Serene Care (UK) Ltd

Abbey Rose

Inspection report

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07 September 2017
11 September 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Abbey Rose on 7 and 11 September 2017. The inspection was carried out by two inspectors. The home is registered to provide accommodation and residential care for up to 24 people. At the time of our inspection there were 20 people living at the home, some of whom were living with a dementia. The home is set out over two floors.

The service had a registered manager at the time of our inspection. 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.

When the service was last inspected in August 2016, we found that improvements were needed in response to our questions in relation to whether the service was caring and whether the service was responsive. At this inspection we found improvements had been made in both areas.

People did not always receive their medicines when they needed them. We found that medicines were not always ordered, administered or recorded safely. Medicines had been administered by staff that had not completed medicine administration training or had their competencies checked.

People had not always had their risks assessed when emerging risks had been identified so that actions could be put in place to minimise possible harm. When risk assessments had been completed care plans explained the actions needed to minimise risk and these were understood by the staff team.

There were not enough planned activities to meet people's social and well-being needs.

People were supported by staff who received training and supervision that enabled them to be effective in their roles.

People's eating and drinking needs were understood and met. This included allergies, likes and dislikes and fortified diets to support people with their nutrition.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards can only be used when there is no other way of supporting a person safely. We saw that the registered manager had made appropriate applications where people were being deprived of their liberty and they had been authorised.

People and their families described the staff as caring and we observed staff being friendly towards people that used the service.

Auditing systems were in place but they had not always recognised areas that needed improvement.

Staff told us they felt able to approach their managers and raise any concerns.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 safe.

There were some shortfalls in the management of people's medicines.

Actions required to mitigate risks to people were not always identified following incidents or changes to people's needs. Where risk assessments had been completed actions were carried out to minimise people's risks of harm.

People were supported by staff who knew how to recognise and report abuse.

People were supported by enough staff and they had been recruited safely

Is the service effective?

Good

The service was effective.

People were supported by staff who had an appropriate induction and on-going training and supervision.

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People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005.

People's eating and drinking needs were understood and met. People had access to healthcare when it was needed.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and patient and had a relaxed, friendly, professional relationship with people.

People were involved in decisions about their care and had access to advocacy services.

People's privacy, dignity and independence was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's need for occupation, stimulation, and activities was not fully assessed and planned for.

Care and support plans contained detailed information explaining how people wanted to have their care provided and was reviewed regularly.

People and their relatives knew how to complain and there were systems in place to receive their feedback.

Is the service well-led?

Requires Improvement

The service was not well led.

The quality assurance systems in place were not effective in monitoring and reducing risks to the health and welfare of people.

The provider had not always taken actions to improve the service people received following feedback from people and their families.

The provider had not sent CQC all statutory notifications as required.

People were supported by staff who felt able to approach their managers.

Abbey Rose

Detailed findings

Background to this inspection

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The service had a registered manager at the time of our inspection. 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.

When the service was last inspected in August 2016, we found that improvements were needed in response to our questions in relation to whether the service was caring and whether the service was responsive. At this inspection we found improvements had been made in both areas.
People did not always receive their medicines when they needed them. We found that medicines were not always ordered, administered or recorded safely. Medicines had been administered by staff that had not completed medicine administration training or had their competencies checked.

People had not always had their risks assessed when emerging risks had been identified so that actions could be put in place to minimise possible harm. When risk assessments had been completed care plans explained the actions needed to minimise risk and these were understood by the staff team.
There were not enough planned activities to meet people's social and well-being needs.

People were supported by staff who received training and supervision that enabled them to be effective in their roles.

People's eating and drinking needs were understood and met. This included allergies, likes and dislikes and fortified diets to support people with their nutrition.

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 2005. The application procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards can only be used when there is no other way of supporting a person safely. We saw that the registered manager had made appropriate applications where people were being deprived of their liberty and they had been authorised.

People and their families described the staff as caring and we observed staff being friendly towards people that used the service.

Auditing systems were in place but they had not always recognised areas that needed improvement.

Staff told us they felt able to approach their managers and raise any concerns.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.'

Requires Improvement

Is the service safe?

Our findings

People were at risk of not receiving their medicines as prescribed. Medicine was not always available, administered or recorded safely. One person had not received a prescribed medicine the evening prior to our inspection and another medicine the morning of our inspection. A care worker told us this was due to medicines not being available in the home. A care worker took actions and the medicine arrived and was administered later that day. .

