Premiere Care (Southern) Limited

The Avenues Care Centre

Inspection report

1-5 First Avenue
Cliftonville
Margate
Kent
CT9 2LF

Tel: 01843228761
Website: www.premierecarehomes.co.uk/our-homes/avenues

Date of inspection visit:
23 January 2023

Date of publication:
03 March 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Avenues Care Centre is a residential care home providing personal care to up to 62 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 53 people using the service.

People's experience of using this service and what we found
People and their relatives told us they felt safe at The Avenues Care Centre. However, we found the service was not always safe and people had been placed at risk of harm on occasions.

Some risks to people had not been identified and care had not been consistently planned to keep people as safe as possible. No care had been planned for 2 people. Medicines were not always managed safely and there was a risk people's medicines would not be effective.

Staff had not been recruited safely and the leadership team could not be assured staff were of good character and had the skills and experience to meet people's needs. Staff had not been supported to develop all the skills they needed to meet people's needs. There were not always enough staff on duty and this had caused a delay in people receiving their medicines at times.

Leadership at the service was not consistently effective and people's safety had reduced since our last inspection. The registered manager and provider did not have oversight of all areas of the service. Effective checks had not been completed to ensure shortfalls were identified and action was taken to address them. This left people at risk of harm. Action had not been taken to understand everyone's experiences of the service and act on the feedback received. The management team had not created an open culture where all staff were confident to share information about accidents, so effective investigations could take place. People were not always referred to in respectful ways.

Following our inspection the provider put an action plan in place to address the shortfalls we found. This included the action to be taken, by when and by who.

Action had been taken to keep people safe following accidents and any safeguarding risks had been acted on. People were supported to remain independent. People were supported to have maximum choice and

control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The service was clean and people were able to receive visitors when they wished.

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 15 June 2022).

Why we inspected
We carried out an unannounced focused inspection of this service on 27 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Avenues Care Centre on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk and medicines management, staff recruitment, staff deployment, checks and audits, gathering and acting on feedback 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Avenues Care Centre

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 Health and Social Care Act 2008.

Inspection team
This inspection was completed by an inspector, a medicines 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
The Avenues Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Avenues Care Centre is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 23 January 2023 and ended on 30 January

2023. We visited the service on 23 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people and 8 relatives about their experiences of the service. We also received information from another relative. We spoke with 7 staff including the nominated individual, registered manager and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 12 people's care records, 9 medication records and three staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits were reviewed.

We used 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.

Requires Improvement

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure all risks to people were assessed and mitigated. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People and their relatives told us people were safe at the service. One relative told us, "My relative's being safely cared for and I've no concerns about their care". However, we found people were not always protected from harm. Guidance had not been provided to staff about how to mitigate risks to everyone. Two people had moved into the service the week before our inspection and risks to them had been identified. However, the registered manager had failed to ensure all risks were assessed and guidance was available to staff about how to mitigate risks. This left both people at risk of harm.
● Care had been planned for 3 people with epilepsy, including when to call for emergency medical care. However, staff were unable to describe what the seizures would look like. No care had been planned for 1 person with epilepsy. There was a risk staff would not provide the care the person needed if they had a seizure and this could have an impact on their health.
● Action had been taken to improve guidance for staff regarding the support most people needed to manage their diabetes. However, no guidance was in place for one person. There was a risk staff would not recognise when the person was becoming unwell and offer them the care and treatment they required.
● The risk of people losing weight had been assessed and some people had been referred to the dietician for support. However, effective systems were not in operation to check the actions taken had been effective. Some people could not be weighed and their mid-upper arm circumference was measured to understand their malnutrition risk. These measurements were not evaluated regularly and there was a risk changes in people's needs would not be identified.
● Some people needed support to move around. No guidance had not been provided to staff about how to

support people to move in particular circumstances, for example in bed. Guidance around the hoist and sling size to use had been provided for some people. However, staff told us they used whatever sling they felt was best. There was a risk people would not be moved safely as staff were not always using the correct equipment. A relative told us, "My loved one needs hoisting and I've seen the staff moving them and there hasn't been any problem".

The provider and registered manager had failed to ensure all risks to people were assessed and mitigated. This placed people at risk of harm and was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely

● People's medicines were not always managed safely and this placed them at risk of harm. Some people received their medicines without their knowledge crushed and disguised in food, known as 'covert medicine administration'. One person's medicines were being crushed which was not in line with the manufactures warning label. This meant the medicine may not work or the person could experience side effects.
● Risks associated with some medicines had not been assessed and mitigated to keep people as safe as possible. For example, some people were prescribed paraffin-based creams which can soak into fabric and become a fire hazard. Other people were prescribed medicines that could increase the risk of bleeding and bruising if a person sustained an injury or had a fall. There was a risk staff would not identify when people required treatment.
● Medicines were not always administered in line with the prescribers intentions or safety requirements. For example, there had not always been a gap of at least 4 hours between doses of paracetamol. This put people at risk of overdose and adverse reactions to medicines.

