Leicestershire County Care Limited

Abbey House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

About the service
Abbey House is a residential care home providing personal care to up to 37 people. The service provides support to older people, some of whom are living with dementia and learning disabilities. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found
Right Support:
Medicines were not always managed safely. We found concerns with transdermal patch medication administration records. There were not always enough staff to meet people's needs. People told us, and call bell audits demonstrated, people were waiting for prolonged periods of time for support. Some staff training was not up to date or completed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Safe recruitment processes were followed

Right Care:
Infection prevention and control measures were not always robust, we identified multiple cushion covers and mattress covers to be soiled. People were not always supported in a person-centred way. People were safeguarded from the risk of abuse. Appropriate Deprivation of Liberty Safeguards (DoLS) applications were in place for people. Staff knew people well; they had a good understanding of people's needs and the support they required.

Right Culture:
Quality assurance systems and service oversight was not always effective. Actions taken to drive improvements were not always effective. People using the service and their relatives found the registered manager to be approachable. The service sought the views of staff and people using the service. People told us they enjoyed the activities within the service. Staff felt supported by the manager.

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.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, people's needs not being met and the maintenance of the premises. A decision was made for us to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to dignity, safe care and treatment, governance and staffing at this inspection.

Full information about CQC's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Abbey 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors and an Expert by Experience on site. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. A further inspector provided remote support by making calls to staff.

Service and service type
Abbey House 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. Abbey House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 sought feedback from the local authority contracts monitoring team and reviewed the information they provided. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who use the service and 4 family members to share their experiences of care received. We also spoke with 8 staff members including the registered manager, operations manager, deputy manager, senior care workers, care worker, activities coordinator and housekeeper.

We reviewed a range of records. This included 9 care records, 3 staff files in relation to recruitment and supervision, and multiple medication records. A variety of records relating to the management of the service, including policies and audits were reviewed.

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; Learning lessons when things go wrong

● Risks to people were not always fully assessed. Where people were at risk of falls there was not always clear guidance to support people. For example, 1 person who had recently had a fall did not have an appropriate risk assessment in place. However, we saw where people had fallen action was taken to support people in a timely way. For example, when people fell staff sought medical assistance for them in line with their needs.

● Care records did not always contain sufficient information to reflect people's health and well-being needs. For example, 1 person's record failed to provide staff with guidance on the associated signs and symptoms of their diabetes. This meant people were at risk of staff not identifying signs of deterioration in their health condition.

● Personal Emergency Evacuation Plans (PEEPs) for people were in place. However, they were not always reflective of people's needs. For example, 1 person's PEEP detailed they were likely to resist support from staff during an evacuation but failed to provide staff with guidance on what to do in the event the person declined to evacuate. Another person had been admitted to the service the week before our inspection however, their PEEP was not completed until the day of the inspection. This meant staff did not have guidance on how to support the person in an evacuation during this time.

Preventing and controlling infection

● The provider did not always provide a clean, hygienic, and well-maintained environment for the people living at the service. We identified concerns with the cleanliness and upkeep of people's living accommodation, including multiple mattresses and cushion covers which were stained and malodorous.

● Some areas of the service were in a state of disrepair. For example, handrails and door frames had chipped paintwork exposing porous wood. This meant areas around the home could not be thoroughly cleaned or sanitised. This left people at risk of cross infection.

●People were not always protected from water borne infections. We found a build-up of limescale on multiple taps around the service. Limescale deposits can be a breeding ground for dangerous bacteria including Legionella bacteria which causes Legionnaires' disease.

Using medicines safely

● Medicines were not always managed safely. Transdermal patch (medicines applied directly to the skin through an adhesive patch) records were not completed consistently. Records were not always completed to confirm the location of the new patch. This meant the provider could not be assured the patch was rotated on different areas of the person's body appropriately. This placed people at risk of skin irritation.

● Handwritten medicine records were not always countersigned by another member of staff. This meant

information had not been checked to ensure it was accurate and matched the prescriber's instructions, which placed people at risk of their medicines being administered incorrectly.
● Protocols to help staff know when to give 'as required' medicines were not always in place. This meant people were at risk of not having their medicines as prescribed.

