Abbeyfield Society (The)

Abbeyfield Malmesbury Care at Home

Inspection report

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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

The inspection took place on 10 September 2018 and was announced. We gave the service 48 hours' notice of the inspection to ensure people we needed to meet with were available. The service had not been rated previously and this was the first comprehensive inspection.

The service is provided to people who live in the Burnham Court housing complex and to people living at home in the community within a five mile radius. There are 49 apartments within the complex and at the time of our inspection a care and support service was provided to 22 people on site and to seven people in the local community.

The service provides care and support to people living in a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community.

There was no registered manager in post at the time of the inspection, although there was an acting head of care. A new operations manager had started employment the week prior to the inspection, but was unavailable on the day. The operations manager had submitted their application to apply to be the registered manager. 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.

Although staff we spoke with said they believed there was enough staff on duty to meet people's needs, people using the service gave mixed feedback. Some people said staff always attended planned visits. Other people said staff did not always attend visits and did not always stay for the agreed length of time because of staff shortages. The process for monitoring how long staff attended visits was not robustly monitored. Missed visits were not monitored.

Risk assessments in place did not cover all areas of risk. Risks in relation to choking had not been assessed. Other risk assessments had been carried out and where risks had been identified, care plans provided some guidance for staff on how to reduce the risks to people.

Care plans lacked detail on the level of support people needed from staff. Plans in relation to people's clinical needs were not in place. Daily records were not always maintained. Some of the terminology used by staff in records lacked person centredness.

The providers quality assurance framework was not always robust. Provider audits were carried out. However, these did not cover all aspects of care planning and delivery. Incidents had not always been

reported via the provider's incident reporting procedure. In addition the provider had not sought feedback from people using the service.

Staff understood their responsibilities to protect people from harm and abuse. People gave mixed feedback about the staff. Although the majority of people told us that staff were "kind" and "caring", not all did. One person said, "One member of staff is very abrupt." Another said, "[Staff name] is not sympathetic or caring." All the people we spoke with said staff maintained their privacy and dignity.

People and staff spoke highly of the acting manager. Medicines were in the main, managed safely.

Staff had been trained and were supported to carry out their roles. Consent to care was sought in line with legislation.

We found three breaches of the Regulations in 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 always safe.

The service did not monitor the number of missed visits and the system for monitoring how long staff stayed with people was not robust. People told us staff did not always attend scheduled visits to assist with care needs. They also said did not always stay for the allocated amount of time.

People had not been assessed for all areas of risk. Care plans did not always inform staff how to support people safely.

Incidents had not always been formally reported.

Staff knew how to keep people safe from harm.

Safe recruitment practises were in place.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had been trained to carry out their roles.

Staff had regular opportunities for support from a supervisor.

Consent to care was sought in line with legislation.

Is the service caring?

Good

The service was caring.

Although people gave mixed feedback about staff, the majority of people told us staff were kind and caring.

People said staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not provide staff with enough information on how to meet people's needs.

Documentation was not kept up to date.

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits did not identify shortfalls in care planning and care delivery. Actions arising from audits had not always been met.

There was no registered manager in post although an application had been submitted.

People and staff spoke highly of the acting head of care.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 10 September 2018 and was announced. We gave the service 48 hours' notice of the inspection because the manager is often out of the office supporting staff or providing care and we needed to be sure that they would be in.

The inspection was undertaken by one adult social care inspector. Before the inspection we reviewed other information we held about the service including notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people, three members of staff, the acting head of care and the business manager. We reviewed four people's care plans. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, staff training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Care plans contained risk assessments for areas such as falls and mobility. However, not all risks had been assessed. For example, in one person's daily notes staff had documented that the person required thickener to be added to their drinks. Thickeners are used to help to reduce the risk of people choking. There was no choking risk assessment in place and no plan in place which referred to the use of the thickener. Staff gave conflicting responses when we asked how much thickener the person needed. One said, "One scoop" and another said, "Two scoops." This meant there was a risk that staff did not have access to clear guidance on how to reduce the risk of choking or the necessary action to be taken in the event of choking.

Other plans showed that people had been assessed as being at risk of falling. When people used walking aids and needed staff supervision to walk around, this was documented. One person needed staff to use moving and handling equipment for safe transfers and this was documented.

