The Abbeyfield (Maidenhead) Society Limited

Nicholas House

Inspection report

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19 May 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Nicolas House is a residential care home that is registered to provide care for up to 30 people, this includes people living with dementia. Accommodation is situated on three floors with two lounges and a conservatory. There are specialist baths and wet rooms. The home also offers respite provision and day care facilities for non-residents. At the time of our inspection 16 people were using the service.

People's experience of using this service and what we found:
People's relatives expressed concerns about the falls their family members had experienced at the service, comments included, "I really don't know how mum falls so often, although she does have high blood pressure. I do get a phone call each time she has fallen. In my opinion the home needs to keep regular observations during the night with mum's high risks of falls." Another relative felt their family member was safe in the home but stated, "[Family member] has had several falls which has rendered her quite disabled. She broke her hip and was admitted into hospital following one fall."

We found people were placed at significant risk of harm because the provider demonstrated a lack of knowledge and understanding of how to assess, monitor and manage risks. Records showed people who had been identified at risk of falls, continued to sustain injuries, some of which resulted in fractures. Action taken by management and staff when people fell, were not in line with the provider's prevention and management of falls policy. As a result of this, people remained at significant risk of harm.

People and relatives told us staff wore personal protective equipment (PPE). However, one person commented, "When assisting with bathing the carers are in full kit, but they are not always completely masked."

We observed staff did not always wear PPE in line with government guidelines and best practice.

We found quality assurance systems and processes in place to identify and assess risks to people's welfare and safety, remained ineffective. For example, care plans were not regularly reviewed and updated when people had sustained injuries; audits and monitoring systems failed to identify risks; records were not fit for purpose, inaccurate and partially completed. Audits failed to pick up on the issues we had picked up during our visit. There was no scrutiny at board level to identify these issues and ensure senior managers were accountable and well supported to meet their statutory duties.

The provider did not always notify The Care Quality Commission (CQC) when incidents that affected people happened and failed to work in accordance with the Duty of Candour. This is about provider being open and transparent when things go wrong.

People and relatives said they felt safe from abuse and medicines were administered safely. We have made recommendations in relation to the provider's safeguarding and medicines policies.

Rating at last inspection and update: The last rating for this service was inadequate (published 1 May 2020) and the service was placed in special measures. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not, enough improvement had been made and the provider was still in breach of Regulations.

Why we inspected:
We carried out an unannounced comprehensive inspection of this service on 9 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance, staffing and fit and proper persons employed.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to, safe care and treatment and good governance.

Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Nicholas House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection took place on 18 and 19 May 2021. The inspection was carried out by an inspector and an 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.

Service and service type
Nicholas House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This was an unannounced inspection.

What we did before inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection-
Throughout the inspection we gave the provider and registered manager opportunities to tell us what improvements they had made.

We spoke with two people using the service, seven relatives, the maintenance manager, physiotherapist, deputy manager, registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from four care staff.

We viewed three care plans, four staff files in relation to recruitment, training data, medicine administration records, policies and procedures and a variety of records relating to the management of the service.

After the visit
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from a GP who regularly visited the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last visit, we found people were placed at potential risk of harm as the provider had failed to effectively manage risks to people's safety.This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had made improvements in relation to fire safety however, not enough improvements had been made with regard to other safety issues and the provider was still in breach of regulation 12

● People were not protected from the risk of avoidable harm. We found the provider had failed to address shortfalls identified at our previous inspection. For example, falls risk assessments and risk management plans remained ineffective as people remained at risk of significant harm, especially in relation to falls.
● Relatives raised concerns about the amount of falls their family members had experienced. Comments included, "I really don't know how mum falls so often, although she does have high blood pressure. I do get a phone call each time she has fallen. In my opinion the home needs to keep regular observations during the night with mum's high risks of falls." Another relative felt their family member was safe but stated, "[Family member] has had several falls which has rendered her quite disabled. She broke her hip and was admitted into hospital following one fall."
● Staff did not receive relevant information and guidance required to minimise or mitigate risks of falls and protect people from harm.
● We looked at the care records of four people who had experienced falls. One person's mobility plan stated they had three medical conditions which could cause them to fall including being partially sighted in both eyes. However, their falls risk assessment had not taken this and the other two medical conditions into consideration and therefore put the person at risk of potential harm.
● The provider's 'prevention and management of falls policy' stated, that 'risk management plans 'must be reviewed whenever there is a significant change indicated in the resident's condition or after an adverse event such as a fall.' One person's care records showed they had experienced approximately 17 falls in 2020 and 6 falls in 2021, some of which resulted in the person being admitted to hospital. Records viewed showed this did not happen, as their falls risk assessment showed only one review had taken place on 7 January 2021. Care records showed in response to the person's increased falls, the provider had spoken to a GP and made referrals to a physiotherapist and specialist health professional. However, there was no evidence to show that further risk management plans had been developed to stop the person coming to further harm from falls.
● Another person had experienced falls on 6 November 2020, 5 April 2021 and 4, 8 and 10 May 2021. The

