Minster Care Management Limited

Abbeywell Court

Inspection report

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Date of inspection visit:
25 May 2022
26 May 2022

Date of publication:
01 July 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Abbeywell Court is a care home providing personal and nursing care to up to 45 people. The service provides support to people with physical and mental health needs in one adapted building across two floors. At the time of our inspection there were 34 people using the service.

People's experience of using this service and what we found
The monitoring of people's risks required improvement as whilst staff were aware of people's needs some people's care records showed conflicting or out of date information. People's medicines were not always managed effectively. The provider's systems to monitor and review the service required improvement.

Staff were trained to recognise and report on any harm or abuse. People were supported by enough staff and the managers were working to recruit permanent staff. The provider had effective infection, prevention and control systems in place. Lessons were learnt when things went wrong.

Managers and staff were clear about their roles. The manager was working to instil a positive culture among staff and staff were encouraged to be open and honest. People, their relatives and staff were involved in the service. The provider was working with health and social care professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was good (published 19 February 2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety, medicines, staffing and risks associated with people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed from good to requires improvement based on the findings of

this inspection.

Since our inspection the manager had taken action to make improvements and mitigate any risks.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbeywell Court on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Abbeywell Court

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 Health and Social Care Act 2008.

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 was carried out by one inspector.

Service and service type
Abbeywell Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Abbeywell Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection the manager was in the process of registering with us.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who lived at the home and four relatives of people who lived at the home. We spoke with seven members of staff, which included the manager, area manager, permanent and agency nurses, senior carers, support workers, the home administrator and a cook. We reviewed several records including people's care and medication records, audits, policies and procedures, staff files and staff training matrix.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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

- The monitoring of people's risks was not always effectively recorded, and some people's records showed contradicting information or required updates.
- People had risk assessments in place, which included risks associated with pressure damage to the skin, mobility, eating and drinking, environmental risks and COVID-19. They had been regularly reviewed; however, some reviews did not always prompt the requirement for a new risk assessment. For example, one person's fall risk assessment identified them as medium risk, however their care plan referenced them as high risk and staff were supporting them as required.
- Staff were aware of people's risks and how to support them, however these risks were not clearly recorded in people's care records.
- The manager and area manager had identified people's risk assessments and care plans required updating. They were in the process of this. Following our inspection, they demonstrated the action they had taken and planned to take, to review people's records and make changes to ensure people's risks were effectively monitored and managed.
- People and relatives, we spoke with confirmed staff were aware of people's needs and risks. One relative told us, since their loved one had been at the home staff supported them and there had been a decrease in a behaviour they demonstrated.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
- The provider had updated people's MCA records to ensure they were decision specific and person centred.

Using medicines safely

● People's medicines were not always managed effectively.

● We found where people were prescribed medicines on an 'as required' basis, the protocols in place did not always contain enough specific detail. For example, the protocol detailed they might become anxious or agitated, however there was no information about what that looked like for that person. Staff were aware of what this looked like and how to support the person; however, it was not clearly recorded. We also found some people's protocols were out of date and required reviewing. We raised this with the manager who confirmed they had already identified this and were having difficultly arranging reviews with the GP, however they were in the process of reviewing people's care plans.

● A visiting diabetes nurse informed us one person had been prescribed one medicine and staff administered a different one, the manager was made aware of this and took immediate action to investigate this. There was no evidence of harm and the visiting nurse had suggested the GP prescribe the medicine which had been administered. The manager confirmed they had conflicting information and was completing a route cause analysis for this incident, as both medicines were prescribed but staff had not identified this. Lessons learnt were also identified with staff to mitigate the risk of it happening again.

● The manager sought medical advice and completed a supervision with staff members where any medicine errors were identified. The manager confirmed they planned to re-complete staff medicine competencies to ensure they were competent.

● We found people's medicines were received and stored safely and people's medicine administration records (MAR) were completed. Staff completed room and fridge temperature checks and reported any concerns which were addressed.

Systems and processes to safeguard people from the risk of abuse

● Staff were trained to recognise and report any harm or abuse. Staff we spoke with confirmed the process they would follow if they had any concerns for people's safety or wellbeing.

