Care Quality Commission

Avery Homes RH Limited

Albion Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out on 1 October 2015 and was unannounced. This was the first inspection since the service was registered with Avery Care RH Limited in March 2015.

Albion Court Care Centre provides nursing care to up to 89 people. At the time of our inspection there were 80 people that lived there.

Albion Court Care Centre is required to have a registered manager in post. There was a registered manager in post. 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 did not always receive their medicines as prescribed. This was a breach of regulations. You can see what action we told the provider to take at the back of the full version of the report

Summary of findings

There was a positive and inclusive atmosphere in the home and people were protected because staff understood the different types of abuse and knew what actions to take if they thought a person was at risk of harm.

Systems were in place to protect people from avoidable harm but staff did not always follow safe systems of work.

There were sufficient numbers of staff that received the training and support they needed to meet people's needs. However, staff practices did not always ensure that people received individualised care.

People's rights were protected and staff ensured that decisions were made in people's best interests and involved people's representatives if they were unable to make decisions for themselves. People's rights were not always protected when they received medicines disguised in their food or drink.

People were supported do have food that met their dietary and cultural needs however, mealtimes were not always well managed.

People were supported by staff that were generally caring and kind but there were times when people's dignity was not always promoted. People were encouraged to remain independent and their health needs were met.

People were provided with some group and individual activities but not everyone's needs were met. People knew how to raise any concerns they had and where they had been raised these were addressed appropriately.

The service was in the process of a lot of changes due to the change in registered provider and the systems in place to monitor and improve the quality of the service were not yet robust and embedded. The registered provider had identified some improvements that were needed and had plans in place to improve the quality of the service.

Summary of findings

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.

People were protected from abuse and avoidable harm because the provider had effective systems in place.

Risks to people were assessed and plans put in place to keep people safe but staff did not always follow safe systems of working identified in management plans.

There were sufficient numbers of staff available to support people and staff had been checked for their suitability to work with people before they were employed.

People did not always get their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were happy with the care and support they received because staff had the skills and knowledge to meet people's needs. However, the care provided was not always appropriate to the individual needs of people.

People's rights were not always protected. Decisions were made in people's best interests.

People generally received the food and drinks that met their dietary requirements however, mealtimes could be better organised so that people's needs were met in a timely manner.

People's health care needs were met by a number of healthcare professionals.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were caring and helpful and involved people in making choices. Sometimes staff were not mindful of people's dignity. People's independence was promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were known by staff. However, we found that the care provided was not always individualised to people.

People were supported to take part in activities but these could be improved so that everyone's needs were met.

Summary of findings

People were supported to maintain contact with friends and relatives and had any concerns raised addressed in a timely manner.

Is the service well-led?

The service was not consistently well led.

People benefitted from an open and inclusive atmosphere in the home. Management systems had not ensured that the quality of the service was monitored and actions taken to improved the service.

Requires improvement

Albion Court Care Centre

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 inspection took place on 1 October 2015 and was unannounced. The inspection team comprised of five inspectors including a pharmacist 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 service. Our expert by experience had experience of using this type of service.

We looked at the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. Notifications are information the provider has to send us by law.

During our inspection we spoke with 19 people that lived in the home, one relative and 15 staff including nurses, senior care staff, care staff, the cook and an activities organiser. We also spoke with the registered manager. We looked at the care records of four people to check that they received care as planned and some records relating to the management of the home.

Some people in the home were living with dementia and had limited verbal communication and were not able to tell us if they were happy with the care they received. We observed how staff supported people throughout the inspection to help us understand their experience of living at the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

We reviewed the medicine administration records of eight people and found that their prescribed medicines were not always being used appropriately so that people received the required amounts of medicines to manage their medical conditions. For example, the dose counters for two inhalers compared with the administration records showed that two people had received less of their inhaler than had been prescribed. Two people had not had their pain relief patches applied at the frequency they had been prescribed. The records for one person showed that over a one month period a patch had not been applied as required on nine occasions. One person we spoke with who should have had a patch applied two days prior to our inspection confirmed the patch had not been applied. This meant that they had not received the required amount of a pain relief. We also reviewed the administration record for a topical medicine and the records showed that it was only being applied once a day when it had been prescribed for a twice daily administration.

