Aveland Court Care Limited

Aveland Court Care Home

Inspection report

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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
Aveland Court is a residential care home providing personal and nursing care to 11 people aged 65 and over, some of whom were living with dementia and mental health conditions, at the time of the inspection. The service can support up to 30 people.

People's experience of using this service and what we found
The provider's wider quality assurance and governance systems had not always ensured actions were taken to address any issues and risks in a timely manner.

The provider had failed to sustain improvements in the service. The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Aveland Court. This had exposed people to on-going poor care and risk of avoidable harm.

The provider had not properly maintained the premises to ensure people and staff were protected from risks associated with their environment. We found some aspects of the environment unsafe and parts of the building in need of extensive refurbishment. This put the health and safety and well-being of people using the service at risk. We asked the provider to take immediate action to address these concerns during the inspection.

We were not assured that safe infection prevention and control (IPC) measures were being followed. Whilst we observed cleaning taking place during the inspection, the premises did not look clean or hygienic because of the general disrepair and poor condition of the carpeting, paint work and wallpaper. We were not assured that the provider was preventing visitors from catching and spreading infections as staff were not following government guidelines in relation to visitors coming into the service.

People's monitoring charts were not being completed consistently to ensure staff had sufficient oversight of each person's needs and changing risks. For example, repositioning charts did not always show people had been repositioned as documented in their care plan to avoid the risk of skin damage.

Medicines had not always been administered as prescribed to support people's well-being. People did not always have access to their medicines when they needed them. Medicines were not being stored safely.

We received negative feedback from relatives about how the service was managed. Relatives told us they did not have confidence in the management at the service.

People and their relatives had limited opportunities to express their views about the service or influence changes. Relatives told us they had not been asked for feedback and reported a lack of communication and information from the provider.

People told us they were happy living at Aveland Court and relatives felt that people were safe. Staff spoke confidently about how they would protect people from harm and said they were confident any concerns raised about poor practice and/or people's safety, would be addressed promptly by the manager.

There were enough staff on duty to meet people's needs. We observed staff were attentive and responsive and call bells were answered promptly. Robust recruitment practices ensured the right staff were available to support people safely.

Accidents and incidents were recorded and reviewed by the new manager. Where people had accidents, involvement from health care professionals was sought when required.

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

Rating at last inspection
The last rating for this service was requires improvement (published 16 December 2020). The service remains rated requires improvement.

Why we inspected
The inspection was prompted due to concerns received about infection prevention and control practices within the service. As a result, we undertook a focused inspection to review the key questions of safe and well led.

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 have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aveland Court on our website at www.cqc.org.uk.

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 monitor the service.

We have identified breaches in relation to risk management, infection prevention and control, medicines and the governance and leadership of the service at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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.

Aveland Court Care 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
This inspection was conducted by one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aveland Court 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 service did not have a manager registered with the Care Quality Commission. This meant the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection this included information we had received from whistle-blowers and the local authority safeguarding team. We sought feedback from the local authority and professionals who work with the service.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff including the manager, head of care, care staff, domestic staff and maintenance staff. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We reviewed a range of records. This included six people's care records and 11 medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

Prior to our inspection CQC had received concerns about infection prevention and control. We looked at this as part of our inspection and found improvements were required.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- People's monitoring charts were not being completed consistently to ensure staff had sufficient oversight of each person's needs and changing risks. This included risks in relation to their skin and nutrition and hydration.
- People's repositioning charts did not always show that they had been repositioned as documented in their care plan. For example, the care records of one person with a pressure sore, guided staff to change their position two hourly during the day and four hourly overnight. Records showed that this had not always been achieved. This meant the person was put at increased risk of further pressure damage to their skin.
- Some people were at risk of becoming malnourished or dehydrated and were having their food and fluid monitored to effectively manage this risk and ensure people's nutritional needs were met. However, people's food and fluid charts were not completed consistently and did not always show exactly what people had consumed throughout the day or the amounts. This meant staff could not be sure people were getting sufficient to eat and drink.
- The provider did not properly maintain the premises to ensure people and staff were protected from risks associated with their environment. For example, lighting was either insufficient or not working at all in corridors on the first floor. The ceiling in the laundry room was at risk of collapsing due to a water leak which put staff, tending to people's laundry, at risk of harm. Flooring in the dining room was torn putting people at risk of tripping.
- People did not always have access to their prescribed medicines when they needed them. The service did not have a medicine trained staff member available to administer people's medicines at night. Staff told us prescribed nighttime medicines were given by day staff at eight PM before they left to go home. This meant that people did not have access to medicines they might need such as, pain relief, until day staff came on duty the next day.
- Medicines had not always been administered as prescribed to support people's well-being. For example, one person was prescribed an antibiotic four times a day, every six hours. Staff told us they administered medicines at eight AM, midday, five PM and then again at eight PM. This meant that the person was receiving their medicine too early. Taking antibiotic medicines every six hours is important to ensure drug levels in the blood remains constant.
- Additionally, this person's medicine records showed that on two consecutive days they had been asleep at eight PM when staff went to administer their antibiotic. This meant that they missed this dose and did not