Although we found no evidence to suggest people had been harmed the provider failed to assess and mitigate risks to people, and ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On CQC intervention, the provider took action to improve infection prevention and control practices at the service and replaced all stained mattresses, and cleaned all stained cushion covers.
● There was ongoing redecoration at the service during the inspection. The provider shared with us their service improvement plan which included the re-painting of woodwork. They also told us they had plans to replace the taps at the service.
● Medicines were stored safely and disposed of correctly. Storage temperatures were monitored to make sure medicines would be safe and effective.

Staffing and recruitment
● There were not always enough staff available to meet people's needs. Some of the people we spoke with told us they often had to wait for care when they needed it. One person said, "They are very short staffed, we sometimes have to wait a long time to get attention." Call bell records showed people sometimes had to wait a significant period of time for staff to attend when they needed them. For example, records for October demonstrated people waited longer than 20 minutes on 22 occasions, with the longest being over 58 minutes.
● The provider used a dependency tool to determine staffing levels at the service. However, records demonstrated staffing was not always in line with this. For example, staff rotas demonstrated on 24 days between November and the end of December there were not enough staff on duty in the afternoons. We also observed on inspection people to be waiting prolonged periods of time for staff support when it was needed.
● Whilst care staff had received training to meet the needs of people diagnosed with a learning disability, training records demonstrated other staff including, kitchen staff and housekeepers had not received training in learning disability awareness as required by law.

The failure to ensure there was enough staff to meet people's needs and safety placed people at increased risk of harm. This was a breach of Regulation 18 (Staffing) (Regulated Activities) Regulations 2014.

● Staff were recruited safely. We found appropriate checks such as Disclosure and Barring Service (DBS) checks had been completed prior to staff starting. Disclosure and Barring Service checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe.
● Staff had received training in safeguarding and understood how to identify signs of possible abuse and how to escalate any concerns. They were confident any concerns or issues raised would be dealt with appropriately and in a timely manner.

Visiting in care homes

● Visitors were welcomed at the service, and people were encouraged to spend as much time with their loved ones as they wanted.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People who required support from staff to eat experienced a disjointed mealtime. We observed the mealtime to be noisy and rushed, with people being supported by different members of staff during their meal. One person told us, "The music is much too loud here, and it can get a bit noisy generally."
- We received mixed feedback about the meals provided at the service. One person told us, "The food is always cold. The mashed potato is like water, you can pour it. I have told them, but they don't like it when you say anything, so I don't say it anymore." Another person said, "Vegetables are overcooked and can be repetitive. I get fed up with sandwiches every teatime." Records of feedback sought by the provider regarding whether people were happy with the variety of meals offered included comments such as, "Yes the food's alright", and "Yes, there's never been a time where there was nothing I would eat."

Adapting service, design, decoration to meet people's needs

- Some people's bedrooms were not individualised. For example, we found a person's name was spelt incorrectly on their bedroom door.
- The building was in need of redecoration. The environment needed repair such as chipped paint along handrails, skirting boards, and walls. This had been identified by the provider and there was redecoration work going on during the inspection. The provider shared with us their refurbishment plans.

Staff support: induction, training, skills and experience

- Staff were being supported to receive online and face-to-face training relevant to their roles, but training was not always up to date.
- The provider completed supervisions and competencies for staff. Staff received competencies in areas such as medicines and moving and handling.
- Staff told us they felt supported. They told us the management team were accessible and approachable.

