Colten Care (1993) Limited

Avon Reach

Inspection report

Farm Lane
Mudeford
Christchurch
Dorset
BH23 4AH

Tel: 01425272666
Website: www.coltencare.co.uk

Date of inspection visit:
07 January 2019
08 January 2019

Date of publication:
29 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Avon Reach provides accommodation for up to 60 older people who require residential or nursing care. The building offers accommodation over three floors with lift access to each floor. People have single rooms with en-suite facilities and access to specialist bathrooms. There is a range of dining and sitting areas and secure accessible outside space. There were 51 people living at the home at the time of inspection.

Avon Reach 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.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People told us they felt safe living at Avon Reach. Staff had been trained to recognise suspected abuse and understood the actions they needed to take if they had concerns. People were protected from discrimination as staff had completed equality and diversity training. Risks to people were assessed and actions to minimise the risk of avoidable harm respected people's freedoms and choices. People were supported by enough staff, who had been recruited safely, to meet their needs.

Medicines were stored, administered and recorded safely. When errors were identified appropriate actions had been taken. Accidents, incidents and safeguarding were reported appropriately and seen as a way to learn lessons and improve practice.

People had their needs and choices assessed and regularly reviewed. Care and support plans were person centred and provided details of the actions staff needed to take when caring for people including their end of life wishes.

Staff had received an induction, training and support that enabled them to carry out their roles effectively. People's eating and drinking requirements were understood by both the catering and care teams and people were involved in decisions about the menus.

Access to healthcare was available for planned and emergency events and information was shared appropriately when people were transferred between services. During our inspection a visiting dental service was sourced as this had not been previously available to people.

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

People and their families described the staff as kind and caring. We observed a friendly and relaxed relationship between people and the staff team. People felt listened to and involved in decisions about their day to day lives. Advocacy was available for people if needed. Staff understood the importance of protecting people's privacy, dignity and independence.

A complaints process was in place and people and their families felt if they needed to raise a complaint appropriate actions would be taken.

The registered manager promoted an open and transparent culture and understood their legal responsibilities for sharing information with CQC and the local authority. Quality assurance processes were robust and effective at monitoring and improving service delivery. Staff spoke positively about teamwork at Avon Reach and had a clear understanding of their roles and responsibilities.

People, their families and staff had opportunities to be involved in the development of the service and felt they had a voice. Community links had been made which provided people with additional opportunities to be involved in their local area.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Avon Reach

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 checked 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 began on the 7 January 2019 and was unannounced and the inspection team consisted of an inspection manager, inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued on the 8 January 2019 with the inspection manager and inspector was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with nine people who used the service and three relatives. We spoke with the registered manager, the operations manager, clinical manager, quality manager, the clinical lead nurse, admiral nurse, and two nurses. We also spoke with seven of the care staff, two staff involved with activities, two members of the catering team, the receptionist and a housekeeper. In addition, we spoke with a visiting optician and social worker about their experience of the service.

We reviewed eight peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

After our inspection we received an email from a relative providing feedback of their experience of the service.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe; no problems. The staff are very nice and caring towards me". A relative said, "I feel (relative) is absolutely safe living here".

All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. Posters providing information on how to report safeguarding concerns were displayed around the home. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Assessments had been completed that identified risks people experienced. Staff understood the actions needed to minimise the risk of avoidable harm. Some people were at risk of skin damage and had specialist pressure relieving equipment in place which was being used correctly. Another person had a high risk of falling and explained "(Staff) have adjusted my medication and I am much more stable and don't fall so much". When people had a risk of choking referrals had been made to a speech and language therapist. When people had safe swallowing plans we observed these being followed by both the catering and care staff teams. Records showed us that people had been involved in decisions about risks they lived with and their freedoms and choices had been respected. One person had a risk of malnutrition but had decided not to have prescribed supplementary drinks but instead drink more milk. We observed this being offered.

Equipment had been serviced regularly including the lift, boiler, fire equipment, and hoists. Staff had completed fire training and were involved in monthly fire drills. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

Staff were safely recruited. Checks were undertaken before staff started work to ensure their suitability. Checks included, staff employment history, identification and checks with the Disclosure and Baring Service. The registered manager confirmed registered nurses employed were appropriately registered with the Nursing and Midwifery Council and a regular check was undertaken to ensure these registrations remained active.

There were enough staff to meet the needs of people. One person told us, "The staff are available when I need them; I don't feel rushed at all". Waiters had been introduced to help with meal times. A care worker told us "It helps because we can be with the residents helping with the loo and other things".

Medicines were managed safely. Medicines were absent from the monitored dosage system and signed as given on the Medicine Administration Record (MAR). However, one person had not received their blood thinning medicine as prescribed. The registered manager sought medical advice regarding this and told us they would look into how this error had occurred.

