Jasmine Healthcare Limited

Avenue House Nursing and Care Home

Inspection report

173-175 Avenue Road
Rushden
Northamptonshire
NN10 0SN

Tel: 01933358455
Website: www.avenuehouse.co.uk

Date of inspection visit:
04 January 2017

Date of publication:
30 January 2017

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 4 January 2017. It was unannounced.

Avenue House Nursing and Care Home provides a service for up to 45 older people, who may have a range of care needs, including dementia. There were 35 people living at the service on the day of the inspection.

We carried out an unannounced comprehensive inspection of this service on 5 October 2016 and found that two legal requirements had been breached. Systems were in place to ensure people's daily medicines were managed in a safe way; however these had not been followed adequately on the day of the inspection. We found medication that had been missed, not given and one that had run out.

We also found that the provider had carried out appropriate checks on new staff to make sure they were suitable to work at the service. However, the checks for agency staff were not as robust. Although checks had been carried out by the supplying agency, there was no evidence to show that the provider had ensured these were satisfactory and agency staff were safe to work at the service.

After the inspection the registered manager submitted an action plan which outlined the improvements they planned to make to address these areas.

We carried out this inspection to check the progress with the improvements detailed in the action plan. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Avenue House Nursing and Care Home' on our website at www.cqc.org.uk.

During this inspection, we found action had been taken to address the two previous breaches. However, further work was still required to ensure required improvements were made and fully effective.

After the October 2016 inspection, the registered manager informed us they were leaving the service. This meant there was not a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

A new manager had been appointed who assisted with this inspection. They informed us they were going to apply to register with the CQC soon.

New systems had been introduced to ensure medication was managed safely, including a change of pharmacy to supply medication to the service. However, the new systems for ordering medication had not yet been fully implemented, resulting in four people running out of prescribed medication prior to this inspection. This was a continued breach of the legal requirement to ensure people's medicines are

managed so they receive them safely. The manager had taken appropriate action and reported this to the relevant authorities. Although they were still in the process of investigating how the error had occurred, they shared their initial findings and described further changes they had started to implement to strengthen the systems relating to medication. This was to ensure people consistently received their medication on time and in a safe way in future.

Improvements were found in terms of safe recruitment checks for agency staff. We found that information was readily available for agency staff members working at the service, and there was no evidence that any of the agency staff were not safe to work there. However, we found anomalies in the detail of the information available for staff that had been provided by different agencies, making it difficult to know whether all legally required checks had been carried out prior to them working at the service. The new manager acknowledged our concerns and told us about additional work she planned to undertake with the agencies in question, to ensure the service was in receipt of the right information for all agency staff in future.

Although we found that improvements had been made during this inspection, more time and further work was needed to fully implement and embed required improvements. We have therefore not changed the rating for 'safe' on this occasion, because to do this would require consistent good practice over a sustained period of time. We plan to check these areas again during our next planned comprehensive inspection.

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

Action had been taken towards making the service safe.

New systems had been introduced to ensure medication was managed safely.

Improvements were also found in terms of safe recruitment practices for agency staff.

However, we also identified further improvements that were required in both these areas. We could not improve the rating for 'safe' from 'requires improvement' on this occasion therefore, because to do so requires consistent good practice over time. We will check this again during our next planned comprehensive inspection.

Avenue House Nursing and Care Home

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.

This was an unannounced focused inspection of Avenue House Nursing and Care Home which we undertook on 4 January 2017. The inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 5 October 2016 had been made. The inspection was undertaken by one inspector.

Before the inspection, we checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority and clinical commissioning group; who have a quality monitoring and commissioning role with the service.

During the inspection we focused on one of the five questions we ask about services: Is the service safe? This is because the service was not previously meeting legal requirements in relation to this area.

We spoke with the new manager and a member of the nursing team. We then looked at records relating to the running of the service, including staff records and medication records; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

We did make general observations during the inspection and speak with other people, including people living at the service, a relative and a care member of staff. However, we have not reported on this within this

report, because this was not relevant to the areas we were inspecting on this occasion. This information was shared with the local authority and clinical commissioning group after the inspection, and will also be used to inform our planning for the next comprehensive inspection of this service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 5 October 2016, we found that people's medicines were not always managed in a safe way. One person had only been given some of their medication; the rest had been left in the packaging. One of these tablets had also been signed for in error, because it had not actually been given. This meant there was a risk that the person would not receive all their medication as prescribed.

Another person had not been given a tablet that should have been given to them on an empty stomach. By the time this was noticed, it was too late for the person to take the tablet because they had already eaten.

Another person had run out of a particular medication two days before the inspection.

Individual medication profiles were in place which provided clear information for staff in terms of the purpose of each medication prescribed for people. The profiles contained a photograph of each person, which provided an additional safeguard in terms of staff, including agency staff, being able to match the right person to their medication, and minimise the risk of them giving the wrong medication to someone. We saw profiles however that did not contain a photograph.

In addition, the breakfast medication round went on past 11:00 am, due to the errors found and there being only one member of staff administering medication. We were concerned that there was a risk that people would receive their lunch time medication too soon after their morning medication.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that safe recruitment processes were not always followed for agency staff. We found information of concern on one agency member's records, which had potentially placed people living in the service at risk. The recruitment checks for the member of staff had been provided by the supplying agency and it was clear that the manager at that time had not known about this. There was also nothing on record to confirm that the provider had satisfied themselves, when the staff member had first started working at the service, that they were safe to do so.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the October 2016 inspection, the registered manager submitted an action plan, which outlined the improvements they planned to make to address these areas. We carried out this inspection to check progress with the actions stated. It was clear that actions had been taken to address the two breaches, and some improvements were noted in both areas.

