We communicated with another person who was hard of hearing by writing questions down for them to which they responded verbally. They told us that staff took the time to write questions or information down for them to make sure they understood what was happening and that they felt included in what was going on around them.

We spoke with a visiting community nurse who told us that the service acted upon their guidance. They gave an example of a pressure area that had healed as a result of staff responding in accordance with their instructions about how to support the person with skin care and repositioning.

The service had been without any activities provision for two months. Some people were unconcerned about this, particularly those who were more independent and were able to come and go as they pleased. A few had interests that they were able to persue on their own in their rooms. For example, one person enjoyed computers and this kept them occupied. However, others had little to do and spent time sleeping or passively looking around. The television was on in the lounge but the few people in here told us they were not interested in watching what was on. One person told us that they had read all the books that were of interest to them in the home and wanted something else to read.

A new activities co-ordinator had commenced work on the first day of our inspection. They told us about their plans and contacts they had in the community that could be utilised to benefit people living in the home. They were speaking with people, getting to know them and seeking their views on how they would like to spend their time. This was an improvement, but they were only employed for two hours a day, twice a week.

Everyone we spoke with said they felt able to raise any concerns if they had any. One person told us, "The manager comes around every day. She's very approachable." Another person told us, "Complaints? You're wasting your time here. No-one has any. But if we did, they'd be looked at properly." One person told us that they had raised a concern with the manager and that the issue had been resolved promptly and to their satisfaction.

The service periodically issued questionnaires to obtain the views of people, staff and health professionals. These were all positive. The manager had held a residents meeting in September 2015, but none had been held since. They told us that they intended to get these organised on a quarterly basis.

Inadequate

Is the service well-led?

Our findings

The registered manager had left the service in August 2015. We had not received an application from them to deregister. The provider had promoted a senior care staff member from another of their services in the area to become the manager of Abbeyville Lodge in October 2015. The manager told us that they had commenced the process of applying to register as the manager.

The manager had continued the auditing programme already in place, but was unsure about the frequency required of some environmental checks. Some audits were not effective at identifying problems. The infection control audit completed earlier in April 2016 had ticks to show that toilet environments were visibly clean, ceilings and fans were free from debris and that floor coverings were washable and impervious to moisture. We found concerns in all these areas. A monthly fire safety audit carried out earlier in April 2016 did not identify that the home's fire risk assessment needed updating. There was no system to audit care plan content, individual's risk assessments and the efficacy of the monthly reviews.

The service had put in place a recording system to account for medicines but this was not always being completed accurately. The manager told us that members of staff were regularly monitoring medicines and their records, but we concluded that at the time of inspection this was ineffective at identifying medicine discrepancies.

The failure to have effective systems in place to ensure the service was managed appropriately had the potential to impact upon people's welfare. People, or their relatives, could not be assured that the service was identifying or meeting people's needs because there was no expectation of the standard or content of people's care records or how to manage risks to people's welfare. People were at risk from the spread of infection because poor hygiene standards had not been identified or remedied. Failure to ensure that staff training was up to date put people at risk of receiving care that was inappropriate or unsafe.

The service and the manager lacked sufficient and effective leadership, guidance and oversight from the provider. The manager had last received a supervision from the provider in January 2016. This was limited in scope. When asked if the provider audited the service, the manager showed us an entry referring to an audit being carried out by the provider in September 2015, before the manager took up their post. There was no documentation from this audit in the home, so the manager did not know what areas of the home had been identified as requiring action when they commenced their role. The provider had not subsequently carried out another audit of the service in order to help guide and support the manager in their duties and inform themselves of any risks in the service.

The provider did not understand the importance of ensuring that risks to people's welfare were identified and reviewed and had no systems in place to do so. They had not identified the poor practices in place in the service. The provider relied heavily upon a manager from one of their other two services to oversee the day to day running of all three services. This manager was also tasked with implementing a computerised care records system across all three services. In addition they were managing their own service, where we had found significant concerns during our last inspection.

The third of the provider's services had been inspected by us in August 2015. Our inspection of Abbeyville Lodge had identified very similar findings to that of this third service. The provider, although aware of failings in two of their services, had not taken the necessary action to ensure that their third service did not have similar issues. There had been no attempt to determine whether there were systemic failures in the way that their services operated and were managed. The provider was insufficiently involved in the day to day management of the organisation to ensure that suitable and effective systems were in place to meet people's needs and drive necessary improvements forward.

These concerns constituted a breach of Regulation 17 (1)(2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager in post was friendly and approachable. They had the support of people living in the home, relatives we spoke with and the staff. One person told us how the manager was always available if they had any queries and that they made sure to speak with people on an individual basis regularly. Another person told us that the manager was, "…on our side." A staff member told us, "I couldn't wish for a better boss." Staff told us their morale was good, a good staff team was in place and they all supported each other. The GP had recently completed one of the home's questionnaires. They had stated that the new manager had improved patient care and staff organisation in the home.