There was guidance for staff to follow for medicines which were administered on a 'as required' basis. However, a person was prescribed a medicine commonly used for a heart condition which was to be taken

when required. There was not a plan or guidance in place to direct staff in the administration of the medicine. Medicines were stored securely and temperature checks were recorded daily. Medicines in use were within their expiry dates and where liquid medicines were used the date of opening was recorded on the bottles. Medicines requiring additional security were managed appropriately and stock of these medicines corresponded with the stock detailed in the register.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand cleansing facilities were available around the building. All areas of the home were clean and odour free.

Lessons had been learnt when things went wrong. Incidents, accidents and safeguarding's were seen as a way to improve practice and formed part of a daily-inter departmental meeting. When actions were identified these took place in a timely manner.

Good

Is the service effective?

Our findings

Pre- admission assessments had been completed with people, and when appropriate their families and health and social care professionals. The information had been used to create person centred care plans that clearly described how people's needs and choices needed to be met. This included people's spiritual, cultural and lifestyle choices. Assessments and care plans were in line with current legislation, standards and good practice guidance.

Staff had completed an induction and had on-going training and support that enabled them to carry out their roles effectively. A care worker told us, "There is always lots of training. We also get handout learning sheets that we have to complete about things such as wounds and infections which is good". The chef had completed training relevant to the people living at Avon Reach including safe swallowing and the use of drinks thickeners. Nursing staff had on line access to clinical training and updates through a subscription with a national nursing journal. Staff received regular supervision, an annual appraisal, and had opportunities for professional development such as diplomas in health and social care.

People had their eating and drinking needs understood by both the catering and care teams. Daily menus offered nutritionally well-balanced meals and choices. We observed when people requested something different to the menu it was provided. One person told us, "The food is good here and there is a choice every day. Snacks and drinks are always on offer". We read how one person liked a particular jam and observed a jar on their breakfast tray.

People were able to choose whether to share their meal with others or eat privately in their rooms. People and their families were part of a catering committee that focused on food. A member of the catering team told us "(Catering Committee) wrote the Christmas gala menu. They chose a flambé for desert. Residents loved the theatre of it and all cheered when it arrived". When people needed assistance with eating and drinking we observed care staff providing support at the persons pace, being encouraging and respecting people's dignity.

Working relationships with other organisations supported effective care outcomes for people. Examples had included tissue viability specialist nurses advising on wound management and a rheumatoid nurse specialist supporting with clinical reviews. People had requested a visiting physiotherapist. This had taken place and supported people with a range of issues including improving their mobility. People did not have access to a visiting dentist. We spoke with the clinical lead who told us they would source a dentist and did so by the end of our inspection. Records showed us that when needed people had access to healthcare both in planned and emergency situations.

People had access to communal areas, private areas to spend time with family and friends and accessible outside space. People had been involved in decisions about their environment. Examples included a recent refurbishment where people had chosen a beach theme.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The registered manager told us that no one living at Avon Reach was subject to a DoLS authorisation although applications had been made to the supervisory body for consideration.

The principles of the MCA were followed. People were assumed to have capacity to make their own decisions. Capacity assessments were carried out when necessary and were decision specific. Where the assessment concluded the person lacked capacity, a best interest's decision was made. Best interest decisions involved relevant people such as the persons family and healthcare professionals. Decisions were recorded for a variety of decisions such as the use of bed rails and the administration of medicines. However, it was not always clear who was involved in making the decision as on occasion involvement in the decision making process was recorded as 'staff at Avon Reach' rather than the specific names and positions of the people involved.

Good

Is the service caring?

Our findings

People and their families described the staff team as caring and kind. One person told us, "The staff are very caring towards me. They always use my first name; very respectful". A relative said, "Staff are superb from the receptionist up".

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything. We spoke with one person who spent all their time in bed. They told us, "I'm warm and comfy" and went on to describe with affection a care worker assisting them as, "Lovely and kind". We observed a relaxed and friendly rapport between people and the staff team.

Families told us they always felt welcome and could visit at any time. People were supported to keep in touch with their families and friends. One person had relatives living abroad and staff helped set up a skype video link. We observed people sharing lunch with their families and enjoying a celebration. One person had a birthday and over lunch staff presented them with a birthday cake and gift. The whole dining room spontaneously burst into happy birthday creating a special birthday moment.

People had single rooms which were personalised with their belongings. They reflected the persons history, hobbies and interests and included photographs and ornaments to help people feel at home. A relative told us, "(relative) phoned me at home to tell me they had new curtains and cushions and wanted me to know how happy they were to live here".

People had their communication needs understood. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them. One person had difficulty putting words together to express themselves. We spoke with a specialist dementia nurse who told us, "We are looking at picture communication to see if the ones we have need changing for new pictures". Some people wore hearing aids to improve communication. We found that care staff were not cleaning them. They told us they had not received training and didn't have the necessary cleaning materials. The registered manager was not aware of this. On the second day of our inspection they had sourced training material and a hearing aid cleaning kit.