One person's Medicine Administration Record (MAR) had been handwritten and information transferred from the previous months MAR had been copied incorrectly. The person had been prescribed a medicine twice a day but it had been copied across as once a day. Some people were at risk of not having their topical creams administered safely. Body maps had been completed and showed were staff needed to apply topical creams but records did not always reflect this had been carried out. People told us they had their creams applied. One person told us "They (care workers) are very good with my skin. It's examined every day. They are very vigilant and put cream on". This meant people were at risk of avoidable harm as medicine records were not correct.

Medicines were not administered safely. People had been prescribed medicines 'as required' which included medicines for pain control. We checked one person's records who had needed medicine for pain in the night. When we checked the signature of the care worker who had administered the medicine they had not completed medicine administration training. We discussed this with the registered manager who told us that night care workers had not been medicine trained. Following our inspection the registered manager told us the information they had provided had been incorrect as some night staff were trained in medicine administration and provided a training certificate as evidence. They also told us that the practice was that if people needed medicine through the night and trained staff were not working a member of the day staff trained to administer medicines would be contacted and return to the home. This process had not been followed. This meant people were at risk of avoidable harm as untrained staff had administered medicine as trained staff had not always been available to administer medicines when required. Another person had been prescribed pain relief medicine four times a day. We checked records between 9 August 2017 and 4 September 2017 and each day it had been administered at 0800, 1200, 1700 and 1900hrs. This medicine required a four hour gap between doses. This meant the person was at risk of avoidable harm as a medicine had been administered without a safe gap. The registered manager told us they would immediately review the medicine administration timings.

The provider's medicine policy did not provide information to staff on the procedure to follow if a medicines error occurred or the procedures to follow on the safe management of controlled drugs.

People who had chosen to self-administer their medicines and the risks associated with this had been regularly reviewed with the person and a district nurse to ensure the person's ability to carry this out safely.

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This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People were at risk of avoidable harm as risk assessments were not always completed in response to identified emerging risk. Shift handover notes reported each day that a person had been aggressive. A risk assessment had not been completed in relation to the person's behaviour. A care plan was not in place to explain to staff the actions they needed to take to reduce the risk of aggressive behaviour and keep the person and others safe.

Daily records for one day described an incident whereby the person's aggressive behaviour and actions in the communal lounge had led to another person becoming upset. An incident form had not been completed which meant that details of how the incident occurred, how it was dealt with and any actions needed to reduce the risk of further incidents had not taken place.

Another person had risks associated with their behaviour. To support with managing risks the service had worked with the persons GP, social services and the community mental health team. A care worker told us "We have had good support. When the problems first arose we were told how to deal with it. Step back, don't agitate them. I feel we have been trained pretty well".

People were supported by enough staff to meet their assessed needs. A care worker told us "There's enough staff to do what is needed to be done". A clinician who visited the service regularly told us "There always seems plenty of staff". A relative told us "If you press the call button somebody is here in minutes if not seconds". Throughout our inspection we observed care workers responding to call bells in a timely way.

When risks assessments had been completed actions had been put in place to reduce risk whilst respecting people's freedoms and choices. One person had a health condition that impacted on their breathing. Their care plan included details of what care workers needed to look out for to identify if their condition was deteriorating. Records showed us that care workers understood the risks and had acted appropriately when deterioration had been identified. We observed care workers frequently checking on the person throughout our inspection.

Another person had an identified risk of malnutrition. They had been involved in discussions in how the risk could be managed. They had decided not to take prescribed food supplements and their care and support plan read '(Name) makes their own choices of how much food they like to eat". The person told us "I'm fickle with food. They know what I like and don't like and the cook comes to see me most days". Their weight was recorded weekly and remained stable.

People had personal evacuation plans detailing what support each person would require if they needed to leave the building in an emergency.
Equipment had been regularly serviced including boilers, fire equipment, lifts and hoists.

People were supported by staff who had been trained to recognise signs of potential abuse and understood their role in reporting concerns. A care worker told us "If I had any concerns I would call CQC. If I had concerns about somebody's performance or care I would go to the manager and I know they would deal with it. I would not be doing my job properly if I didn't". People told us they felt the care was safe. One person said "I have an alarm mat and if I move about somebody comes. I like it; it makes me feel safe".

Good

Is the service effective?

