Avondale Care Home Limited

Avondale Rest Home

Inspection report

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Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Avondale Rest Home is a residential care home providing personal care for up to 19 people aged 65 and over. At the time of the inspection there were 13 people living at the service.

People's experience of using this service and what we found
The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements were not reliable or effective in identifying shortfalls in the service. Information relating to people's individual risks were not always recorded or mitigated and did not provide enough assurance that people were safe. Appropriate measures were not in place to prevent and control the spread of infection. Government guidance relating to COVID-19 was not always being followed.

People told us they were safe and enjoyed living at Avondale Rest Home. Observations demonstrated staff had a good relationship and rapport with the people they supported. People received their medicines as prescribed. There were enough numbers of staff to meet people's needs and recruitment practices were safe.

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

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 24 August 2021). The provider's representative completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and sustained and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about care home visiting. A decision was made for us to inspect and examine those 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.

We inspected and found there was a concern with the services infection, prevention and control measures, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe and Well-Led.

Enforcement

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

We have identified breaches in relation to people's assessments, risk management, including those related to infection control practices and governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Avondale Rest Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by one inspector.

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

The provider was also registered with the Care Quality Commission as the registered manager. This means they are legally responsible for how the service is run and for the quality and safety of the care provided. The provider had appointed a representative to assist them with the day to day management of Avondale Rest Home.

Notice of inspection
This inspection was unannounced.

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

site visit and reviewed information held by the Care Quality Commission. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with the registered manager, the provider's representative, the provider's administrator and three care staff. We reviewed five people's care records and six medication administration records. We looked at two staff files in relation to recruitment procedures and profiles relating to agency staff deployed to the service. We also looked at the service's quality assurance arrangements.

After the inspection
We continued to seek clarification from the provider to validate evidence found and additional information was requested. We contacted nine relatives by email about their experience of the care provided for their family member.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection risks to people's safety and wellbeing were not routinely recorded. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 12.

Preventing and controlling infection

• The provider's infection, prevention and control procedures to keep people safe were not being followed in line with best practice government guidance. The provider did not ensure people's discharge from hospital and admittance to Avondale Rest Home was safe and in line with government guidance. Three people admitted to the service between September 2021 and December 2021 had not isolated in line with government guidance either in their room, or a specific designated area. This placed people at increased risk of contracting COVID-19 or other infections.

• We were unable to determine if the testing regimes practices for people using the service and staff were in line with current government guidance as data to demonstrate compliance was not recorded and maintained. This also referred to people who were admitted to Avondale Rest Home from hospital.

• People's relatives or those acting on their behalf were able to visit their family member prior to the recent COVID-19 outbreak. However, following a recent outbreak of COVID-19 the provider had stopped people's relatives from visiting. Individual risk assessment and visiting plans had not been completed in line with the provider's own visiting policy and procedure.

• Cleaning schedules could not be located by the provider's representative to evidence records and checks of compliance with the cleaning schedule for the service, including the kitchen. However, despite ongoing refurbishment in progress throughout the service, communal areas and people's room looked visibly clean.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

• Systems were in place to monitor and record the vaccination and COVID-19 status of staff and visiting professionals. However, this was not completed for all staff employed at the service, including regular staff deployed to Avondale Rest Home via an external agency or staff who worked between both services owned

by the provider.

We identified a breach of Regulation 12[3], but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Although there was no impact for people using the service, not all risks to people's safety and wellbeing were assessed and recorded or provided enough detail as to how identified risks should be mitigated. This placed people at potential risk of not having risks to their safety met in an appropriate and safe way.
• The care plans for two people referred to them mobilising with a wheeled walking frame. However, daily care records recorded there had been occasions whereby both people had been unable to weight bear and staff had used a hoist to enable the person to mobilise or transfer. The latter had not been formally assessed to ensure the hoist and sling used was the correct item of equipment or the correct size. This could lead to inadequate support and a risk of falling for the person using the service.
• The records for another person documented the person had recently incurred a skin tear and developed pressure ulcers. The person's care plan and risk assessment had not been updated to reflect this. This could lead to inadequate support being provided by staff.
• Where people had a catheter in place, not all risks associated with the catheter had been considered or recorded, for example, bladder spasms, leakage around the catheter, blood or debris in the catheter tube, dehydration and the importance of monitoring people's fluid intake and output. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag. This could lead to inadequate support being provided by staff.
• Current and emerging risks presented by the pandemic had not been identified for all people or staff at Avondale Rest Home. This meant people and staff who may be at increased risk of contracting COVID-19, for example, those with underlying health conditions and including staff from black, Asian and ethnic minority groups.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to manage and mitigate risk, including those related to the service's infection control practices and procedures. This was a continued breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• We were assured the provider was using Personal Protective Equipment [PPE] effectively and safely. Staff were observed to wear appropriate PPE, such as masks, gloves and aprons. Staff were observed during the inspection to dispose of their PPE appropriately.
• Staff training data demonstrated all staff had attained infection, prevention and control training in 2021.
• At our last inspection to the service in July 2021, improvements were required to some aspects of the service's fire arrangements. At this inspection we found the required improvements had been made. Staff had participated in fire drills to ensure they knew what to do in the event of a fire emergency. Staff had received updated fire training and Personal Emergency Evacuation Plans [PEEPs] were now accurate and person-centred.