Supporting people to live healthier lives, access healthcare services and support;
Staff working with other agencies to provide consistent, effective, timely care

- Care records demonstrated oral health assessments had been completed. However, we received feedback that 1 person's dentures had been missing since their admission, and this was not accurately reflected within their care record.
- Records demonstrated referrals were made to healthcare professionals when people's needs changed. For example, people were supported to access the GP and the community nurse team where needed.
- Staff supported people to access emergency medical attention when needed.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where people lacked capacity to make decisions the provider had mental capacity assessments in place. However, it was not always clear what questions were asked as part of the assessment to reach the decision the person lacked capacity.
● Where people were deprived of their liberty, the provider had appropriate authorisations in place and ensured conditions were met.
● Staff had received training in the MCA and had a clear understanding of their role and responsibilities in line with legislation. Staff were observed gaining consent before providing care and support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had their needs assessed prior to moving into the service to ensure their needs could be met.
● Staff had a good understanding of people's needs and the support they required.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to monitor and improve the service were not used effectively and concerns identified through audits had not always been effective at driving improvements. For example, audits on call bell timings identified people were waiting for long periods of time for support, as detailed in the safe section of the report. However, actions taken by the registered manager failed to improve the call bell response times. Maintenance checks carried out recorded taps had been descaled but this was identified on inspection to have not been effective to make adequate improvements.
- The auditing system for medicines was not always effective in monitoring the safety of medicines and did not always pick up on the concerns found during the inspection. For example, medicines audits were not always completed during periods when the registered manager was absent. This placed people at risk of concerns regarding their medicines not being identified in a timely manner.
- Systems and processes failed to identify concerns in relation to infection control. For example, we identified 6 chair cushions in communal lounges and multiple mattress covers to be soiled and malodorous.

Whilst no harm occurred, the systems to assess, monitor and improve the service were not sufficiently robust. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most people spoke positively of the management team. People told us they felt confident action would be taken promptly in response to their feedback. One person said, "[Manager] is very good and deals with everything well." However, under effective, a person said "The mashed potato is like water, you can pour it. I have told them, but they don't like it when you say anything, so I don't say it anymore."

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

- People were not always treated with dignity and respect. People spoke of the lack of staffing to support with their toileting needs, resulting in episodes of incontinence which negatively impacted them. One person told us "I could tell them I needed the toilet if anyone was around but there usually isn't, so I wear pads. I don't get to sit on the toilet. They don't offer to take me to the toilet." Another person said, "I wait a long time for the toilet. When I need to go to the toilet I need to go straight away. I have had to wait up to 2 hours to be taken to the toilet by which time it was too late."

● We received mixed feedback from people regarding personal choices being offered. One person told us, "I was taken to bed at 8pm last night though I usually prefer to go at midnight. [Staff member] put me to bed and didn't put the television on." Another person said, "The night staff get me up before 7am, I like that because I wake early but it means I don't get a shower very often, I would like to have one more often."

The provider failed to ensure people were always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people spoke positively of the staff. One person told us, "The staff are lovely and friendly here. It's really homely."
● People told us they frequently enjoyed the activities on offer at the service. One person told us, "I miss church, so the minister comes here occasionally and [they] are very nice." We saw there was a comprehensive activity plan at the service. Staff told us how they involved all people living at the service in the activities and adapted them where necessary. One staff member said, "If no one wants to do anything pre-planned we can always offer something else."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Equality and diversity training was in place for staff, but at the time of inspection most staff had not completed their refresher training in the last 3 years. The provider could therefore not be assured people's individual diverse needs would be respected in line with their protected characteristics.
● The provider used surveys and meetings to obtain the views of people using the service and their relatives. Records demonstrated that feedback was mostly positive and complimentary. One relative told us, "There are family and resident meetings. They discuss any events coming up and things that are happening."
● Staff meetings were held regularly. Records of the meeting minutes found some staff had raised concerns around the culture of the service. Key information was also shared in these meetings which included updates on the service.

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 registered manager understood their legal requirement to ensure that where mistakes were made they apologised to those affected.
● The provider is legally required to notify us of certain events that happen. We have been notified as expected.

Working in partnership with others
● The provider worked collaboratively with the local authority and healthcare professionals to promote the health and well-being of people living at the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks relating to the health, safety and wellbeing of people were mitigated.

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 The provider failed to ensure effective governance systems and processes were in place to improve the quality and safety of the service.

The enforcement action we took:

Issue Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff deployment was sufficient in meeting people's needs and safety.

The enforcement action we took:

Issue Warning notice