We saw records of incidents and accidents. However, not all incidents had been reported. In one person's care plan it had been documented on 08 July 2018, "Found on floor." We asked to see the incident report but were told it was unavailable. The report of the incident was sent to us following the inspection and we were informed by the operations manager that the incident had not been formally reported using the provider's reporting system because the staff member had not given the form to the management team. In addition one person said, "A [person] came into my flat once. I had to use my wrist buzzer and the staff did come quickly. I felt relieved when I was told [they] had moved out." Another said, "One [person] did go round and wander into people's flats. [They] came in here once." We asked to see the reports of these incidents but were told that they were also unavailable because staff had not formally reported them. This meant the provider was not able to indentify trends or concerns because they did not have a clear oversight of incidents and accidents

People using the service had scheduled visits when staff attended to provide the support they required. However, some people told us staff did not always attend visits and did not always stay for the scheduled length of the visit. One person said, "I had five missed visits during June. Sometimes staff don't stay as long as they should. They tell me they don't have time or they're short staffed" and "I didn't have a carer yesterday morning. My neighbour had to help me." Another person said, "They don't always turn up when they should. And don't stay for long if they're in a rush." Most of the staff we spoke with said they believed there was enough of them on duty to meet people's needs. However, one member of staff said, "I sometimes feel rushed trying to see everyone at the right time."

One person said, "I have a schedule of when they [staff] should come to me. Night times are usually fine, but sometimes in the morning I've had to wait for over half an hour." Other comments included, "The staff are usually on time. It depends how busy they are. If they've got a lot to do, I understand they might be late." Two people said they had never had a missed visit. There was no process in place for monitoring missed visits or for monitoring whether visits took place on time as planned. The business manager told us a new system was due to be implemented which would monitor these aspects of the service and would provide the management team with real time information.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person said, "I do feel safe, yes. I've got no worries." Another person told us, "Safe? Yes, I'm safe here."

Staff were trained to recognise signs of abuse and knew how to report any concerns they had. One staff member said, "Anything worrying, like bruises, I'd report it to the manager." Another member of staff said, "I'd check if anything had been documented, then report it to a senior. The manager would then find out how it happened and stop it happening again."

Staff were also familiar with the term whistleblowing. We saw information in the staff room which informed staff how they could raise any concerns about poor care. Comments from staff included, "I'd report it and go higher and higher" and "I would definitely report it [poor care]. I'd go to the senior, the manager or higher in the company."

In the main, medicines were managed safely. Staff administered and prompted people to take their medicines. One person told us, "My medicines are locked away and the staff come and get them out for me. I want to look after them myself now, so I'm going to ask [acting manager's name] if this can be sorted." We discussed this with the acting manager who said they would go and speak with the person about making this happen. Another person said, "They [staff] come and give me my medicines, but they don't always put it in a pot. Sometimes they have them in their hands, which I don't really like." We discussed this with the acting head of care who showed us that medicine pots were available for staff to use. They said they would remind staff of the correct procedure to be followed.

We looked at medicine administration records (MARs). These had been signed by staff to indicate that people had received their medicines as prescribed. Some people were prescribed creams or lotions which staff applied for them. There were no topical administration records in place and no clear instructions for staff on where to apply the creams. For example, on one chart the instructions for staff for one cream were "x 2 daily." There was no guidance on where to apply the cream or the reasons why it was needed. We discussed this with the acting head of care and the business manager. They said they would implement a topical recording chart with clear instructions for staff. Although MARs were checked each month for completeness, this was an informal process which was not documented. This meant there was no overall monitoring of medicines management.

The provider had procedures in place to ensure staff had checks undertaken before commencing their employment. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Although three of the four recruitment files we looked at showed that all checks had been undertaken, we saw one staff record where the references on file were all character references. A provider audit had been carried out during April 2018 which stated that staff recruitment files were to be audited. However, this issue had not been noted or addressed.

Good

Is the service effective?

Our findings

People's needs were assessed prior to using the service. The assessments we saw showed that people were asked about the level of support they required. This included personal care, getting up and going to bed, meal preparation, and washing and cleaning. One person told us, "I needed a lot of support and care when I first moved here, but I've gradually improved."