Using medicines safely
• At our last inspection to the service in July 2021, improvements were required to some aspects of medicines management. At this inspection those improvements had been made.
• The Medication Administration Records [MAR] for six out of 13 people living at the service were viewed. These were in good order, provided an account of medicines used and demonstrated people were given their medicines as specified by the prescriber.
• Improvements were required to ensure where people were prescribed a topical cream, these were only

administered to those people. We found one person's 'over the counter' medication was not stored correctly and was easily accessible to others. This was brought to the immediate attention of the registered manager and removed for safekeeping.
• Medication audits were completed at regular intervals and demonstrated a good level of compliance.
• Staff had received medication training and had their competency assessed within the last 12 months.

At our last inspection appropriate arrangements were not in place to protect people from abuse. This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe and comments included, "I feel safe" and, "Yes, I think I'm safe here."
• Interactions between staff and people using the service were relaxed and comfortable.
• The staff training summary demonstrated staff employed at the service had achieved up to date safeguarding training.
• Staff demonstrated a satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate concerns to the management team and external agencies.

Staffing and recruitment
• The deployment of staff was appropriate and there were enough staff to meet people's needs, with staff responding to people in a timely way.
• Staff told us staffing levels were appropriate and there was enough of them to provide safe care to people living at Avondale Rest Home. Staff confirmed they picked up additional shifts when required and staff were deployed from an external agency to plug staffing shortfalls.
• Appropriate arrangements were in place to ensure the right staff were employed at the service. Relevant checks were carried out before a new member of staff started working at the service. This included obtaining written references, ensuring the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS].

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider's quality assurance arrangements were not effective. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• Since our last inspection to the service in July 2021, the provider had employed another person to offer additional support to them, with emphasis on making required improvements to achieve compliance with regulatory requirements.
• Despite the above, the lack of oversight and monitoring at both provider and service level has meant quality assurance and governance arrangements in place were not reliable or effective in identifying risk and shortfalls within the service. This placed people living at the service at risk of potential harm.
• The provider's arrangements for assessing and checking the quality and safety of the service had failed to identify the concerns found as part of this inspection. People had care plans in place, but these did not accurately reflect people's care needs or identify all risks relating to their safety and wellbeing. The provider's representative confirmed audits relating to records in respect of each person had not been considered or completed. Infection, prevention and control audits viewed failed to identify the service was not fully compliant with government guidance. This placed people living at the service at risk of potential harm and not having their care needs met.
• Following our last inspection to the service in July 2021, the provider's representative forwarded an action plan to the Care Quality Commission. This recorded the action to be taken to achieve compliance, including timescales. At this inspection we found that the actions recorded relating to care plans and risk assessments had not been actioned as stated. Therefore we could not be assured the provider and their representative fully understood their governance arrangements to ensure these were effective and managed well.
• The provider's 'Service Improvement Plan' dated December 2021, provided an inaccurate picture of the achievements and actions completed. For example, the document stated there was an induction folder for agency staff deployed to the service and this included agency staff profiles. At this inspection, no inductions were evident for agency staff and not all profiles were readily available and had to be requested. The document stated a review of people's care plans and risk assessments had been completed in November

2021, but this did not concur with our findings.

We found no evidence that people had been harmed. However, arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance with regulatory requirements. This placed people at risk of harm. This was a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• The provider's arrangements for assessing people's needs was not robust. No information was considered or completed to mitigate the risks and challenges associated with admitting people safely into the service, for example, where people had refused to stay in their room and isolate or were living with dementia and unable to settle.
• Assessments had not been completed to demonstrate the role of 'essential care givers' and the potential impact placed on people as a result of no visitors allowed at the service.

Arrangements were not in place to ensure people's needs were fully assessed. This placed people at risk of harm. This was a breach of Regulation 9 [Person-centred care] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider's representative confirmed arrangements were now in place for gathering people's, relatives and staff views of the service. Responses to satisfaction surveys were completed by one relative, five people using the service and four members of staff. Comments recorded were positive relating to the care and support provided by staff.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.

Working in partnership with others
• Information showed the service worked closely with others, for example, the Local Authority and healthcare professionals and services to support care provision.

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 9 HSCA RA Regulations 2014 Person-centred care Not all of a person's care and support needs had been assessed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to manage and mitigate risk, including those related to the service's infection control practices and procedures.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the service to ensure compliance with regulatory requirements.

The enforcement action we took:

Warning Notice