We saw that medicines were not always administered according to the manufacturer's guidelines. For example, one person should have received an antibiotic before food but staff spoken with were not aware of this. As a consequence the person received their antibiotic with or just after meals which meant the antibiotic would not work properly. There was not a robust system of recording where the various types of analgesic patches were being applied to the body of people they were prescribed for. This meant that it could not be assured that the manufacturer's guidelines that patches should not be applied to the same site for a certain number of days was avoided.

Medicines were not always being stored securely and at the correct temperatures for the protection of people. For example, we found a topical medicine was being kept in a person's room and therefore there was a potential risk of it being inappropriately used by people it was not prescribed and suffering harm. We could not be confident that medicines stored in the refrigerators were being stored correctly. We measured the maximum temperatures of two refrigerators and found that the maximum temperature of both refrigerators were above the accepted maximum temperature. However, the refrigerator temperature records showed that the refrigerators were being maintained within the accepted temperature range and this was inconsistent with our findings. We asked the nursing staff how they obtained the temperatures that had been recorded but they were unable to demonstrate this stating they were not sure how to do this.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People were protected from the risk of injury because risks to people had been identified and management plans put in place to minimise the risks. However, staff did not always follow the management plans putting people at a potential risk of injury. We spoke with one person about the use of bedrails and they told us they were to prevent them falling out of bed. Staff spoken with were aware of the risks to people and we saw that equipment such as pressure relieving mattresses, lifting equipment and wheelchairs were available to manage identified risks. We saw that one person was taken to their bedroom to be repositioned in the chair they were sitting in. The person's care plan showed that a slide sheet was to be used for repositioning. When we asked the staff how they had undertaken the repositioning they told us they had used the slide sheet. However, when we asked the staff to show us where they had put the slide sheet in the bedroom they were unable to locate. This showed that the repositioning was undertaken without the use of the equipment although the staff knew they were supposed to us it.

The majority of people we spoke with were able to tell us that they felt safe and well cared for. One person told us, "They are looking after me okay." Another person said, "I feel safe. They [staff] are looking after me well." Another person said, "They help me a lot." However, some people using the service had limited verbal communication skills and were unable to tell us if they were concerned about their safety and if they were protected from abuse and harm. As part of our inspection we observed the interactions between staff and people that lived in the home to get a view of the care they received. We saw lots of kind and caring interactions between staff and the people they cared for.

Staff spoken with told us that they had received training in protecting people from abuse and they were knowledgeable about the types of potential abuse and gave examples of the types of things they would consider to be unacceptable. Staff were knowledgeable about how to raise any concerns they had and how to raise concerns within the home and with other organisations. Staff told us

Requires improvement

Is the service safe?

about examples of where they had raised concerns to protect people. Staff knew about the whistle blowing procedures. Whistle blowing means staff can raise concerns and their identity would be protected. Records we hold showed us that the provider reported concerns to us as required? and appropriate referrals were made to the appropriate authority.

People told us that there were enough staff to assist them when they needed. One person told us “I am quite happy.” Staff told us that they felt that there were enough staff although sometimes they felt ‘rushed’. We saw that most of the time people did not have to wait for assistance. We saw that the call bells were answered within a few minutes. The registered manager told us dependency levels were assessed to determine the number of staff needed to meet their needs. The registered manager told us that the registered provider allowed the service to recruit ten percent over the required number of staff to assist with staff illnesses and holidays. People were supported by staff that had undergone the appropriate recruitment checks before they started work at the home so that only suitable people were employed.

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Requires improvement

Is the service effective?

Our findings

People told us that they were happy with the food they ate. Menus were available on the dining tables but they were not in a format that was suitable for people living with dementia. One person said, "I chose stew, it was good. I'm eating well." We saw that there was a daily menu in place which provided two choices at each mealtime and alternatives that were available for people who did not want the choices of the day. We saw that one person who had changed their mind about the meal they wanted was given an alternative meal. However, we saw that at mealtimes some people living with dementia struggled to understand the meal options that were available and staff did not use alternative methods of communication to help them make an informed condition such as pictures of the meals available or plated up options so that they could choose. We heard one person tell a member of staff that they were vegetarian and unable to eat the cooked breakfast presented to them. The member of staff was very apologetic however, had the individual not had capacity they may have eaten food they were not supposed to eat

We saw that the management of mealtimes could be improved. We saw that for some people the time between their breakfast and lunch was not sufficient for them to digest their breakfast and build up an appetite for their lunch. For example, one person was given a cooked breakfast at 11.30am and their main meal of the day for lunch at 1pm. The individual did not eat much of their lunch. We saw that on one floor of the home the staff explained what was being served to people but on another floor no explanation was given of what had been served. We discussed this with the registered manager who was not able to explain why this had happened.