person's mobility care plan stated the person was able to mobilise independently with a walking aid, attended regular visits with a physiotherapist and, they were inaccurately assessed as at low risk of falls. We noted the person's last fall on 10 May 2021 resulted in them suffering from a fracture which required them to be hospitalised for a couple of weeks.

● Another person had experienced four falls between 6 January 2021 and 3 March 2021. A completed falls risk assessment assessed them as at high risk of falls. However, there were no recorded management plans documented to enable staff to mitigate risk of falls. We noted the person had been referred to a physiotherapist, who supported the person to undertake a programme of exercises. However, specific interventions recommended to mitigate further risk of falls, had not been added to the person's falls risk management plan. This meant staff did not have the information they required to help prevent the person from falling.

● Many people had experienced were whilst they were in their rooms. There was no consideration of the use of assistive technologies such as sensor mats. This would have alerted staff if people started to mobilise whilst in their rooms and enable staff to assist and support them if they were at risk of falling to keep them safe.

● We looked at the provider' service improvement plan (SIP). This stated a falls management plan was in place and completed after every fall and care plans were reviewed and updated to reflect risks. The records we viewed showed that this was not happening and therefore we could not be assured that people were being adequately protected from avoidable harm.

People had suffered harm as a result of falls and systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● When referring to whether staff wore personal protective equipment (PPE), a person told us, "When assisting with bathing the carers are in full kit, but they are not always completely masked."

● During our visit, we observed the registered manager did not always wear their face mask correctly. It was at times worn below their nose to the point where it fell below the mouth. We observed a person being supported by three staff members as they attempted to rise from their chair. We noted two staff members supporting the person were not wearing face masks. As soon as they saw us, their masks were immediately put back on. On another occasion, we observed another staff member walking into a person's room to support them without wearing a face mask.

● We saw documents that showed people and staff had been fully vaccinated. However, in light of the COVID-19 pandemic and emerging variants, staff not adhering to PPE guidance put people risk of harm. The registered manager admitted there had been a 'lapse' in judgement on their part and assured us they would ensure staff followed current Government guidance to keep people safe.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider had not taken enough action to ensure learning from incidents. We saw several incidents where people had sustained serious injuries as a result of falls. However, there were no documents to show these had been thoroughly investigated; monitored to make sure appropriate action was taken to prevent further occurrences; and shared to promote learning.

● The provider had acted to ensure the premises was safe to use for their intended purposes. We saw a letter of fire safety matters from the fire service dated 11 February 2021. These highlighted areas of concern which required the provider to take prompt action. Documentation viewed showed all areas had been addressed. We looked at the service's fire risk assessment dated 6 October 2020 and saw all identified actions had also been addressed. Regular health and safety checks, such as Legionella tests and regularly reviewed to ensure people's safety.

Staffing and recruitment
At our last inspection we found there were not enough staff to provide care and support to people and recruitment practices were not safe. This was a breach of Regulation 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives felt they were enough staff to provide care to their loved ones. Comments included, "Yes, absolutely and most definitely. All staff have been working in the home certainly for the three years mum has been at the home. There is continuity in their staffing levels. The staff are skilled and knowledgeable and very committed", "Staffing levels during the day are okay but at night the level goes down to just 2 members of staff...this also is the same for weekends" and "I haven't seen anything that is detrimental with staffing levels."
● During this visit, we found there were enough numbers of suitably qualified and skilled staff to meet people's care and treatment needs. Staff rotas for March and April 2021 confirmed there were enough staff to provide care and support to people.
● There were safe staff recruitment procedures in place. We looked at the records of five staff members. We found job applications showed full employment histories, satisfactory references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. This meant the service only recruited staff who were suitable to meet people's care and support needs.

