Abbeville RCH Limited

Abbeville Residential Care Home

Inspection report

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Tel: 01493844864

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 3 April 2017 and was unannounced. Our previous inspection carried out on 6 and 7 October 2016 identified seven breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found that improvements had been made. Some further improvements were still required and the provider remained in breach of one regulation.

Abbeville Residential Care Home provides accommodation and care for up to 38 older people, some of whom may be living with dementia. At the time of this inspection in April 2017 there were 13 people living in the home.

A registered manager was in post. 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 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people were not supported to regularly engage in meaningful social interaction. This had resulted in boredom for some people whilst others who required support with their emotional health did not receive this.

The provider was no longer in breach of regulations relating to safety, staff recruitment, nutrition and hydration, complaints handling, governance and the requirement to display the most recent inspection report.

The environment had improved and was clean and whilst a few issues relating to the premises required some attention, there were no significant areas of concern.

People received their medicines safely and there were effective systems in place to monitor medicines administration.

There were enough staff on duty to meet people's care needs. However, there was insufficient resource directed towards supporting people with social engagement.

People's consent was sought on a day to day basis. Staff understanding of the Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards needed improving. The provider was aware of this and further staff training had been arranged.

Staff were caring and supported people in a patient and kindly manner. People we spoke with were complimentary about the staff that supported them.

The service had improved it's responsiveness when concerns were raised. Apart from some ongoing concerns raised about the laundry provision concerns that had been raised with us during the previous inspection had been rectified.

With the support and guidance of a management consultant there had been considerable improvements in the monitoring of the quality of service that people received. Some of the improvements made were very recent.

The service had made considerable improvements since our October 2016 inspection. However, we remain concerned about the ability of the provider to make further progress and sustain improvements made.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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.

Considerable improvements had been made in the identification and reduction of environmental risks and risks specific to individuals. This work was still ongoing.

Recruitment processes had improved and were now safe.

There were enough staff to meet people's physical needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent was obtained on a day to day basis. However, there was limited understanding and practical application of the Mental Capacity Act 2005 in relation to the assessment process. This meant that the service was not meeting the requirements of the Mental Capacity Act.

People received a choice of food and drinks and those requiring additional support received it.

Staff received suitable training and support.

Is the service caring?

Good

The service was caring.

Staff supported people in a patient and kindly manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was little time available to support people socially. People were bored and some people living with mental health conditions did not receive enough stimulation to connect with other people.

People told us they knew who they could raise complaints with.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Substantial improvements were being made in the governance of the service. Some of the changes were yet to be implemented but a good framework was in place.

A management consultant was providing a high level of support to the provider and manager in order to make improvements to the service that people received.

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 checked 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 3 April 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines and an expert-by-experience.

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

During this inspection we spoke with four people living in the home and relatives of three people. We also spoke with three staff members, the registered manager, the provider and their management consultant.

We made general observations of the care and support people received at the service. We looked at the medication records of all thirteen people living in the home and care records for three people. We viewed records relating to staff recruitment as well as training 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

Our previous inspection in October 2016 identified a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we had identified concerns in relation to the use of portable electric heaters, unused rooms which had not been sealed off for safety reasons and ripped flooring in one person's room. In addition, there was no assessment of risks in relation to legionella bacteria and we found considerable concerns in relation to the cleanliness of the premises. We also found that some people were not adequately supported with their nutritional requirements which put their welfare at risk. Prescribed topical creams had not been secured which meant that there had been a risk of inappropriate access or accidental harm.

This April 2017 inspection found that whilst some issues remained, the majority of our concerns had been addressed satisfactorily. However, some unused rooms on the first floor had not been sealed. The access to these rooms needed to be secured to reduce the risk of people going in to the rooms and coming to harm. One person's toilet seat riser was not fixed to the toilet bowl. The lighting in some corridors and bathrooms was not bright enough and way finding signage needed improvement.

We found that the home was clean throughout and there were no odours. The ripped flooring in one person's room had been replaced.

A legionella risk assessment was in place. This had been completed by the manager. This was not comprehensive and did not include an inspection of the water system to consider the condition of the water service and sytem as a whole. A professional was required to undertake this type of work. A specialist company had been booked to come in and carry out a full inspection. Routine water system maintenance, including the testing of water temperatures, was being carried out.

There was a general improvement in the standard of risk assessments, particularly in relation to mobility requirements and pressure care. For example, clear details were provided for staff about the assistance people needed to mobilise and what equipment and equipment settings were required to support the person to move safely. Risk assessments were regularly reviewed.

