Abbottswood Lodge Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 May 2016 and found breaches with regulatory requirements. As a result the service attained an overall rating of 'Inadequate' and was placed in 'Special Measures.' We served a warning notice on 23 May 2016. The date for compliance to be achieved was 19 June 2016. The provider shared with us their action plan on 7 July 2016. This provided detail on their progress to meet regulatory requirements.

We undertook a focused inspection on 5 and 9 August 2016 to check compliance with the warning notice and to confirm that the provider now met legal requirements. We found that although improvements had been made compliance with the warning notice had not been fully achieved and not all of the improvements the provider told us they would make had been implemented and actioned. The level of risk to people was now judged as minor and we met with the provider to discuss their intended progress and get assurances of their actions to sustain continues improvement. At the time of this inspection there were 11 people using the service.

Abbottswood Lodge Care Home provides accommodation and personal care for up to 13 older people and older people living with dementia.

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 report only covers our findings affecting requirements relating to risk, medicines management and staff training. You can read the report of our last comprehensive inspection by selecting the 'all reports' link for Abbottswood Lodge Residential Care Home on our website at www.cqc.org.uk

Further work was needed to ensure that suitable control measures consistently in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. The arrangements for the management of medicines although improved were not always consistent as medicines had not always been administered in line with the prescriber's instructions or effectively recorded.

We have made a recommendation about the completion of a nutritional screening tool where people are at risk of malnutrition and poor hydration.

Staff had received appropriate training to enable them to carry out their duties and to meet people's care and support needs safely.

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.

We could not be assured that people received safe care and support that met their needs or that risks were recorded and in place to mitigate future risk so as to ensure peoples safety and wellbeing.

The arrangements for the management of medicines were inconsistent and required further improvement.

Is the service effective?

Good

The service was effective.

Staff were supported to undertake training so as to enable them to fulfil the requirements of their role.

Abbottswood Lodge 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.

This inspection took place on 5 and 9 August 2016 and was unannounced. The inspection was undertaken by one inspector.

Before the inspection, we looked at all of the information we had received about the service. This included information we received prior to the inspection and notifications from the provider. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with the provider and six members of staff working at the service. In addition, we spoke with four people who used the service. We looked at the provider's arrangements for managing risk to people living at the service and medicines management. We also looked at four care plans for people who used the service and the staff training records for all staff employed at the service.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection to the service on 11 May 2016, we found that not all care was provided in a safe way for people using the service. Where risks had been identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. This specifically related to poor staff practice in relation to moving and handling. We found that staff did not have the qualifications, competence or skills to carry out manual handling tasks safely or to the required standard. In addition, where people were assessed as at risk of developing pressure ulcers, we found it was not possible to determine if the equipment was correctly set in relation to a person's weight as no weight records had been maintained. Additionally, we could not be assured that people received care and support that met their needs, in particular, where people were cared for whilst in bed and required their body to be repositioned at regular intervals. Furthermore, arrangements for the management of medicines were not consistently safe. The observation of the medication round showed that this was not always completed with due regard to people's dignity. There was no evidence to demonstrate that people's topical creams were administered as prescribed. Where people were prescribed a variable dose of medication, the specific dose administered had not always been recorded. Confirmation of up-to-date medication training was not available and a written record had not been completed to show that staff had been assessed as to their continued competency to administer people's medicines.

As a result of this we served a warning notice on 23 May 2016. The date for compliance to be achieved was 19 June 2016. The provider shared with us their action plan on 7 July 2016. This provided detail on their progress to meet regulatory requirements. At this inspection on 5 and 9 August 2016, we found that the provider had made some improvements but compliance with the warning notice had not been fully achieved because of this we met with the provider to discuss their intended actions to ensure future compliance and continued sustained improvements to ensure people's ongoing safety.

The arrangements for the management of medicines were inconsistent. Whilst medicines were stored safely for the protection of people who used the service, we identified that four people's medication had not been appropriately managed to ensure their care and wellbeing, however the provider was aware of this and had already discussed the above with people's GP and were looking to have the prescriber's instructions amended for the future so as to reflect that this could be given as PRN 'as and when required' medication. This related to three people who were prescribed specific medication for effective pain relief management. Although the MAR form recorded that each person should take this specific medication four times daily, it was evident that staff who administered the medication were not following the prescriber's instructions and were making the decision as to when the medication should be given.

The provider's action plan stated that a new form would be devised and implemented by 21 June 2016 to record the specific dose of medication given where a variable dose of medication was prescribed. Records showed that where people were prescribed a variable dose of medication, for example, one or two, the specific dose administered had not always been recorded. This meant that people could be at risk of receiving too much or too little medication. Although there was a potential risk of harm to people using the service we found no evidence to indicate that this lack of recording had impacted on people's safety and

wellbeing. The provider was unable to provide a rationale as to why the form as stated had not been completed and introduced effectively and this remained outstanding from the previous inspection in May 2016.

The inspection highlighted that at least two people who used the service were prescribed a thickening agent. This is used to help make fluids safer to drink and to reduce the risk of choking, aspiration and pneumonia. Although staff told us how they thickened people's drinks for them, the dispensing label and associated Medication Administration Record [MAR] stated 'As directed'. The care records did not instruct staff on an explanation as to what 'As directed' entailed or provide evidence of specific advice sought by a healthcare professional so as to safeguard service users from the potential risk of choking, aspiration and pneumonia. Following the inspection the provider confirmed that they had contacted the GP and pharmacist. The latter agreed to record the specific instructions for staff on the prescribing label and MAR form so as to ensure that staff had the necessary advice and guidance.