Our findings

People had their eating and drinking needs met and described the food as good. One person told us "They do feed us well; a really good breakfast, you can't complain". People were able to choose where they had their meals and share them with friends and family. People had a range of choices for breakfast and supper but choices were not consistently offered for the main meal of the day. The menu showed two main meal choices for each day but on both days of our inspection everybody had the same main dish. We discussed this with the chef who told us "I tell them (residents) one choice and wait then say the second choice as I don't want to confuse them". We checked records for August 2017 and found that although two choices were listed each day other than one person on one occasion everybody had the same meal choice. One person told us "We don't get offered any choice albeit the food is not bad at all". Another told us "One main choice for lunch". We read feedback from a person who had completed a quality assurance survey that read 'Only sometimes offered a choice of food". We discussed this with the registered manager who showed us examples of how breakfast and supper options had been increased in response from feedback from people. They told us they had not been aware people were not being offered the lunch time menu options and would immediately review. We observed people being offered drinks throughout our inspection and drinks were available in people's rooms and the main lounge area.

People were supported by staff that had completed an induction and on-going training that gave them the skills to carry out their roles effectively. For some staff induction included the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. We spoke to one person who told us "Staff are 100% in what they do". We spoke with a care worker who told us their induction included moving and handling training and shadowing other members of staff. They told us "We had to do certain training and shadowing before we could start helping people. We were given about 15 learning packs; to be honest it felt a little overwhelming". We spoke with an agency care worker who told us "It's my first shift. I was orientated to the building and then told who I needed to help. I started working alongside another carer and then on my own. The staff have been helpful".

Training primarily was completed by e-learning. Staff told us that it needed to be completed in their own time and this sometimes was difficult. One care worker told us "When you work full time you don't always feel like more work on your day off". Training records showed us that staff had completed training relevant to their roles. Training completed included dementia awareness, challenging behaviour, dignity and respect and communication. The registered manager told us that staff had been given the opportunity to feedback on training in the staff questionnaire. As a result they had been looking at more interactive dementia training.
Staff told us they felt supported and had regular supervision. We checked supervision records which included observational checks on competencies including respecting a person's dignity and privacy. Appraisals had taken place annually and staff had opportunities for professional development which had included diplomas in health and social care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found people's rights were protected because staff acted in accordance with the MCA. Most people had the capacity to consent to their day to day care and support. We observed staff offering people choice around what they would like to eat or drink, times they wanted to go to bed and get up in the morning. Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this.

People were supported to access health care when needed. One person told us "They good at getting me sorted with the opticians and the doctor". Records had been kept of healthcare professionals who had visited people and included GP's and district nurses. One visiting healthcare professional told us the staff were, "very professional" and had provided information relating to the person that was relevant and current.

Good

Is the service caring?

Our findings

When the service was last inspected in August 2016, we found that improvements were needed in response to our questions in relation to whether the service was caring. At this inspection we found improvements had been made.

People and their families spoke positively about the care they received. One person told us "I've not been well and the staff look after me". Another told us "The staff make me laugh; they make life worthwhile for you". We spoke to a visiting clinician who told us "Staff have the right attitude. It's their (residents) home and staff respect that". One person chose to spend all their time in their room. They told us "Staff pop in and out all day and night checking I have got drinks and I'm ok".

We observed a relaxed and friendly relationship between people and the care workers. Staff spoke with people in a kind way, using their preferred name and offering choices. One care worker entered a person's room and their face lit up and they shared a hug and a smile. Another person was being supported with their mobility and the care worker was patient and provided support at the person's pace. We observed a care worker asking a person if they had a headache and showing concern that they looked tired. The person needed some pain management and the care worker went off to organise this.

Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, talking with people at eye level and using hand gestures and facial expressions. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that interested them such as family or the garden.

People were involved in decisions. One person told us "We can have discussions about how I like to be helped". People were involved in decisions about where they spent their time, took their meals and in participating in any activities. People who needed an independent representative to speak on their behalf had access to an advocacy service. People's clothes and personal space were clean and reflected a person's individuality. Rooms had photographs, books and music that people proudly shared with us.

People had their dignity, privacy and independence respected. One person told us "Staff respect my dignity very much so". A relative told us "Staff are busy but show a lot of respect. Once a man helped (with personal care) but (relative) didn't like it and this was respected and hasn't happened again". Another person explained "If I'm not well I always want to come home (Abbey Rose). This room feels like my home. Staff respect that very much so". Staff explained to us how they respected people's dignity by knocking on bedroom doors and ensuring people were covered with a towel when being supported with personal care.

Requires Improvement

Is the service responsive?

Our findings

When the service was last inspected in August 2016, we found that improvements were needed in response to our questions in relation to whether the service was responsive. At this inspection we found some improvements had been made but more were required.