However, there were still some inconsistencies and gaps. For example the nutritional care plan for one person who was cared for in bed stated that they needed to be in a 'semi-reclining position' when eating and drinking. Another part of the same care plan stated that professional advice was that the person needed to be 'sat upright' for meals. The same person's care records stated that they had bed rails in place. However, there was no risk assessment in place for this.

One person told us that if they had any pain, "Staff get you paracetamol or something as soon as they can." A relative told us, "Things have improved. Staff watch people taking their tablets now. In the past I have found tablets on the floor."

A member of CQC medicines team 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 being stored safely for the protection of people who used the service and at the correct temperatures. Records showed that people were receiving their oral medicines as prescribed. There were frequent internal audits in place to enable staff to monitor and account for medicines. Recording errors were promptly identified and investigated. However, we noted there were gaps in records for topical medicines prescribed for external application where they did not confirm these medicines had been applied as prescribed.

During the inspection we observed that staff followed safe procedures when giving people their medicines. Staff handling and giving people their medicines had been assessed as competent in these tasks.

Supporting information was available to staff to enable them to give people their medicines safely and consistently. There was personal identification, information about known allergies/medicine sensitivities and details about people's preferences about having their medicines given. Additional charts were in place to record the application of prescribed skin patches and these had been completed by staff.

There were care plans in place about people's medicines. When people were prescribed medicines on a 'when required' basis, written information was available to show staff how and when to give people these medicines. However we noted some medicines prescribed on a 'when required' basis where this information was absent. This was rectified during the inspection.

For people lacking mental capacity to make decisions about their own care or treatment and who refused their medicines there were appropriate assessments in place. These showed they lacked mental capacity and that there was consultation with their doctor to give them their medicines crushed in food or drink (covertly). There was information available for staff to refer to about how and which medicines should be given to people in this way to ensure that staff gave the medicines consistently and appropriately.

We were satisfied that whilst further improvements were required, that the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection in October 2016 identified a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the recruitment practices in place were not robust and did not fully mitigate the risks of employing staff unsuitable to their role.

During this inspection we checked a sample of three recruitment records for three staff members. We found that references had been obtained and checks were made to determine whether prospective staff members had a criminal record before they were employed. However, proof of identity had not been obtained in relation to one staff member.

We were satisfied that whilst there was room for further improvement, that the provider was no longer in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "You press your buzzer and staff come pretty quickly. At weekends there aren't as many staff about." Another person said, "There's always someone about. If you press your buzzer staff will come and help if you're in a muddle." A third person said in relation to staffing that, "It tends to be quieter here at the weekend." One relative told us that they didn't always see staff about and thought that there were only two care staff on at weekends.

At the time of this inspection there were 13 people living in the home. The manager told us that there were three care staff members on duty between 8am to 10pm and two staff members overnight. Staffing rotas we were provided with for the last full four weeks indicated that the service was able to maintain this staffing level. In addition there were kitchen staff and domestic staff on duty during the day.

We asked the manager about people's comments about there being less staff on duty at weekends. They advised that there were the same numbers of care staff, kitchen and domestic staff on at the weekends as during the week. They thought this perception had arisen because during the week there were generally more staff around. This included themselves and often of late, the provider and the provider's consultant.

People told us that they felt safe living in the home. A relative told us that, "[Family member] is as safe as they can be." The majority of staff had received raining in safeguarding. Staff we spoke with understood what type of concerns would mean that a safeguarding referral needed to be make to the local authority in order to help support people's safety and welfare.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in October 2016 identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to meeting people's nutritional and hydration needs. This inspection had found that there was a poor knowledge of and provision of specialised diets and where people were at nutritional risk the provider could not be sure that people received suitable support.

This April 2017 inspection found that substantial improvements had been made.

People enjoyed the food in the home and they told us that they had choices in what to eat and when and where they wished to have their meals. One person told us, "Breakfast is between about 7am and 9am, but if you are later it doesn't matter and we can have tea whenever we want it." A second person said, "The food is very good. You get a choice for lunch and tea and staff ask you what you want during the day." A relative told us that the service had recently begun to ensure that their family member, who was living with diabetes, had a more balanced diet.

There was guidance in the kitchen about specialised diets. The home was using Scottish NHS guidance in relation to dysphagia diets, rather than the same guidance used by local health professionals. This varied in relation to guidance about pureed diets. However, this was not impacting upon anyone currently living in the home.

The monitoring of people's nutritional health had improved. Staff were mindful to ensure that people requiring additional nutritional support received it and that this was recorded. Where people were at risk of not eating or drinking enough we found good recording of their fluid and food intake so we were confident that people were receiving the support they required.