The provider and registered manager had failed to ensure the proper and safe management of medicines. This placed people at risk of harm and was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider had been unable to recruit sufficient staff and shifts were not always fully staffed. However, the registered manager continued to admit new people to the service. The provider had introduced incentives for staff to cover vacant shifts and used agency staff each day, but some shifts went uncovered. There was a risk people would not receive their care and support they needed in a timely way.
● Rotas showed on 18 days in a 28 day period the number of care staff working at the service was lower than

the number the registered manager had assessed were needed to meet people's needs. We observed little interaction between staff and people during the day, except when care was being provided. A staff member told us they did not have time to spend with people.

● There were not always enough staff deployed to administer people's medicines when they were prescribed. People took most of their medicine in the morning. At times administration was delayed because only one trained staff member was deployed to administer everyone's medicines. There was a risk people's medicines would not be effective. Following our inspection the provider put strategies in place to reduce the risk of people's medicines being delayed.

● People were at risk because some staff had not been supported to develop the skills they needed to safely fulfil their role. Most staff had not completed in depth dementia training, which is essential at a service for people living with dementia. Staff had not completed other training to meet people's needs, including diabetes and epilepsy.

The provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent and skilled staff to provide the service. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not protected by safe recruitment practice. Any gaps in staff's employment history had not been identified and explored. Checks had not been completed on some staff's conduct in previous care roles to ensure they were of good character. One staff member had been 'let go' by a previous social care employer. No action had been taken to find out why the staff member had left their previous employment

● The staff member completing the recruitment process was not aware the provider was required to check staff's performance in previous social care roles. No checks had been made on one staff member's social care employment to confirm they had the skills and experience to meet people's needs.

● Five care staff working at the service did not have a Disclosure and Barring Service (DBS) check in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Following our inspection the provider introduced weekly meetings to review on-going recruitment processes to assure themselves effective checks had been completed on candidates skills, experience and character before they began working with people.

The provider and registered manager had failed to ensure staff were of good character and had the qualifications, competence, skills and experience to fulfil their role. This placed people at risk of harm. This was a breach of regulation 19(1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us the staff were kind and caring. One relative told us, "The staff are very patient with them and very good; very kind and caring people".

Preventing and controlling infection

● We were somewhat assured that the provider was responding effectively to risks and signs of infection. Some people were at increased risk from infections such as Covid-19. Risks to people had not been assessed and action planned to keep these people as safe as possible.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The registered manager was unaware of changes in the national guidance in relation to the wearing of face masks.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely. However, the registered manager was not aware of changes in national guidance in relation to staff wearing face masks.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

● There were no restrictions on people receiving visitors. We observed people sending time with their relatives and joining in activities together. Relatives told us they visited regularly and were able to spend as much time with their loved one as they wished. One told us, "I can visit whenever I want, at any time".

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not consistently protected from the risk of abuse. Some care staff and other staff who came into contact with people as part of their role, such as housekeeping and maintenance staff, had not completed safeguarding training. It is important all staff have the skills to recognise safeguarding risks and know how to report them, to keep people as safe as possible.
● Staff we spoke with knew how to identify the signs of abuse and would raise this with a senior carer or someone from the leadership team. They were confident action would be taken to keep people safe. The registered manager had notified the local safeguarding team about potential abuse so the concerns could be investigated.
● Staff knew how to blow the whistle outside of the service to raise any concerns they had with the local authority, police or CQC. We had received concerns prior to our inspection which we had investigated.
● Effective action was taken to learn lessons when things went wrong and prevent them from occurring again. For example, if people had fallen they were referred to the falls clinic. Any additional equipment people needed to keep them safe, such as mats to alert staff when they were walking around, had been provided.