have their next antibiotic until eight AM the next day. Interrupting the antibiotic dosage means that a person may remain unwell for a longer period of time.
● Records showed that medicines prescribed to be applied to people's skin were not given as prescribed. For example, one person was prescribed an emollient cream once a day to protect their skin. Their Topical Medicines Application Record (TMAR) showed they had not received this medicine as prescribed for them.
● The provider could not be assured that medicines were stored at the required temperatures, due to the lack of temperature monitoring in the medicines administration room.
● Medicines in a liquid or cream formulation had not been dated once opened. This meant that staff could not be assured that the medicine was safe and effective to use.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst we observed cleaning taking place during the inspection, the premises did not look clean or hygienic because of the general disrepair and poor condition of the carpeting, paint work and wallpaper.
● Throughout all areas of the first floor there was a strong unpleasant odour of damp/mould.
● We were not assured that the provider was preventing visitors from catching and spreading infections. On the first day of the inspection, staff did not check inspector's temperature or screen them for symptoms or potential exposure to COVID 19. We spoke with the manager about this and by the second day of the inspection this was in place.
● We were only somewhat assured that the provider was using PPE effectively and safely. Although staff were using PPE effectively, improvement to the immediate availability of PPE and hand gel around the service was needed to ensure safe practice. We spoke with the manager about this and by the second day of the inspection this was in place.
● Therefore we were not fully assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We found no evidence that people had been harmed however people were not protected from the risks associated with monitoring their care, the environment, infection prevention and control and receiving their medicines in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Risk associated with people's care had been assessed and guidance was in place to mitigate risks. These covered a wide range of areas such as mental health and wellbeing, medicines, falls, skin care, mobility, and nutrition and hydration.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People told us they were happy living at Aveland Court. One person said, "The staff are very friendly, and kind and I am very happy." A relative told us, "I do feel she is safe there, certainly more safe than when she was at home. At least she has got 24-hour care. The staff know how to look after her and she is happy. If she is happy then I am happy." Another relative said, "They spend so much time with her and make so much effort that I feel she is safe. They are very good."
● Staff had completed safeguarding training and spoke confidently about how they would protect people from abuse. Staff said they were confident any concerns raised about poor practice and/or people's safety

would be addressed promptly by the manager. One staff member said, "I would straightaway report it to my manager and CQC and go through QAIT (Quality Improvement Team) and to the local authority."

Staffing and recruitment

● Robust recruitment practices ensured the right staff were available to support people safely. Checks such as disclosure and barring service checks (police checks) had been carried out before staff were employed. This made sure staff were suitable to work with people they supported.

● There were enough staff on duty to meet people's needs. We observed staff were attentive and responsive and call bells were answered promptly. People and their relatives confirmed that there were enough staff on duty to care for them. One relative said, "There always seem to be enough staff there. When we visit they usually have six staff there. They all seem to get on with what is needed." One relative felt that a staff member in the lounge with people would be beneficial and would help ensure that people were safe.

Learning lessons when things go wrong

● Accidents and incidents were recorded and reviewed by the new manager. Where people had accidents, involvement from health care professionals was sought when required.

● The new manager responded to incidents by reviewing the underlying causes and taking action based on their findings to prevent recurrence. For example, where one person was having an increase in the number of falls, they were having, staff contacted health professionals for a review which resulted in a change to their medicines helping them with balance issues.