Staff had been trained to carry out their roles. There was a training plan in place which showed when staff were due to attend training. Staff undertook a three month induction when starting their employment and completed all of the provider's mandatory training and the care certificate during that period. When people with additional needs used the service, additional training was sought. For example, the acting head of care told us that one person needed specific support with their personal care needs. They said a member of the hospital team had attended to provide training for staff. One member of staff said, "A nurse came in to do the training, but I still wasn't confident. So I didn't support [person's name] until I'd had more training." They said they had been supported with this by the acting head of care. They told us, "I was able to tell [acting head of care] I didn't feel able to deal with it."

Staff were supported in their roles. There was a supervision plan in place and staff confirmed they were regularly supervised by a line manager. All staff confirmed if they had any problems between supervision sessions they were able to ask for support.

Care plans detailed whether people needed support to prepare and eat their meals. There was a restaurant on site which people could purchase food from if they wished. Some people needed staff to assist them to the dining room. Others preferred to eat in their apartments and ordered food from the restaurant which staff delivered to them.

One person was having their fluid intake monitored by staff. Charts we saw had been filled in, but there was no daily target and staff had not totalled the amount the person had drunk. This detail was not included in the care plan. We asked the acting head of care how much fluid the person needed to receive, but they didn't know. They said the person's GP had asked for the fluid intake to be monitored. However, with no daily target, it was not clear how staff would know when to escalate concerns to the GP.

Staff were been trained in the Mental Capacity Act 2005 (MCA). People we spoke with said staff always asked for their consent prior to providing care and support. We saw that people had signed to indicate they consented to their plan of care.

Staff supported people to access ongoing healthcare. This included accompanying people to attend appointments if needed. Specialist advice and support was sought when required. For example, we saw staff had involved an occupational therapist to provide advice with moving and handling equipment. One person told us, "I had a problem so they rang the GP for me and arranged for a visit."

Good

Is the service caring?

Our findings

The majority of people spoke highly of the staff. One person said, "Most of the staff are very, very nice and very caring. There are two I particularly like." They also told us, "They [staff] have let me do things in my own time. They encouraged me to regain my independence without pushing me." Another person said, "The staff are wonderful" and "All of them are good."

However, some people gave us less positive feedback. One person said, "There's one member of staff; if I ring the bell, [they] say, 'what do you want? What's wrong?'" The same person also told us, "Most of the staff are friendly." Another said, "There are some wonderful staff, but not all are sympathetic or caring. The agency staff are nice, but they don't always know what to do."

People said staff respected their privacy. One person said, "I keep my front door unlocked, but the staff don't come in without knocking or ringing the bell and they wait for me to say it's ok to come in." Another person said, "All the staff ring the bell and call out hello to me before they come in." We saw that staff didn't enter people's apartments without permission. We asked to speak with some of the people using the service and the acting head of care gained people's consent prior to this. One member of staff said, "I always make sure the front door is shut, curtains closed and keep people covered up during personal care." Another said, "It's really important to give people privacy. I always ask if I should lock the front door when they're having a shower to stop people coming in."

Staff spoke highly of their roles. One member of staff said, "I really enjoy my job. I enjoy pleasing people, cheering them up if they're a bit down and supporting them to do things they can't do on their own." Another said, "We try to keep people as independent as possible. One person needs encouragement to do things themselves, but I always try to keep it positive, happy and cheerful. Sometimes memory problems mean people just need prompting." One staff member said, "I think this is a more relaxed way of working. We make sure people's needs are met and help them to stay as independent as possible." They also told us, "People often ask 'is it you tomorrow?' They thank me for helping them. It makes me feel like I've done something worthwhile."

Requires Improvement

Is the service responsive?

Our findings

Care plans lacked detail and were not consistently person centred. People's preferred times to be assisted out of bed, what time they liked to eat breakfast and go to bed had been documented, but their preference for a male or female member of staff for example had not been written. Care plans for gentlemen did not specify if they needed assistance with a wet or dry shave. One person had specific needs in relation to their personal care, but there was no guidance for staff on how to provide this, other than "I need help with my [area of need]". There was no information for staff on how to carry out the procedure, or things they needed to be aware of. In another person's plan, staff had documented the person had a urinary catheter, but there was no catheter care plan in place. In another person's daily records we saw staff had written, "compression stockings put on" but there was no reference made to these within the care plan. This meant staff did not always have access to the most up to date information about people's care and support needs.

Despite this, staff we spoke with demonstrated a good understanding of the support people required. When we asked staff how they knew this, one said, "I read the care plans, talk to people." Another said, "I read the care plans or people tell us. We have an allocation sheet which tells us what to do."