Systems and processes to safeguard people from the risk of abuse
● People and relatives said they felt safe from abuse. Comments included, "When mum was first admitted she most certainly felt safe. I have observed safe practices when staff are helping her when her needs have increased. I would speak to the manager if I had any doubts of safe practices", "Mum does feel safe. She has the carers there and is in a room with all the facilities and an alarm bell. Mum would tell me if she felt unsafe" and "Yes, mum feels safe, I believe so. She has never told me otherwise. I would speak to the manager if mum didn't feel safe."
●Staff told us they had attended safeguarding adults training and knew how to keep people safe from abuse. Comments included, "My understanding of safeguarding is to support and encourage individuals to make their own decisions; protect them from harm through neglect, and report any concerns" and "I feel confident in knowing what actions to take if or when a safeguarding matter occurs. I would follow the safeguarding procedures that are laid out in my work's policies."
● Training recordings confirmed staff had undertaken the relevant training and a safeguarding policy was in place. We noted the provider had incorrectly instructed staff to follow safeguarding guidance from a local authority not located in their area.

We recommend the provider ensure its policy is updated to reflect accurate information.

Using medicines safely

At our last inspection we recommended the service seek best practice and national guidance in relation to the completion of staff medicine competency assessments.

●Relatives felt medicines were administered to their family members safely. Comments included, "Yes as far as I am aware, I haven't been in the home for over a year, I have no concerns", "Yes, staff do support mum with her medication and she does get it on time, I am reassured and I have no concerns", "Staff are very strict with the administration of medicines. Mum does know why she takes her medication. She does get it on time, and I have no concerns."

● During this visit, the provider had completed competency assessments for staff who were responsible for administering medicines.

● Staff knew how to administer medicines safely and told us they had attended the relevant training. Training records viewed confirmed this.

● The provider had a medicine policy which had been updated in December 2020. We noted the policy did not refer to national guidance and current best practice.

We recommend the provider take action to ensure its medicine policy clearly refers to national guidance and current best practice.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as inadequate. At this inspection this key has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found quality monitoring systems were ineffective and did not protect people from inappropriate or unsafe care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- We found quality monitoring systems remained ineffective as they still failed to adequately identify, monitor and address significant issues in relation to people falling and sustaining injuries. This put people at significant risk of harm.
- After our visit in January 2020, the provider sent us a service improvement plan (SIP). This outlined the actions they would take to ensure all identified concerns would be addressed.
- We looked at the SIP which had been updated on 28 April 2021. This stated the registered manager and deputy manager had ensured falls management plans were in place for learning; appropriate actions were taken following a fall and, care plans were reviewed and audited in relation to risk. We found care plans were not regularly reviewed and updated when people had sustained injuries; audits and monitoring systems failed to identify risks; and there was no analysis to pick up on any trends to aid learning.
- The registered manager did not receive adequate supervision and support to enable to them to carry out their job role effectively. Since our last visit in January 2020, the registered manager had formal supervision meetings on 9 December 2020, 21 January 2021 and an appraisal on 4 February 2021. These meetings failed to show what further training and support needs had been identified to enable the registered manager to carry out their statutory duties and achieve compliance with the regulations previously breached.
- The concerns identified during this visit demonstrated senior management were not aware of the regulatory requirements; the concerns identified at our visits in February 2019 and January 2020, had not been addressed.
- Records were not always fit for purpose, complete, legible, accurate and up to date. For example, although the provider had systems in place to enable them to identify and assess risks to people's health, safety and welfare, falls management plans did not document the measures staff were to take to reduce the risk effectively.
- Records failed to accurately document how many falls people had sustained. For example, a person's incident and accident record stated they had sustained a fall at 4.30pm on 29 April 2021. However, their post falls assessment indicated the person had another fall at 6pm on the same day. Another person's accident and incident form documented they had sustained a fall on 5 May 2021 whilst staff were assisting them to