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 good. At this inspection this key question has now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service had not had a registered manager in post since August 2019, they later deregistered with CQC in July 2020. The legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run was the responsibility of the registered provider. The service had a new manager in post that had not yet completed and application to register with the CQC.
- Since June 2017, CQC have inspected this service six times to address different concerns taking enforcement action and imposing conditions on the providers registration to help drive improvement in the service. However, this had not been effective in driving improvement or preventing repeated themes of concern re-occurring in relation to people's safety, the quality of care or the environment at Aveland Court.
- The risks and concerns found at this focused inspection followed themes which had been highlighted in repeated inspection reports since June 2017.
- The provider had failed to use the findings from our previous inspections to drive enough improvements.
- Due to a history of repeated failures to provide safe and well-led care for people and despite the receipt of assurances, we remained concerned about people's safety at the service.
- The providers systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively.
- Although health and safety audits and managerial oversight had identified environmental hazards, the provider had failed to address safety concerns in relation to the environment in order to protect people from injury or harm. For example, insufficient lighting in corridors on the first floor, ceilings badly damaged and at risk of collapse due to water leaks and torn flooring in the dining room which was a trip hazard. During the inspection, as a result of these serious safety concerns, the provider was asked to take urgent action to address these concerns. The provider and new manager responded swiftly and a programme of immediate and necessary improvements was commenced straightaway. However, it should not have taken a CQC inspection to address these risks.
- Despite giving assurances to health professionals in the past, the provider had failed to ensure people had access to medicines when they needed them at night. During this inspection the provider and new manager was asked to address this immediately. The new manager allocated staff to cover and arranged for night staff to receive training.
- The provider had failed to ensure people lived in a comfortable, attractive and well-maintained home. The rundown and neglected condition of the premises did not demonstrate that people living at the service were valued or cared for by the provider. The provider had not created a homely environment for people to enjoy, that promoted their health and wellbeing.

● The system in place to monitor the safe management of medicines was not effective. The quality audits had not identified concerns about the storage of medicines, timings and administration of prescribed medicines, including topical creams.
● The providers systems and processes had not identified that poor record keeping had not been addressed. Oversight of monitoring charts to ensure people received appropriate care, such as, repositioning charts and food and fluid charts had failed to identify that people were not being repositioned as they should and food and fluid intake was not being recorded consistently.
● The providers systems and processes failed to ensure infection control was well managed in the service to ensure people were not at risk from cross infection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received negative feedback from relatives about how the service was managed. Relatives told us they did not know who the new manager was did not have confidence in the management at the service. One relative said, "I have no idea who the new manager is. I wasn't even told there was a new person. I would have thought they could send an email out introducing themselves. They've had two new managers in the last year which is concerning." Another relative told us, "There have been a number of manager's and they have not always been successful. I am really not sure about the new manager. She is very difficult to get hold of."
● People and their relatives had limited opportunities to express their views about the service or influence changes. There were no residents or relatives meeting's taking place and satisfaction surveys had not been sent out.
● Relatives told us they had not been asked for feedback and reported a lack of communication and information from the provider regarding significant events in the service. One relative told us, "They never let you know what is happening either about her or the home. The lack of communication is very poor."

The providers lack of effective governance and oversight of the service, placed people at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider took immediate action to make improvements to the general condition and décor, and developed an action plan based on our feedback and their own observations and shared this with the CQC and Commissioners. We are continuing to closely monitor the progress and effectiveness of the actions the provider told us they would take.
● Staff were clear about their job role and responsibilities and who they needed to go to for support.
● Staff were extremely complimentary about the new manager. One staff member told us things had recently improved at the service, including morale, commenting, "It has been a lot better and things have improved for the better and there is now more order. That is due to [manager's name], she has come in and looked at what needs to be done and got on top of it which is what we needed." Another staff member told us, "[manager's name] is trying to turn everything around at the moment and I think she is doing a great job and it is going to take time bit we are working on it."
● The new manager was creating a culture of honest and open person centred care. Care records had been updated and were now person-centred, identified people's needs and individual preferences for care and support.
●Staff had good knowledge of people's likes, dislikes, preferred routines and communication needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The new manager told us they understood their responsibility under the duty of candour to be open and honest when things went wrong.

● Throughout our inspection visits the new manager was open and honest. They welcomed our inspection and feedback.

● The rating from the previous inspection was on display at the home as required.

Working in partnership with others

● People were referred to and received support from other health and social care professionals as and when required. For example, the speech and language team, physiotherapists, local GP's and mental health services.

● We saw on people's care files they had attended appointments such as the dentist and optician.

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 An effective system was not in place to assess, monitor and mitigate risks relating to the health and safety of people. Medicines were not managed safely and a system to assess, prevent, detect and control the spread of infection was not fully in place. Regulation 12 (1)(2)(a)(b)(f)(g)(h).

The enforcement action we took:

We propose to cancel this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to ensure compliance with the regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety. The provider failed to ensure the service was assessed and monitored to improve quality and safety. Regulation 17 (1)(2)(a)(b)(e)(f)

The enforcement action we took:

We propose to cancel this location.