The Orders Of St. John Care Trust

Avon Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Avon Court is a residential care home providing accommodation and personal care for up to 48 people. The service provides support to people who are living with dementia. People live over three floors in one adapted building. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
Risks to people were not always effectively assessed and managed. Action was not consistently taken following incidents to reduce the risk of a similar incident happening again.

People were not always supported to take their prescribed cream medicines.

The provider had not notified CQC of significant events in the service they are legally required to.

We made a recommendation that the provider reviews communication plans for people to ensure information is always provided to people in an accessible format.

The provider's systems to assess the quality of the service provided and make improvements had not identified the shortfalls we found during the inspection.

The home had good infection prevention and control procedures in place. Procedures had been reviewed and updated to reflect the COVID-19 pandemic. Systems were in place to prevent visitors catching and spreading infections.

Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care. Staff worked with health and social care specialists where needed to develop plans to support people. People were supported to see their doctor and other health professionals when needed.

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.

People were treated with kindness and relatives were positive about staff's caring attitude. We observed staff interacting with people in a kind and respectful way.

People had been supported to keep in contact with family and friends throughout the COVID-19 pandemic. Relatives said staff had provided very good support, which had been particularly helpful when they were not able to visit.

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

Rating at last inspection
This service was registered with us on 22 August 2019 and this is the first inspection as an individual location. The last rating for the service when it was registered as one location with the neighbouring service, as Avonbourne Care Centre, was requires improvement, published on 8 August 2019.

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service sustained a serious injury. This incident is subject to a further investigation. As a result, this inspection did not examine the circumstances of the incident.

The information we received about the incident indicated concerns about the management of risks. This inspection examined those risks. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches of regulations in relation to safe care and treatment and notifying us of significant events in the service at this inspection. We have also made a recommendation about ensuring people receive information in an accessible format.

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 from 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 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Avon Court

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.

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
The inspection was completed by one inspector and an assistant inspector.

Service and service type
Avon Court 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. Avon Court is a care home without nursing care. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. 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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people and three relatives to gather their views about the care they received.
We looked at eight people's care records. We checked recruitment, training and supervision records for staff and looked at a range of records about how the service was managed. We also spoke with the registered manager, manager, area manager, head of care and seven care staff. We received feedback from two health professionals who visit 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.

This is the first inspection of this newly registered service. This key question has been rated 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; Learning lessons when things go wrong

- Systems in place to manage risks to people were not always effective.
- There had been three incidents of altercations between two people resulting in one of them being hit. The member of staff who observed the incidents had not reported them through the home's incident management systems and the management team were not aware of the incidents.
- The risk assessments in place did not reflect these incidents or the support staff should provide to keep people safe.
- Staff gave conflicting information about the support they provided to the person when they were distressed.
- Following an incident in which a person sustained a significant injury, changes had been made to their risk management plans in relation to moving and handling. However, not all of the information in the person's plans had been amended and one section contained conflicting information.
- There were hot water boilers on all three floors of the home that were accessible to people in the open plan kitchenette. The boilers had a tap to dispense hot water for drinks and an exposed pipe that was very hot. The risk assessment for hot water boilers was not specific to the service and was written for a kitchen that could be closed off.

Systems had not been established to assess and mitigate risks to the health and safety of people using the service. This placed people at risk of harm. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They took action to assess the risks from the hot water boilers and adapt them to make them safer. Communication cards were reprinted for one person and moving and handling plans had been updated to remove conflicting information.

Using medicines safely

- People were not always supported to apply topical cream medicines they had been prescribed.
- One person had a prescribed cream medicine that had been recorded by staff as 'none found' on 18 occasions in the previous three weeks.
- Another person had three occasions during this period when staff had recorded their medicine was not administered, stating there was 'none in room'. On a further three occasions during this period staff had left a gap in the administration record so it was not clear whether they had supported the person to use the cream.

● A third person had not been administered their medicine on two occasions and staff had recorded there was 'none in room'.