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. One person told us, "Staff do know how I like things done and are very supportive". People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. The registered manager explained, "Equality and diversity is openly discussed with staff. We have recently shared information with staff about gender differences that's specific to care homes". A care worker described how they supported a person with limited mobility. They said, "We walked together a few steps and they felt a great sense of achievement". Confidential data was accessed by electronic passwords or stored in a secure place ensuring people's right

to confidentiality was protected.

Good

Is the service responsive?

Our findings

People received personalised care because they had care plans which reflected their personal care needs and choices. Care plans were understood by staff and reviewed at least monthly. Care plans reflected people's diversity and included information about how a person's cultural and spiritual needs were met. Records showed us that people, and when appropriate their families, were involved in reviews of care. One relative told us, "I'm involved with (relatives) care plan; they keep me in the loop at all times".

Clinical care plans were in place and included the management of wounds. The wound care plans included photographs, wound descriptions and specific treatment plans which records showed us were being followed. One person had experienced two separate infectious conditions which required different actions by care staff. We found the care plan had not been changed to reflect this. A new care plan was put in place during our inspection.

The staff team told us they felt kept up to date with people's changing care needs. A handover meeting took place at the start of each shift which discussed any changes with people's health, care and support needs. An inter-departmental meeting took place daily ensuring a cohesive response to people's needs. An example was planning for a new admission and ensuring equipment was in place and the catering team understood their eating and drinking requirements.

Activities were available seven days a week and included group activities, one to one activities and trips into the local community. People were provided with a monthly activity planner enabling them to choose activities they wanted to join. A member of the activity team explained how they supported a person who needed to remain in bed. "We both speak (second language) together as (name) was a teacher and we are both from (name of city). They can feel a little low in mood so we pop in with jaffa cakes and perhaps chat about their artwork". Walks had taken place to a nearby beach and people had enjoyed a picnic and reminiscing with the locals.

People's skills were recognised and encouraged. Examples included three people who wrote poetry and created a CD. Another person had been a florist and was involved in floristry arrangements around Avon Reach. Another person had suggested a knitting group which was being well attended. A member of the activity team told us "We gather information about people's memories and that helps us get to understand a person's personality".

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The registered manager gave us an example. "We can provide information in larger print such as when we produce minutes of meetings".

Complaints were appropriately managed. The providers complaints process was displayed in the reception area and the registered manager told us this was also sent to people with their contracts. Complaints were recorded along with the investigation and outcome. For example, a complaint had been received regarding

the management of a person's laundry. This complaint was investigated and the provider apologised to the complainant and spoke with the staff involved to ensure this would not be repeated.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. The clinical lead had developed an end of life strategy which included a training DVD for new staff who may not have experienced a person dying. The strategy focused on the management of symptoms, oral care, comfort, dignity and respect and was overseen by the nursing team. Signposting to bereavement services was available for families and the staff team.

Good

Is the service well-led?

Our findings

Avon Reach has a 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.

People, their families and the staff team spoke positively about Avon Reach and the management of the service. One relative told us, "The new registered manager has quietly and calmly instilled a level of professionalism which is second to none since coming into a not so easy role". One person said, "The staff and management all seem to get on well together which means there's a nice atmosphere at this home". Another told us, "This home runs very smoothly; it must be well run". A care worker told us, "Great teamwork; it's a really friendly environment".

The registered manager understood the requirements of the duty of candour. This is their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They fulfilled these obligations, where necessary, through contact with families and people. They also had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. 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.

Staff told us communication was good and they had a clear understanding of what was expected from them. Systems and processes were in place to ensure effective communication and engagement with people, their families and staff in developing the service and sharing information and learning. Regular meetings were held with staff, residents and their relatives providing an opportunity for sharing ideas and information. One relative told us, "The home ticks over ok. I go to the meetings and anything that gets raised gets sorted". We read at one meeting that people had asked for more evening activities and we found this had begun to happen.

The registered manager had begun to visit community resources and establish links with Avon Reach. One example had been visiting a community social club that offered members activities such as tea dances and a tool shed for the men. We read minutes whereby the registered manager had shared this with people and some had decided to go along and give it a try.

Audits were completed monthly including infection control, nutrition, infections and medicines. When improvements were identified actions happened in a timely manner. We read a care plan audit that had identified improvements were needed in recording wound reviews and involving specialist support. We saw that these actions had been completed and had provided an opportunity for reflective practice.

People's comments and suggestions were listened to and acted upon. A quality survey had been completed and feedback was on display in reception detailing the findings and outcomes. People had asked to see

more of the registered manager and in response they had set up a monthly coffee morning with residents and their families.

The staff team worked with other organisations and professionals to ensure people's care and support was in line with best practice guidance. This included national organisations linked with clinical and social care practice. The registered manager told us they kept up to date through registered managers meetings, access to the 'Nursing Times' publication and CQC provider information.