Requires Improvement

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
At our last inspection the provider had failed to ensure checks of audits at the service were effective and drove improvements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17

● People were not always protected by robust checks and audits of the service. Checks and audits completed had not been effective and the registered manager and provider were unaware of the shortfalls in quality and safety we found.
● The registered manager had delegated checks and audits to other staff, but had not checked these to ensure they were accurate. For example, a recruitment audit had been completed the week before our inspection but had not identified the shortfalls we found. Following our inspection the provider put systems in place to ensure there was oversight of all checks and assure themselves these were completed accurately.
● The operations manager completed checks of the service each month. In December they had noted accident and incident monitoring had not been completed. No deadline had been agreed for the completion of these checks and they remained outstanding at the time of our inspection. They were completed after our inspection and systems were put in place to ensure the provider's policy for monthly audits was always followed .
● The provider had recruited a staff member to complete risk assessments and write care plans. This had not been effective in driving improvement in how risks were assessed and mitigated and some people continued to be at risk of harm. It was the provider's policy to review care plans and risk assessments monthly but many had not been reviewed and updated. Following our inspection systems were put in place

to support the staff member to priorities tasks to ensure staff had accurate information about people's needs.

The provider and registered manager had failed to ensure checks and audits of the service were effective and drove improvements. This was a continued breach of regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection the provider sent us an action plan showing how they would address the shortfalls we found, by when and who would be responsible. This included increased checks and audits by the registered manager and operations manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Effective action had not been taken to gather and act on the views of people and their relatives. A meeting had been held in September 2022 for people and their relatives, this was not well attended. It was agreed new ways of communicating would be explored but this had not happened.

● Surveys had been completed by 12 people, but other people had not been supported to share their views. People had fed back that they had not been involved in developing their care plans or reviewing them. No action had been planned to address this and ensure people were fully involved in planning their care. Feedback had not been provided to people about any action taken in response to their feedback.

● The response to other surveys had been low, for example, 2 out of 20 relatives contacted had responded, along with 3 out of 12 professionals. Alternative ways to obtain feedback had not been considered to understand people experiences of the service.

The provider and registered manager had failed to effectively seek and act on feedback for the purposes of continually evaluating and improving the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they were given the opportunity to share their views at meetings and this was encouraged by the provider and operations manager. One staff member told us the provider was approachable and "I know I can go to him".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The registered manager had not informed us when they had contacted the police on 2 occasions requesting support to keep people safe. We had been informed of other important events which had occurred at the service.

The registered manager had failed to notify CQC of incidents reported to the police. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The registered manager did not have oversight of delegated tasks such recruitment, training and care planning. They had not kept some staff's practice under review to ensure they were adequately fulfilling their role and meeting legal requirements. Following our inspection the provider put systems in place to support the registered manager have oversight of delegated tasks and ensure all staff were supported in their roles.

● Staff told us communication from the leadership team was not always effective. For example, several staff we spoke with were unclear about one person's continence needs and if they had a catheter. Following our inspection the provider reviewed and amended communication strategies to ensure staff always had the information they needed in a timely way.
● People and their relatives had not been informed that CCTV was in use in communal areas of the service. This was important to ensure they were happy to be filmed before they began using the service. This is an area for improvement.
● Staff had a shared aim to support people to maintain their independence. We observed some people making their own drinks and getting their meals from the serving area. People told us they enjoyed doing this. A relative told us their loved one was supported to complete small domestic tasks they enjoyed. People told us staff supported them to do what they could and helped them only when they needed it.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager had not lead by example to developed a culture where people were always treated with respect. One person was described as a 'picker' and the registered manager told us another person "is like a little hedgehog". They did not understand these terms were not respectful. This in an area for improvement.
● We observed most staff interacting with people in caring ways and offering them the support they required. People's preferences regarding staff's gender were respected. A relative said, "Staff respect what my loved one wants; they didn't want to have personal care from male staff and that's happened".
● Action had not been taken by the registered manager to ensure staff were always open about what happened at the service. An investigation they completed had not established the circumstances around the accident as staff told them they did not know anything about it. We discussed this with the registered manager and operations manager. The operations manager completed further investigations and established the circumstances of the incident. They followed the provider's disciplinary processes to keep people safe.

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 provider understood their duty of candour and had apologised when things had gone wrong.

Working in partnership with others
● The provider had struggled to recruit staff to vacant posts. They had worked closely with an employment agency to successfully recruit staff. They had also reviewed the shift pattern to offer employment to parents and carers with child care responsibilities.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to ensure all risks to people were assessed and mitigated. The provider and registered manager had failed to ensure the proper and safe management of medicines. 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to ensure checks and audits of the service were effective and drove improvements. The provider and registered manager had failed to monitor and improve the quality of the service by keeping the culture under constant review. The provider and registered manager had failed to effectively seek and act on feedback for the purposes of continually evaluating and improving the service.

17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager had failed to ensure staff were of good character and had the qualifications, competence, skills and experience to fulfil their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent and skilled staff to provide the service. 18(1)