mobilise. However, the person's post falls assessment indicated they had fallen earlier that day whilst in the lounge and had sustained a cut to the head. Care records showed another person had fallen on six separate occasions but there were no completed accident and incident records or post falls assessments in relation to these. This meant people were placed at risk of harm as the provider did not know the full extent to which people were falling due to inaccurate record keeping.
● Audits of care records failed to ensure any identified actions were completed within specific timescales. For example, a care plan audit that was signed by the deputy manager on 3 February 2021, identified a person did not have a moving and handling risk assessment in place. The deputy manager had instructed a staff member to get this completed by 3 March 2021. During this visit, we noted this had still not been actioned. The deputy manager explained the staff member had been busy but there were no records of discussions held with the staff member to see what further support they needed in order to get this task completed.
● The nominated individual told us due to Covid-19, no trustee board meetings were held. This meant there was no scrutiny at board level to ensure quality assurance systems and processes operated effectively. Reports to the executive committee we looked at did not reference what action was being taken to address the previous shortfalls found at the service. We noted, the general manager's (nominated individual) report to the executive board dated 26 May 2021, failed to accurately reflect the concerns we had fed back to them during and at the end of this visit. Instead the nominated individual reported, 'I am confident that our ratings will rise, hopefully if they rise to good our overall rating should change to good.'

We found quality monitoring and improvement systems were ineffective and therefore put people at risk of harm. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. We found this did not consistently happen. For example, we received a statutory notification informing us that a person had passed away but, the provider had failed to notify us the same person had a fall before their death during which they sustained a serious injury.
● Records showed two other incidents on 30 November 2020 and 27 January 2021, where the same person had been admitted to hospital after sustaining injuries due to falls that we had not been notified of.

This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● The provider had a Duty of Candour (DoC) policy dated December 2020 which stated, 'The registered manager will inform the relevant person in writing of any incident detailing what may have been reported verbally already, along with results of any enquiries that have been made since the original report.' We found no records to support this had happened. This meant outcomes of investigations into incidents were not shared with people, their relatives and those who represented them. Therefore we could not be assured that the provider was being open and transparent with people and their families, in relation to their care.

This was a beach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● The provider did not take a pro-active approach to ensure senior managers were equipped with the

knowledge and skills to understand their statutory obligations and how to apply this to their work practice.
● Training records showed senior managers had attended relevant training regarding the management and assessing of risk however, there was no evidence to show this had been fully embedded in practice to drive forward improvements in order to keep people safe.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us their morale was quite low and stated this was due to the management team not recognising how hard they had worked over the last 14 months. Staff said they were able to raise concerns with management team but found confidentiality was an issue. Comments included, "I feel that I can raise any concerns with Management but am wary of confidentiality so this may inhibit any personal matters that I wish to discuss" and "There is no confidentiality with the managers." This was not experienced by all staff, other comments included, "Any concerns I have they (management) are always happy to support me and give advice." We noted the provider's annual quality assurance report 2021 had captured this feedback and management had scheduled a date to discuss issues with staff.
● Relatives provided positive feedback about management. Comments included, "I think it is very good. The management work as a good team. They are very caring and inspire you with confidence that they have things in hand", "From my point of view its fine. I really don't know what happens in leadership structure'', "It's okay… all the staff show such love and devotion", "I think it's very good however I have said that one manager doesn't know what the other manager does, communication needs improvement" and "I think the managers do a good job. They normally phone us regularly, only when they need to."
● The provider sought and encouraged feedback in various forms such as, residents' meetings and quality assurance questionnaires. Documents showed action was taken in response to feedback received.

Working in partnership with others
● Relatives told us the provider worked with health and social care professionals to ensure their family members received the care required. Comments included, "The GP surgery. They liaise with the hospital when mum had a chest infection", another listed, "Physiotherapist, chiropody and GP" as health professionals the home had organised to support their family member. We spoke with the physiotherapist who told us about the actions they had taken working jointly with the service to meet a person's mobility needs. We saw documents that supported this.
● A GP confirmed the good working relationship they had with the service. They told us, " I have always found the residents to be very happy with the care they receive as well as getting some very positive feedback from relatives. During my rounds the staff are knowledgeable about the residents under their care. The patients are always treated with dignity and respect. The rooms are clean and airy. The staff are well trained and know when to access tele-medicine and the surgery if they become concerned about patients at other times of the week."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met The provider had failed to notify us of all the events it was legally required to. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the regulation was not being met The provider did not always act in an open and transparent when things went wrong. This was found when people had sustained injuries due to falls. Regulation 20 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The provider failed to effective systems in place to ensure the health, safety and welfare of people was assessed and monitored. Regulation 17 (1)

The enforcement action we took:

We issued a warning notice