A list at the front of the medication folder confirmed that eight members of staff administered medication to people using the service. Records showed that only four out of eight members of staff had undertaken and completed medication online training since May 2016. Four members of staff had not completed this training despite the provider's action plan stating that medication training had been completed by 27 June 2016. The action plan also stated that staff would be assessed as to their continued competency to administer medication by 27 June 2016. We discussed this with the provider. The provider advised that a form had been devised but not yet implemented and that staff had not had their competency to administer medication assessed. The provider confirmed during their meeting with us after the inspection that all staff had now received the appropriate training to administer medications to people.

The provider's action plan stated that the Malnutrition Universal Screening Tool [MUST] was to be introduced by 22 July 2016 where people were at nutritional risk. This is a five-step screening tool to identify where people who are underweight and at risk or potential risk of malnutrition may benefit from appropriate nutritional advice and intervention. Records identified and the provider confirmed that the MUST tool had not been formally recorded and completed for three people. For example, the weight records for one person for the period May 2016 and June 2016 demonstrated that there had been a small weight loss during this time, however only two out of the five steps of the MUST tool had been actioned and recorded. Whilst a numerical score was recorded which identified the person's Body Mass Index [BMI], following a discussion with the provider this was noted to be inaccurate. This meant that management guidelines as detailed by the MUST tool if followed correctly, such as, increase of the overall nutritional intake for the person and documentation of the person's dietary intake had not been undertaken. Following a meeting with the provider on 5 September 2016, an assurance was provided that an appropriate nutritional tool would be implemented.

The weight records for another person showed that over a four to five week period between July and August 2016 they had sustained a weight loss of seven kilograms. The MUST tool showed that only two of the five steps of the MUST tool had been actioned and recorded. It was initially unclear as to what actions the provider had taken to mitigate the risks of further weight loss for the person. Following the inspection the provider confirmed in writing to us that a discussion had been undertaken with the person's GP in relation to the person's significant weight loss and associated underlining healthcare needs. The provider also confirmed that a lot of the person's weight loss was due to extreme water retention which had improved since staying at the service. However, despite the person's daily care records consistently showing and staff confirming that the service user's food and fluid intake was very poor no risk assessment was in place to identify the steps to be taken to address the above. This meant that appropriate steps had not been taken to mitigate the potential nutritional risks to the person.

We recommend that the provider seeks advice from a reputable source on the completion of a screening tool to identify where people are at risk of malnutrition and poor hydration.

The accident records for one person showed that since their admission to the service they had experienced two falls, one of which had resulted in a skin tear to their body. Following the inspection the provider confirmed that as the person had only sustained two falls since their admission and the person was assessed as being able to mobilise independently, they had judged it not necessary at this time for them to be referred to the local falls team at this stage. However, no formal falls risk assessment had been completed to provide the level of risk and no information was recorded detailing the steps to be taken to mitigate the future risk of falls for this person so as to ensure their safety and wellbeing. The provider confirmed that this was an oversight on their behalf.

Although records showed and staff confirmed that they had received moving and handling training on 25 May 2016, we were not able to determine if staff's practice in relation to this was effective as no moving and handling procedures were completed and observed at the time of the inspection. We discussed the above training with six members of staff and they told us that the practical training provided was solely in relation to one hoist and did not include other equipment, for example, standard hoist or slide sheet. Although staff told us this they confirmed that at this moment in time they felt confident to use the equipment shown.

Where people were at risk of developing pressure ulcers and had a pressure mattress in place, we checked to see if the equipment was working correctly and set at the correct setting. We were assured from our observations that the amount of support people received through their pressure relieving mattress was correct to help aid the prevention of pressure ulcers developing or deteriorating further. Additionally, where people were nursed in bed and required their body to be repositioned at regular intervals, records were now in place to show that this was happening. Staff were able to confirm that people were being repositioned as part of a fundamental component of pressure ulcer prevention and treatment.

Good

Is the service effective?

Our findings

At our previous comprehensive inspection to the service on 11 May 2016, we found that staff had not received regular training and the majority of training attained was not up-to-date and refresher training had not been planned or provided. As a result of this we served a warning notice on 23 May 2016. The date for compliance to be achieved was 19 June 2016. The provider shared with us their action plan on 7 July 2016. This provided detail on their progress to meet regulatory requirements. At this inspection on 5 and 9 August 2016, we found that compliance with the warning notice had been achieved and the improvements the provider told us they would make had been actioned.

Records showed that all staff employed at the service had received online training in a variety of topics since our last inspection in May 2016. Although this was positive, it was noted that the pass rate identified by the online training provider was set at 54% or above, however records presented showed that a number of staff had only attained grade E [55% to 64%] or grade D [65% to 74%] to some of the topics completed. There was no evidence to show that the provider had required staff to repeat the online training so as to demonstrate a better level of learning attainment. We discussed this with the provider and they confirmed that although at the time of the inspection they had not requested staff to retake the online training they had reviewed this position following our feedback. The provider confirmed that where staff had attained a test score falling within the grades D and E, staff would through supervision be asked to retake the course.