People had been assessed to determine if they were at risk of not eating or drinking enough and if they had any special dietary requirements. We saw pureed, cultural and medical diets were catered for and people received appropriate support to eat when needed.

Staff told us that they had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). MCA is important legislation that sets out the requirements that ensure that where people are unable to make significant and day to day decisions that these are made in their best interest. DoLS are in place so that any restrictions in place are lawful and people's rights are upheld. We saw that the provider had made applications for all of the people using the service to the local authority to authorise the restrictions placed upon them. At the time of our inspection one person had a DoLS in place and the registered manager was able to describe the purpose of this. We saw that MCA assessments had been undertaken but they did not always contain details about which decisions could be made under a best interest meeting and who needed to be involved in those meetings. We found that where people needed to have their medicines administered by disguising them in food or drink (covertly administered) the provider had not ensured that all of the necessary safeguards were in place to ensure that these medicines were administered safely. For example, we found one person had a best interest's decision and a protocol on how to prepare and disguise three of their prescribed medicines. However, we found this person was having an additional two medicines administered covertly without a best interest decision and protocol in place on how to prepare and disguise the medicines safely. Staff told us they advocated on behalf of people and involved their relatives in making decisions. Staff understood the importance of not depriving people of their liberty.

People told us that they were happy with the support they received. One person told us, "I wouldn't be anywhere else. It's a palace because staff do a good job." Another person told us, "I like it very much. I get up when I wake up and I can have a lie in if I want." We saw that people were being cared for well and there was evidence that people had improved since being at Albion Court. For example, there was a very low incidence of skin damage.

People received care from staff that had been supported to have the skills and knowledge to meet people's needs. One person told us, "They help you to the bath." Staff told us that they received regular training, supervision and advice to be able support people safely and provide effective care that met people's needs. The registered manager told us and training records confirmed that staff received regular training and supervision. Staff confirmed that they felt able to raise issues in staff meetings and the manager could be approached for advice.

People looked well and well cared for. People told us they saw medical professionals when needed. One person told

Requires improvement

Is the service effective?

us, “I see the chiropodist and optician; they all come to the home when needed.” Staff told us people were supported to access a variety of health and social care professionals and records confirmed this.

Requires improvement

Is the service caring?

Our findings

We saw that sometimes people's dignity was not maintained to greater or lesser degrees across the service. We saw notices on some bedroom doors and in dining areas that identified issues pertinent to individual people. For example, for one person a particular ailment was identified the foods they were restricted from eating. During lunchtime we saw that one person who requested to be assisted to the toilet was told to eat their meal first and waited for over 45 minutes before they received the support they had requested. We heard staff discuss across a room that an individual had chosen meatballs for a meal and whether they could be given this choice as they were not allowed meat balls. We heard staff discuss how to manage a person who was disturbing others. during lunchtime. However, this was not always done in a sensitive manner.

The atmosphere in the home was warm, welcoming and generally caring. One person told us, "Staff are good for a laugh, they are good people, like them all." We saw that staff knelt down when speaking with people so that they were at the same level as the individual and repeated things if people did not understand. We also saw good interactions between staff and people when they were being supported to eat. We saw one member of staff dancing with an individual who was listening to music. We saw that staff took time and care to ensure that people were dressed in a way that reflected their gender, personalities, preferences and cultural backgrounds.

People were supported to make day to day choices about what they ate, where they sat and whether they took part in any organised activities. One person told us, "I like to stay in my bedroom and watch the programmes I like on my television." During the day we saw that staff supported people to make choices at mealtimes and dressed in clothes that reflected their personalities and prefrences. Staff spoken with were aware of people's preferences. Records showed that people's likes and dislikes had been discussed with them or their relatives so that their needs were met in the way they wanted.

People's privacy was maintained. We saw that bedroom doors were closed when people were being supported. Staff spoken with gave us good examples of how people's privacy was maintained. For example, by ensuring that doors were closed when providing personal care and ensuring people were covered when being moved with a hoist. We saw that staff addressed people by their preferred names or terms of address that were culturally appropriate.