● People and their relatives confirmed people were safe at the home. One resident told us, "I feel safe here" and one relative told us, "I cannot fault the hands-on care and attentiveness. Staff make sure they are comfy and safe."

Staffing and recruitment

● People, their relatives and staff confirmed people were supported by enough staff.

● The provider had a high number of agency staff; however, these were from the same agencies and regularly worked within the home to ensure people received consistent care. The manager was also recruiting new members of staff and they had recently reduced the number of agency nurses they used.

● Staff were safely recruited to ensure their suitability to work in the home. Staff files we reviewed included pre-employment checks and references.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, we found the sluice room sinks had stains and chipped paint which could be hard to keep clean.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider followed government guidance in relation to visiting. We saw relatives visiting during our inspection.

Learning lessons when things go wrong

● Staff documented any accidents and incidents, and the manager regularly reviewed them to help identify any themes or trends.

● The provider completed audits to analyse any falls and updated people's care plans with actions and support to mitigate the risk of it happening again. The manager planned to implement a falls diary to identify and review trends in a more robust way. They also planned to implement a 'resident of day' review where any lessons learnt will be identified and shared.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- The provider's systems to monitor and review the service required improvement.
- We found areas for improvement within people's care records and risk assessments. For example, people's risk assessments provided contradictory information when compared to their care plans. Whilst the manager was aware people's care plans required updating, and staff understood people's needs, the current systems in place had not identified and ensured people's risk assessments were reflective of their current needs.
- The manager and area manager had acted immediately following shortfalls we raised during the inspection. They were in the process of updating people's care records to ensure people's risks were effectively monitored. For example, when raised, they reviewed and updated a body map chart which provided detail of monitoring entries, review dates, action taken to mitigate the risk and any lessons learnt.
- Prior to our visit the manager and area manager had completed a medicine audit and took action following identifying areas for improvement, some improvements were still required. For example, they identified people's medicine protocols required updating, but not specifically to include further specific detail. They planned to include this as part of their reviews.
- The manager and area manager were aware of required improvements and had identified areas to increase the quality and safety of the service. For example, reviewing people's care plans and adding a 'resident of the day' process to provide more robust reviews. The manager had been newly appointed and was working to make the required improvements to ensure a clear oversight of the service. They also planned to review and update their internal audits and checks to ensure they were effective in identifying and addressing areas for improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had identified a poor culture among staff through a staff survey completed following the previous manager leaving. Since being in the post, the new manager had worked hard to try and instil a positive culture, which was person centred and achieved good outcomes for people.
- Staff we spoke with confirmed they felt more positive and things were working for the better with the new manager. One staff member told us, "Everyone is so much more relaxed and comfortable, the whole running of the place has improved since [manager name] has been here." One relative told us, "The atmosphere is very pleasant, everyone is lovely and friendly."

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

regulatory requirements
● Managers and staff were clear about their roles.
● Staff we spoke with confirmed they were supported by team members and management. One staff member told us, "Staff are really caring and knowledgeable. You can always ask for help; everyone is so helpful".
● The home's last inspection rating was clearly displayed in the home and on their website.

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 and manager investigated incidents, and actions were identified to improve people's experiences of care.
● Staff were encouraged to be open and honest when things went wrong and identify learning to make improvements to the home. Staff confirmed they did not always feel able to do this under the previous manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, their relatives and staff were provided with the opportunity to share suggestions and make improvements to the home.
● Staff attended regular team meetings and they confirmed these were of benefit. One staff member told us, "The team meetings are really helpful, you have chance to go over anything, changes are discussed, [manager's name] always ask for our input before changes are made. We can always go to them separately if needed too."
● People and their relatives confirmed they had the opportunity to provide suggestions to improve the service. One relative also told us the manager had introduced themselves and informed them they planned to implement a relatives meeting. Another relative told us the manager requested family involvement. The manager asked relatives for suggestions of activities and things that were of interest and importance to their loved one.

Working in partnership with others
● The provider worked in partnership with health and social care professionals to achieve good outcomes for the people who lived at the home. These included the pharmacy, Community Psychiatric Nurses (CPN), the local authority, dieticians and Speech and Language Therapist (SALT). The manager was working to build their relationship with the General Practice (GP's).
● Staff were open and worked together to meet the needs of people living in the home.