Documentation was not always well maintained and for some people lacked detail. Some records we looked at were not up to date because the latest daily notes written by staff were not filed in the correct place. In one person's daily notes staff had written, "Concerns about possible [urinary tract infection]/catheter problem. Called for out of hour's doctors' advice. District nurses will call back." This entry was made on 07/09/2018 but there was no subsequent entry to inform staff what the outcome was. We saw later that the outcome of the district nurse input had been documented in the staff communication book rather than the care record. This meant staff might not always have access to up to date information about people.

Some of the terminology used within daily records did not indicate a person centred approach to care. For example, staff had written, "creamed back, legs, sides and knees", "turned" and "fed." One person was having their position changed regularly. This was being documented on a 'turning chart', but there was nothing written on the chart or in the care plan to inform staff how often this needed to happen.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were regularly reviewed. People and their relatives were involved in this process and we saw that records of the reviews were maintained. When people's needs changed, records showed that staff requested a care review.

There was a complaints policy in place. Complaints were logged and investigated using the provider's electronic system. We were unable to view the system during the inspection because the acting head of care told us they were having difficulty accessing it. People knew how to complain. One person said, "Yes, I know how to complain." Another said, "I have highlighted issues, but nothing ever gets sorted." Two other people

told us, "No, never had to complain, but I'd speak to [acting head of care]. [They] would sort it out."

People were invited to attend 'tenant meetings'. One person said, "I go to the regular coffee meetings. The new manager is going to be at the next meeting." Another person said, "Yes, I usually go to the coffee mornings."

Requires Improvement

Is the service well-led?

Our findings

Provider audits had been carried out. However, these were not robust and did not cover all areas of care planning and delivery. Care plan and documentation audits were not routinely carried out which meant the issues we noted during this inspection had not been identified. Actions following audits had not always been completed. For example, a provider audit in April 2018 had led to an action to audit staff recruitment files, but an issue around one staff member's references had not been resolved.

Documentation was not always monitored, well maintained, or up to date. Medicine 'checks' were carried out, but these were not documented. Support visits were not monitored. There was no process in place for monitoring the number of missed visits, late visits or shortened visits. The business manager showed us a draft action plan that had been devised the week prior to our inspection. This included many of the issues we noted during the inspection and indicated that the service was aware of these and had a plan in place to rectify them. Although the plan was in draft form, the actions had been allocated to staff with a target date for completion. Many of the actions had been allocated to the new operations manager.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not a registered manager in post, although an application had been submitted by the new operations manager. 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.

An acting head of care had been overseeing the service since the previous registered manager left. A new operations manager had commenced employment the week prior to our inspection. The acting head of care told us, "We're trying to do our best with no manager. It's been difficult but we're trying to improve, little by little." They said a meeting had taken place the previous week to devise an action plan which they hoped would address the issues identified.

At the time of the inspection formal feedback had not been sought from people using the service.. People using the service said they had received a letter to introduce the new operations manager. One person said, "I had a letter from [them]." Another person said, "I had a letter to say [operations manager] is going to be at the next coffee morning, but I can't attend. [Acting head of care] said they will arrange for the new person to come and meet me personally in my flat." The business manager told us the provider planned to introduce annual surveys, but these had yet to be implemented.

People spoke highly of the acting of head of care. One person said, "[They] are very good. [They've] organised things and sorted things for me." Another said, "[They] listen and try to help. I don't think they get much support from head office though."

One member of staff said, "[Acting head of care] has done a really good job. [They] are very approachable." Another said, "[Acting head of care] has kept us updated and never kept anything from us. [They] have been really supportive of us all."

Team meetings took place regularly. One member of staff said, "We're due one soon. We're always given a chance to voice our views." Another said, "We all meet together regularly. We discuss how to improve care or if people's needs have changed." Minutes of meetings that had taken place confirmed what staff had told us.

Staff spoke highly of the provider. One member of staff said, "We're here to make sure people's needs are met whilst trying to keep them as independent as possible." Other comments included, "It's a good company. We're kept up to date" and "[Provider] is pretty good to work for."

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not monitor the number of missed visits and the system for monitoring how long staff stayed with people was not robust. People had not been assessed for all areas of risk. Care plans did not always inform staff how to support people safely. Incidents had not always been formally reported.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans did not provide staff with enough information on how to meet people's needs. Documentation was not kept up to date. Governance systems were not effective.