People were supported to maintain their independence where possible. One person told us they were encouraged to shower independently by staff and were now having a shower each day. We saw that people had access to walking aids such as walking frames and walking sticks. People had been provided with, plate guards, thick handled cutlery and beakers and straws to enable them to eat independently.

Requires improvement

Is the service responsive?

Our findings

People that lived in Albion Court told us they were able to join in in some group activities. We saw that representatives from different places of worship visited the home to meet people's spiritual needs. One person told us they were taken out to the shops when they wanted by a member of staff. Plants had been bought to help the individual look after them and keep themselves busy. One person told us there was not much to do although an exercise man came into the home; they played bingo sometimes, played cards once but otherwise watched television programmes of their choice in their own bedroom. On the day of our inspection the activity for the day was hairdressing and nail polishing. We also saw one member of staff use cards and jigsaws to occupy some people. However, this meant that there were a lot of people who did not have any meaningful activities to undertake.

People told us they had been involved in planning their care. One relative told us, "The home tries to involve families but they don't turn up to the meetings which is very disappointing." The registered manager confirmed that relative's meetings were poorly attended. Staff told us that they asked people about the care people wanted, ensured they had choices and explained to people what they were doing. People's changing needs were kept under review. Staff spoken with knew about the needs and preferences of the people they were supporting. However, the information was not always used in a responsive way. For example, one person who had limited communication skills was sitting with no music or stimulation in their bedroom although their records stated that they liked to listen to music. The relative of another person told us that their family member used to like to read books. We discussed the use of talking books for this individual with the registered manager so arrangements could be made to meet the person's needs.

People were supported to maintain contact with friends and family. People and relatives told us they could visit at times suitable to them. The registered manager told us that there were no restrictions on people visiting their friends and relatives and those relatives were kept informed if their family member was unwell.

People told us that they knew how to raise any concerns they may have. One person we spoke with was aware of the complaints and compliments forms that were available in the home. They told us that their experience had been that issues raised had been followed up and responded to. The registered manager told us they had received two complaints and they had been addressed and resolved. Staff told us that they would support people to raise any concerns they had.

Requires improvement

Is the service well-led?

Our findings

During our inspection we identified a number of areas that needed improvement. For example, the management of medicines to ensure people received their medicines as prescribed and that the required safeguards were in place in respect of covert medicines. People's dignity was not always maintained and the systems in place were not always appropriate and did not show a personalised approach to care. For example, we saw that one bedroom door had a poster displayed telling relatives that food brought into the home needed to be brought to the nurse's attention on the unit. This may be an issue for some people but not everyone and should be discussed and agreed with the relevant relatives rather than a notice on the bedroom door. We saw that one person had lost a significant amount of weight over the past month however this had not been identified in the quality indicators showing that systems for capturing information were not robust. We saw that care was not always personalised to meet people's needs for example, for people with dementia. We saw each month the provider received reports from the registered manager on a variety of areas including infections, weight loss, deaths and numbers of people who had developed skin damage. The registered manager told us that action plans were in place to ensure that actions were addressed promptly. There were no action plans from the provider's audits but the registered manager was verbally informed during supervision areas that needed to be addressed.

It is acknowledged that at the time of our inspection the service was undergoing a period of change due to the change in provider in March 2015. The registered manager was also overseeing another of the provider's homes which was based on the same site and they were based at the other home more than at Albion Court. Although there had been illness in the management team overseeing Albion Court and it had not been as effective as it could have beensome of the issues we identified should have been addressed through the the quality monitoring processes.

People living in the home were aware that the management of the homehad changed. People living in the home were not always clear about who the manager of the home was. However, people who knew who the registered manager was, were positive about her.

People spoken with were generally happy with the service they received. One person told us, "I would give them [the home] eight out of ten for the service. To get ten out of ten the food and activities need to be improved." The registered manager told us that one of the activities organiser's had been off sick and this would improve once they returned. The registered manager was very positive for the future of the home and told us about the development plans for the staff and the home. For example, the registered provider had planned lots of training to ensure that all staff knowledge was in line with the requirements of the provider. Some staff were being up-skilled so that they were able to provide in house training. One member of staff spoken with confirmed this and was very enthusiastic about the proposed improvements. The new provider had provided new equipment such as hoists and mattresses, ensured that the building was safe and had plans to update the décor of the home. This showed that there was an open culture and commitment to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 How the regulation was not being met: People who use services and others were not protected against the risks of not receiving their medicines safely and as prescribed. Regulation 12(1)(2)(g)