The provider had not ensured people were always supported to apply their prescribed cream medicines. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had been supported to take the tablet and liquid medicines they were prescribed. Records had been fully completed and gave details of the medicines people had been supported to take.
● Where people were prescribed 'as required' medicines, there were clear protocols in place. These stated the circumstances in which the person should be supported to take the medicine.

Systems and processes to safeguard people from the risk of abuse
● Relatives told us they were assured people were safe at Avon Court.
● The service had safeguarding systems in place and staff had received regular training. Staff we spoke with had a good understanding of what to do to make sure people were protected from harm.
● Staff were confident the management team would take action to keep people safe if they raised any concerns. Staff were also aware how to raise concerns directly with external agencies if they needed to.
● The service had worked with the local authority to investigate issues when concerns had been raised.

Staffing and recruitment
● There were enough staff to meet people's needs.
● People and their relatives told us staff were available to provide support when people needed it.
● Staff told us they were able to meet people's needs safely. However, some staff did say sickness absence had added pressure at times, which meant they sometimes felt rushed. Records demonstrated the provider had taken action to address staff shortages through use of agency staff and leadership support from a neighbouring service.
● Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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 were assured that the provider's infection prevention and control policy was up to date.
● The provider was supporting people to have visitors in line with the most recent government guidance. Visitors were able to see people in various parts of the home, including in people's rooms.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed before they moved into the home to ensure they could be met. Relatives told us staff understood people's needs and provided the care they needed.
- Staff demonstrated a good understanding of people's medical conditions and any support they required. This information was included in people's care plans.
- Staff had worked with specialists to develop care plans. Examples included the care home liaison team, who provide specialist mental health support and community nurses. The provider employed a team of Admiral Nurses, to provide specialist advice and support in relation to care for people living with dementia.

Staff support: induction, training, skills and experience
- Staff said they received good training, which gave them the skills they needed to do their job. The registered manager had a record of all training staff had completed and when refresher courses were due.
- New staff spent time shadowing experienced staff members and learning how the home's systems operated as part of their induction.
- Staff had regular meetings with their line manager to receive support and guidance. Staff said they felt well supported.

Supporting people to eat and drink enough to maintain a balanced diet
- People said they enjoyed the food had enough to eat and drink.
- People were offered a choice of meals and support to eat their food where needed. Staff had a good understanding of people's needs, including people who needed food and drinks at a specific consistency.
- People had access to drinks throughout the day and staff supported people if needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- People and their relatives told us they were able to see their doctor and other health professionals when needed.
- Staff had recorded the outcome of appointments in people's records, including any advice or guidance.

Adapting service, design, decoration to meet people's needs
- Specialist equipment was available when needed to deliver better care and support. This included specialist beds for those that needed them, pressure relieving mattresses and equipment to help with mobility.

● The service was modern and purpose built. Bedrooms and communal spaces were large and unobstructed, which meant that manoeuvring of moving and handling equipment was easier.

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 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 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.
● Applications to authorise restrictions for some people had been made by the service. People's needs were kept under review and if their capacity to make decisions changed then decisions were amended.
● Staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity.
● The registered manager had a record of all DoLS applications that had been made, the outcome of the application where that was known and a record of any conditions on the DoLS authorisations. Records demonstrated the conditions in place were being met.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with kindness and relatives were positive about the staff's caring attitude. Comments included, "They do everything they can to look after [my relative]" and "I have no concerns about the care provided or how [my relative] is treated."
- We observed staff interacting with people in a friendly and respectful way. Staff responded promptly to requests for assistance and did not rush people.
- People's cultural and religious needs were reflected in their care plans. Staff supported people to meet these needs.

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people and their representatives to made decisions about their care. People's views were recorded in their care plans.
- Staff had recorded important information about people; for example, personal history, plans for the future and important relationships. People's preferences regarding their daily support were recorded.
- Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided.