We saw that people in communal areas or in their rooms had a plentiful supply of drinks. A variety of snacks were offered throughout the day. Where people did not want meals they had chosen they were offered alternatives. Finger foods were offered to those who preferred to eat their food prepared this way.

Consequently, the provider was no longer in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorisation 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.

Mental capacity assessments were usually in place. However, there was no assessment in place in relation to one person who had recently had bedrails fitted to their bed to help keep them safe. This person was living with dementia. The provider had not acted in accordance with the requirements of the MCA when determining that bedrails were required.

We saw that with some decisions made in people's best interests it was not clear who had made the decision, when it was made or who had been involved in the decision making process. There was sometimes no detail recorded about people's ability to comprehend, remember, weigh up or communicate their decisions other than a 'no' being indicated. Consequently, the provider was unable to demonstrate that they routinely carried out suitable assessments of people's ability to make decisions.

Some DoLS applications had been made to the local authority. However, they did not always include details of the restrictions in place that were the basis for the application. There was no guidance for staff to ensure that they knew how to keep the person safe and that the person was not restricted more than was necessary to provide safe care. Whilst staff had received training in mental capacity, further training was due to assist staff to improve their understanding in this area. This had been arranged.

We saw that staff sought people's permission before they were supported with any tasks. This was done in an informal and conversational way. People were given time to answer and questions were re-phrased when necessary to help people make their own decisions.

Staff we spoke with told us that their training was mostly up to date and refresher training was ongoing. Training records we reviewed confirmed this. Some senior care staff required first aid training still, but we spoke with one staff member who told us that this had been booked and they were due to have this training in the next few weeks. A few staff members required updating training on moving and handling which was also planned, but other than this a high percentage of staff had up to date training in all other areas. Staff members told us that they received regular supervisions and their day to day work practices were observed and they received feedback on this.

People told us that they had good access to a wide range of health professionals including GPs, community nurses and chiropodists. We saw a notice informing people that a visiting optician was due so that appointments could be arranged. One person told us, "If you need to see anyone, it's soon arranged." Relatives told us that when their family members required support from health care professionals this was promptly organised.

Good

Is the service caring?

Our findings

People told us that the staff were caring. One person said, "The staff are very kind. We're well looked after here." Another person said, "The staff are all very nice. I particularly like [staff member], they often help me when I misplace things in my room."

People told us that they were listened to and that they were supported to maintain their independence. One person said, "Staff know me and know I like to do things for myself." Another person told us, "They listen to me. If they can sort something, then they will."

We saw that staff engaged with people in a positive and caring manner. We observed them paying attention when they were using a stand aid to assist one person. They made sure that the person was secure throughout and were clear about what they needed the person to do to assist with the process. Staff were patient and effective and used the person's name clearly to maintain the person's focus. The person was soon seated comfortably again.

Staff assisted one person living with a visual impairment by gently guiding their hands on the table so they could feel where a bowl of crisps and their drink was on their table.

Staff spoke politely and kindly to everyone and were respectful. We saw that people's privacy was respected and that staff knocked on people's doors and waited for permission before entering their rooms. People living in the home were comfortable in the presence of staff. One person told us, "Staff are very good. They supervise me in the bath in case I feel unwell or have a fall."

On previous inspections we had found that some people were not supported with their dignity. Some people had unclean fingernails. During this April 2017 inspection we found that people's nails were clean.

During our previous inspection people had raised concerns about clothing going missing. During this April 2017 inspection we received mixed views about this. One relative told us that their family member was often given clothes that were not theirs. They had purchased a new top for their family member recently. They told us, "It wasn't expensive, but it's never been seen again after just one wash. I can't bear the thought that [family member] could be wearing someone else's underwear." However, a second relative told us that they no longer had problems previously experienced with missing clothes.

People we spoke with told us that they had conversations with staff about their care arrangements. This was not a formalised process. However, we could see from people's records that discussions took place because people's care records contained information about how people liked to be supported and what was important to them. A relative told us that they were involved in the planning of their family member's care.

Another relative told us that the standard of support people had improved and this had had a positive impact upon their family member. Their family member preferred to stay in their room. Recent improvements in the cleanliness of their room and the personal support they received had contributed to

their family member being, "…..bright and breezy."

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection in October 2016 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the assessment people's needs and ensuring that they were met.

In October 2016 we have found a lack of clarity in people's care records about their needs or the response required from staff to meet them. This was due to generic prompts on the service's computerised records system that had not been personalised. We had found records that indicated that people may not have been receiving the care they needed, for example repositioning to reduce the risk of pressure areas developing. There had also been limited time available to support people with their social needs.