Since the October 2016 inspection, there had also been a change of manager. The new manager talked to us during this inspection, about some of the actions that had been put in place by the previous manager, to

ensure medication was managed in a safe way. This had included changing the pharmacy who supplied medication to the service.

During this inspection, we observed part of the morning medication round. Two qualified nurses, who were both permanent members of staff, each took responsibility for administering medication in a different part of the service; ensuring people received their medication at the right time and in a timely way.

On this occasion, there was no evidence that people had missed their medication as a result of staff oversight or error. We observed one of the nurses administering medication and found them to be confident in terms of recognising and understanding the purpose of medication they were giving to people. They were also very careful in checking medication before they administered it to people, only signing medication administration records (MAR) when medication had been given as prescribed.

We checked MARs and found these had generally been completed correctly. However, we found one gap where medication had not been signed for one person the previous evening. The nurse explained the procedure for following up gaps in recording, which included making contact with the staff member responsible for administering at that time. We later spoke to the manager who confirmed this process had been followed, and that the member of staff in question had stated they had given the medication, but had forgotten to sign for it. We were not able to check this due to the medication being in liquid or powder format. However, there was no evidence of any other medication being left in packets or blister packs for that time, indicating that medication had all been given as prescribed. The new manager told us that in future, where medication was supplied in a non-solid format, the amount dispensed would be deducted from an initial stock total, making it easier to audit.

We identified some inconsistencies on the MARs regarding the recording of as required (PRN) medication. There was no evidence that this medication had not been given as prescribed, but some MARs contained clear information about the reason for PRN medication being given, whilst on other occasions, this had not been recorded. This meant that records did not provide full information about the use of such medication. For example, we saw pain relief PRN medication had been given to someone, specifically to target back pain. However, the same medication had been given to the same person on other occasions, but with no explanation for its use. This meant there was insufficient detail to assess whether the person's pain management was being appropriately managed, or if their health needs had changed.

The majority of medication profiles that we saw on this occasion contained a clear photograph of the person they related to. We found one that did not yet contain a photograph and staff explained the person had recently moved into the service. Records supported this. The new manager told us that admission processes would be strengthened to ensure photographs for new people were put in place in a timelier manner.

Prior to this inspection, the new manager had reported that the service had run out of medication for four people over a period of three days. An internal investigation was still underway to establish the reason for the medication running out, but the manager's initial findings indicated that part of the problem was with the ordering system that was being introduced by the new pharmacy. It was also clear from this however, that the actions taken by the service since the last inspection, to ensure medication was managed in a safe way, had not been sufficient.

The new manager acknowledged this and provided appropriate reassurances during and after the inspection, that they understood the concerns found. They clearly outlined further measures that they had started to introduce; to ensure medication was managed safely in future. These included improving

communication with the new pharmacy via a named link person, daily auditing of medication and developing a clear process about ordering medication before it runs out. The new manager explained that all qualified staff currently had a role in managing and ordering medication, but in the future that this would be delegated to a senior member of staff, who would take the lead for overseeing the management of all medication related processes at the service.

In addition to this, the provider contacted us after the inspection to confirm their commitment to supporting the new manager to make the required changes and to ensure people receive their medication in a safe way. They told us that the problem with the new ordering system had now been resolved, and they had recruited an experienced peripatetic manager who would provide direct support to the new manager in making the other required changes.

It was clear that action had been taken to strengthen the arrangements regarding the management of medication. However, more time and further changes were required to ensure people consistently received their medication on time, and in a safe way. We have therefore not removed this breach and will check on this again at our next comprehensive inspection of this service.

We then looked at recruitment checks for agency staff. Prior to this inspection, the previous manager had told us that new internal auditing systems had been introduced to ensure all required information was provided to the service before an agency member of staff started to work there. The new manager provided evidence that they had been going through each agency member of staff's file, to ensure they contained legally required information such as proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate.

We found information regarding recruitment checks was readily available for a sample of agency staff currently working at the service. There was also no evidence on this occasion that any of the agency staff were not safe to work there.

We found that agency staff had been supplied by a number of different agencies, and that the information supplied by those agencies varied in content and detail. Although the majority of files we looked at contained required information, we identified one particular agency that had provided very brief information to the service, which only summarised the recruitment checks they had carried out for their staff. Some of the information supplied was therefore not explicit enough to be certain whether or not the agency had carried out all of the required checks. For example, it is a requirement where a person has previously worked with children or vulnerable adults that satisfactory information is provided about why that person's employment in that position ended. The profiles that we saw simply recorded: '[Name of agency] have interviewed candidate and all employment gaps verified'.

The new manager told us that they would create a checklist that identified minimal expectations for any agency member of staff supplied to the service, and would liaise with the agencies in question to ensure this information was supplied prior to an agency member of staff working at the service. They also told us that they would arrange to meet with all the agencies to carry out random checks of the records they held, to ensure they corresponded accurately with the information supplied to the service.

It was clear therefore, that action had been taken to strengthen the arrangements regarding recruitment checks for agency staff members. However, more time and further changes were required to ensure safe recruitment practices are consistently followed for all agency staff working at the service. We will check on this again at our next comprehensive inspection of this service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication was not always managed in a safe way.