People had limited opportunities for social activity which meant that there were large periods of time without any stimulation. We spoke with a relative who told us "There have been no activities for a couple of months. People are just sitting about asleep. We've been given no information about what is happening with activities". People who enjoyed going out into the community were not being supported to do so. One person was unable to leave the home unsupervised and their care file included information about how they enjoyed going out into the community and to church. We observed the person telling a member of staff that they wanted to go out and being told they had to wait until their family came to take them out. We asked the registered manager when the person had last been out of the home. They checked records which showed it had been in February 2017. A care worker told us "There have been no activities and it's quite difficult for residents and us. We have recently had a full house and it's been difficult to find time to do activities; it's been hard. It's difficult on the residents as no stimulating activities". The registered manager told us that the activities organiser had left in April 2017 and there had been difficulties recruiting into the post but that an appointment had been made and the person was due to start imminently.

The previous activities organiser had left a book which had photographs of activities and events people had been involved in. It included card making, cake making, Easter bunny crafts and outings to a local garden centre. One person told us "I like to stay in my room. Staff always telling me I should try and get out more, but they do respect it's my choice".

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Reviews had taken place monthly and whenever possible had included the person. Daily records had been completed for each person and provided detail about care they had received and how they had spent their time.

Care workers had a good understanding of people's care and support needs and were kept up to date with any changes. A care worker told us "Communication is good. If we have a new admission it's discussed at handover in the morning, afternoon and at night. Handovers are quite informative". They were able to share with us changes that had taken place with people since their last shift. We spoke with a paramedic who had been attending to a person. They told us the staff response and knowledge had been good. They said "They provided more information than we normally are given. They knew the person's history without notes; that's rare. They responded appropriately and applied the correct first aid".

A complaints policy was in place and people told us they would feel happy to use it. We checked records which demonstrated that complaints had been listened to and appropriate actions taken.

Requires Improvement

Is the service well-led?

Our findings

The registered manager oversaw two homes and told us they spend approximately three days a week at Abbey Rose delegating the management of the home in their absence to the care manager. We found that auditing systems had not been effective in recognising areas that needed improvement to ensure the best outcomes for people. This included areas in relation to the management of risks to people and risks with medicine administration identified at this inspection. We checked medicine audit records which recorded a monthly signature from the registered manager that they had checked the Medicine Administration Records and controlled drugs. The audit did not record any detail of what records had been checked and whether there were any actions required. The registered manager told us that they met weekly with the head of care to review peoples care and support needs and this formed part of their auditing process. Records were not available for these meetings.

We spoke with the provider who visited the service a minimum of twice weekly and was available via telephone and facetime when required. They were unable to explain what governance arrangements are in place for them to be assured that checks and audits delegated to the registered manager and head of care were effective and met requirements of the regulation.

The registered manager had not fully understood their responsibilities for reporting incidents which meant that not all statutory notifications had been reported to CQC. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. Examples included one care file that contained details of an incident that had included contact with the police. Another contained details of an altercation between two people living in the service which had led to a physical assault. Neither of these incidents had been reported to CQC. This meant that processes in place to provide extra safeguards to protect people from avoidable harm had not been followed.

A quality assurance process was in place but had not always led to improved service delivery to people. We looked at feedback from five people in May 2017 who all complained of poor activities. Feedback in July 2017 also contained comments about lack of activity. At the time of our inspection no improvements had taken place to improve outcomes for people. The home had been without an activities organiser since April 2017. Feedback from people had not been acted on as actions had not been taken to ensure people's social needs were met. The registered manager told us that an activities organiser had been recruited and would be starting shortly. A relative had provided feedback and suggested a photo menu to aid people with sensory impairment making a choice. We discussed this with the registered manager who told us some had been purchased but had not been suitable. At the time of our inspection a more suitable photo menu had not been sourced. We read in a staff survey carried out in January 2017 that staff would find more dementia training helpful particularly face to face. We discussed this with the registered manager who told us they had been sourced but had as yet not taken place.

Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We observed staff working as a team and were told by care workers that they felt supported and appreciated by the management team. One care worker told us "I feel appreciated. They will take you to one side and tell you you've done well". Staff described the home as organised and told us they understood their roles and responsibilities. One care worker told us "Everybody knows what they need to do on each shift. We help each other out. Works is allocated at each handover". Another said "Each shift is organised so we all know what we do so that nothing is missed. It's good teamwork".

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks identified for people had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare.