Avocet Trust

Avocet Trust - 22a-26 Middlesex Road

Inspection report

22a-26 Middlesex Road
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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Avocet Trust 22a-26 Middlesex Road is a care home providing personal care for up to six people who have a learning disability and/or autism. At the time of our inspection six people lived at the service. The service is split across four bungalows which are adapted to support people's care needs.

People's experience of using this service and what we found
People at Avocet Trust 22a-26 Middlesex Road did not always receive a safe, effective and well led service. We identified concerns relating to people's safety which included poor oversight of fire safety issues, this put people at risk.

The provider had not effectively operated their quality assurance systems to oversee the safety and quality of the service.

Safeguarding concerns had not been reported by staff and management. The registered manager was not clear of their role and responsibility in relation to safeguarding people.

An effective system was not in place to ensure government guidance was adhered to in relation to the management of risks associated with COVID-19.

Medicines were not always managed safely. The provider's policies and protocols were not being followed by staff and management.

Staff training was out of date which meant staff didn't always have the appropriate skills and knowledge to support people's individual care needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible or in their best interests; policies and systems in the service did not support this practice. We have made a recommendation about this.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The ethos, values, attitudes and behaviours of the management team and support staff did not always ensure people lead confident, inclusive and empowered lives. People were involved in their care and future planning. Care provided was centred around the person however, people's

dignity, privacy and human rights were not always considered. The model of care and support provided to people did not always maximise their choice, control and independence.

People and their relatives told us they were happy with the care and support they received.

Systems were not always in place to recruit staff safely. We have made a recommendation about this.

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 good (published 2 October 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding concerns and the way in which the service investigated these. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Avocet Trust 22a-26 Middlesex Road 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 to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to fire safety, management of medicines, staff training and support, failing to operate effective monitoring systems to improve the quality and safety of the service, poor record keeping, notifications of incidents, and safeguarding people from risk of harm.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

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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.

Inspection team
The inspection was carried out by three inspectors.

Avocet Trust 22a-26 Middlesex Road 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, senior care workers, care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who has regular contact with the service.

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.

Using medicines safely
- Medicines were not always managed safely.
- The providers medication policy was not followed by staff.
- Medicine records did not always provide a clear or complete account of what support staff had provided to people. This meant we could not be certain people's medicines had been administered as prescribed.
- Audits had not been carried out regularly to help monitor or make sure medicines were managed safely, and when completed they did not identify the issues found on inspection.

The failure to adequately manage robust medicine systems and practice was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse;
- The provider did not always follow appropriate processes to safeguard people from risk of harm. During the inspection we found they had not reported incidents to the Local authority safeguarding team or CQC.
- The registered manager did not understand their responsibilities in reporting all safeguarding concerns to the local authority.
- The provider did not always fully investigate safeguarding concerns. This put people at possible risk of abuse or neglect.
- Staff had completed safeguarding training and told us they would report any concerns they had to the supervisor or manager. However, one staff member told us they were unsure how to refer straight to the safeguarding team if needed.
- Following the inspection CQC contacted the safeguarding team with their concerns.

A failure to ensure systems and processes were in place to protect people from abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us that they were satisfied that their relatives were safe and well cared for.

Preventing and controlling infection
- People were not protected against the risks associated with COVID-19.
- Appropriate checks were not completed on visitors to the service.
- Staff did not always use personal-protective equipment (PPE) appropriately and safely.

● Staff COVID-19 testing was not carried out in line with government guidelines. This meant people were put at greater risk of catching COVID-19.

The failure to ensure good infection prevention and control systems were in place put 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.

Learning lessons when things go wrong
● Accidents and incidents were not properly monitored, recorded or investigated to identify emerging patterns or trends.
● Records did not always include accurate information about what actions had been taken following the accidents or incidents. This meant opportunities to prevent reoccurrence were missed.

The failure to ensure lessons learnt when things go wrong is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● People were placed at risk of harm because the provider had failed to ensure that fire safety systems were effectively managed. Records such as weekly fire checks and fire assessments, were not up to date.
● Not all staff had completed fire safety refresher training, fire drills or evacuation training. This meant they may not know how to support people in an emergency. One member of staff told us they had never attended a fire drill or fire evacuation practice.

Whilst we found no evidence people had been harmed, the failure to adequately assess and manage risks put 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.

● Personal emergency evacuation plans (PEEPS) were in place and contained clear guidance for staff on how to support people in the event of an emergency.
● Staff were knowledgeable about risks associated with people's care.

Staffing and recruitment
● Recruitment checks had been completed to help make sure suitable staff were employed. However, there were some gaps in these records. This meant we could not be certain the provider had followed a robust and safe recruitment process.

We recommend the provider considers best practice to ensure a robust and safe recruitment process.

● Staffing levels were arranged in line with people's support needs. Staff told us they felt there were enough staff to support people.
● New staff completed an induction when they commenced in their role.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- People were at increased risk of receiving ineffective or unsafe care as a robust system was not in place to make sure all staff were suitably skilled and competent to meet people's needs.
- Staff training was out of date and did not ensure that staff had the correct skills and knowledge to provide safe care.
- Observations and competency checks had not been used effectively to check and make sure staff understood good practice guidance and were supporting people in a safe way. For example, in relation to staff's use of PPE or administering medicines.

Failure to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Principles of the MCA were not always followed.
- Assessments of people's mental capacity were in place however, the registered manager failed to ensure an appropriate capacity assessment and best interests' decision was in place for one person, prior to staff

carrying out cares. This meant the care given was not consented to and may not have been the least restrictive option.
● Best interest decision making principles were not always followed.

We recommend the provider considers best practice and the MCA (2005) legal framework to ensure MCA principles are followed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Peoples needs were effectively assessed, and care plans were written in a person-centred way.
● Advice and guidance were sought from health professionals when required and recorded in peoples care plans.
● Staff made appropriate referrals to other agencies when required such as the SALT team.
● People were supported to access healthcare such as GP's and dentists.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were effectively met.
● Food and fluid charts were completed where needed however; one person required a specialist diet to reduce the risk of choking. Records completed did not always evidence that the person had received their food in the way they should. Therefore, we could not be certain that the person had received their food and fluid as recorded in their care plan.

Adapting service, design, decoration to meet people's needs
●The service provided a homely environment which met the needs of people. People were involved in making decisions about their environment including wallpaper, paint colours, pictures and ornaments.
● Adaptations had been made to meet people's needs such as bathroom adaptations.

Requires Improvement

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 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Working in partnership with others

- The provider had failed to complete effective monitoring of the quality and safety of the service. The issues we found during the inspection had not been identified by the provider prior to our inspection. These issues related to fire safety, medicines, poor standards of record keeping, poor Infection control procedures and lack of staff training.
- The provider had not appropriately notified relevant agencies of all incidents.
- There were shortfalls in the quality of staff's recording of information. For example, regular staff/visitor temperature checks were not recorded and inconsistent recording of accidents and incidents.

The failure to operate robust quality assurance and safety monitoring systems was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- A culture of high quality, person centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this inspection.
- Record keeping had not been adequately monitored at the service and this impacted on staff's ability to provide person centred care to people.
- Investigations and analysis of accidents and incidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.

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

- People and their relatives were involved in the running of the service. One relative told us "Staff go above and beyond for [family member.] We are in regular contact with staff as a family and they really know [family members] care needs and communicate well with them."
- Staff told us the senior carers and registered manager were approachable. One staff member told us "I can go to the manager or seniors if I need them for anything."

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to inform the appropriate agencies of any safeguarding concerns. The provider failed to properly investigate and failed to take appropriate action during a safeguarding incident. Regulation 13 (1) (2) (3) (4c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were skilled, trained and competent to perform their roles. The provider had failed to ensure that staff received supervision and training to support them within their roles. Regulation 18 (1) (2) (a)

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 The provider had failed to adequately assess, monitor and reduce risks to peoples health and safety. The provider had failed to ensure that systems for the management of medicines were safe. Regulation 12 (1) (2) (a) (b) (f) (g)

The enforcement action we took:

Issued a REG 12 Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective governance systems to ensure the safety and quality of the service. The provider had failed to ensure good standards of record keeping. Regulation 17 (1) (2) (a) (b) (c) (d) (e)

The enforcement action we took:

Issued a REG 17 Warning notice.