This April 2017 inspection found that some improvements had been made. People's care records were now tailored specifically to them. However, there were a few instances where a lack of clarity remained. For example, one person's care records referred to a health condition which caused their brain to swell. The records detailed symptoms and side effects. However, there was no explanation to say whether this was historical or whether the person still had any effects from this condition and if so, how staff were to support them.

This April 2017 inspection found that there was limited time to support people socially. Sometimes staff starting the afternoon shift at 3pm came in an hour early to this. If during regular shifts staff had any spare time available then they would spend time with people. We found that most people living in the home spent their time in their rooms, with some coming to the dining room for lunch.

Three of the four people we spoke with told us that they were bored. One person said, "There's not really anything to do. The person who used to do activities left. The staff try and do things but there's not enough time." Another person said, "I do get bored when there's nothing on the television." A third person told us, "I just sit here and watch television all day. I never bothered with it until I moved in here." A relative said, "I have never seen {family member] do anything here. Occasionally her nails are painted."

Throughout the day two people were sitting in one of the lounge areas, both of whom were living with mental health conditions. A shopping channel was on the television, but neither of them showed interest in what was on. One person spoke to themselves all day long and the second person spoke only in periodic angry outbursts but otherwise slept or looked into space. When staff engaged with them in order to carry out tasks or assist them with food and drink they did respond, but otherwise they were left to their own devices all day. There was no stimulation or activity to distract these people from their own thoughts.

Consequently, the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Significant improvements had been made which showed that people were being repositioned in accordance with their care needs.

Our previous inspection in October 2016 identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not taking appropriate steps to deal with complaints or respond to concerns when they were raised.

This April 2017 inspection found that information was readily available to people about how to make a complaint. Records showed that where written complaints were received that appropriate investigations were carried out. However, dates were not always used to show what steps were taken and when.

People told us that they knew how to make a complaint and felt that any concerns would be looked into.

Two relatives told us that the service had responded appropriately when they had raised concerns. One told us how the service had responded to concerns about the appropriateness of the food their family member received as they were living with diabetes. They felt that more care was now being taken with this. Another relative told us that in recent months whenever they raised a question or their family member needed something they received a prompt response and the matter was dealt with.

Consequently, the provider was no longer in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in October 2016 identified a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to display the inspection report from our May 2016 inspection. It is important that people using services, their family members and visitors to the home are able to access this information.

Upon arrival at the home on this April 2017 inspection we found that our report from the previous October 2016 was on display in the entrance foyer. Consequently, the provider was no longer in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The October 2016 inspection identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance arrangements in the service were poor.

This April 2017 inspection found that improvements had been made. A system had been put in place whereby individual staff members on a shift were assigned responsibly to ensure that food, fluid and repositioning records were completed as necessary.

The manager was carrying out daily floor walks around the premises. These helped to identify when issues needed rectifying. A new audit programme was in place which detailed which audits needed to be carried out and when. Some of these audits had commenced, whilst others were yet to be implemented. We saw the audit records of those that had commenced and those that were yet to commence. All audits were comprehensive and those that had been implemented had timescales for improvement actions to be carried out built in. There was also an overall action plan for the home.

A management consultant had devised an audit for the provider to undertake for the service which would result in a report and subsequent action plan. The management consultant was assisting the provider with the implementation of this audit, with a view to the provider carrying the audit themselves in coming months.

Whilst progress was ongoing, as a result of the improvements made, the provider was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that meetings were arranged with people and their relatives and that their views were sought. People living in the home told us that the home was well managed. A meeting with people and their families had been held shortly after our inspection finished. We spoke with some people's relatives after this meeting. One relative told us that this was the first time that they had had any contact with the provider. They did not feel that this was indicative of good management.

Whilst relatives we spoke with felt that whilst there had been some improvements they were not confident that the service would be able to sustain them. One said, "The manager just isn't pro-active." The absence of

sufficient social support meant that some relatives felt their family member's standard of life was still not very good despite the other improvements that had been made.

Staff told us that they felt the service had improved considerably in recent months. They said that with the support and guidance of the management consultant the manager was now more responsive and dealing with issues that previously may not have been addressed. One staff member told us, "[The consultant] sees things straight down the line. They have criticised us about things, but it has been constructive. Staff are embracing the changes."

Whilst substantial improvements had been made these were as a result of a management consultant guiding the provider and manager. At the time of our inspection they were supporting the provider with their three services five days a week.

The provider and manager are yet to demonstrate that the improvements made can be built upon and sustained.