Respecting and promoting people's privacy, dignity and independence

- Staff worked in ways that respected people's privacy and dignity. Staff were discreet when asking people whether they needed support with their personal care.
- Relatives told us staff maintained people's privacy and dignity. One relative was positive about changes to visiting arrangements, which meant they could see their family member in private, commenting "This is much better, I can see [my relative] in his room and not have any other restrictions on visiting."
- Confidential records were locked away when staff were not using them.
- Staff encouraged people to do things for themselves where possible, to maintain their independence.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● One person used English as a second language. One of the effects of living with dementia for the person was reverting their first language at times, including during periods of distress. The person's support plans referred to using communication cards, which staff reported had been lost. Staff could not remember when they had last seen the communication cards. Following the first day of the inspection the management team had reprinted the communication cards.
● Staff gave conflicting information about the best way to communicate with the person. Some said the communication cards had worked well, while others said they used a translation service on their phone. This resulted in an inconsistent approach to supporting the person.

We recommend the provider reviews their current practice to ensure they are consistently meeting the Accessible Information Standard.

● Other people had information about their communication needs recorded. We observed staff using these different methods of communication during the inspection.
● Signs made more accessible with pictures had been used throughout the home to help people find their way. These included personalised signs outside people's bedroom to help them identify it.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People had been supported to develop care plans specific to them. Plans included information about people's life history and what was important to them. The care plans had been regularly reviewed with people and had been updated where necessary.
● Staff knew people's likes, dislikes and preferences. They used this detail to provide support for people in the way they wanted.
● Relatives told us people received care in ways that were specific to them. Comments included, "[My relative] has all his information in the care plan and I'm involved in reviewing it. The residents are all looked after as individuals, in line with their characters. They know the things that make them tick."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had been supported to keep in contact with family and friends throughout the COVID-19 pandemic. Relatives said staff had provided very good support, which had been particularly helpful during lockdowns.

● The provider had supported people to identify 'essential care givers'. These are friends or family who take part in the home's COVID-19 testing programme and can continue visiting in the home in the event of an outbreak. This helps to ensure people can maintain relationships and avoid social isolation.

● The provider had reintroduced a range of planned social activities as COVID-19 restrictions were lifted. People were able to take part in a range of group and individual activities. Staff kept a record of who had participated and their feedback on the activity. This was used to plan future events and ensure everyone had opportunity to participate in something they enjoyed.

Improving care quality in response to complaints or concerns

● Relatives told us they knew how to make a complaint and were confident any concerns would be dealt with. Comments included, "They always follow up well if there have been any problems. They always keep me informed of what is happening" and "I have raised issues with the manager when needed and they have been resolved quickly. I wouldn't hesitate to speak if I needed to and I'm confident any issues would be sorted out."

● Records demonstrated complaints had been investigated and action taken in response. The registered manager had responded to the complainant to let them know the outcome of their investigations and the actions that had been taken.

End of life care and support

● People and their relatives were supported to make decisions about their preferences for end of life care. This information was used in developing care and treatment plans. The service worked with health professionals where necessary, including the palliative care team.

● Staff understood people's needs and received training and guidance in end of life care. People's religious beliefs and preferences were respected and included in care plans.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

- The provider had not notified CQC of significant events when they were legally required to.
- We identified four incidents which had not been notified to CQC. The incidents included three where a person had been hit by another person using the service and one where a person had sustained a serious injury that required emergency medical assistance.
- For the serious injury the provider had sought medical support and reviewed and updated how risks to the person were managed. Action had been taken to minimise the risk of similar incidents re-occurring. For the three incidents where a person had been hit, staff had not reported the incidents and the management team were unaware of them. Action had not been taken to minimise the risk of similar incidents re-occurring.
- CQC uses these notifications to monitor services and failure to complete them does not give an accurate picture of events in a service.

The provider had failed to notify CQC of significant events in the service. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

- The service had quality assurance systems which included reviews of care records, staff files, the environment and quality satisfaction surveys. In addition to checking records the management team completed observations of staff practice, including unannounced out of hours visits. The results of the quality assurance checks were used to plan improvements to the service. However, despite these systems in place, the provider was not meeting their legal requirements and the service was in breach of regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 service had experienced changes in management, which had been unsettling to some staff. The service had a registered manager who worked in the home two days a week. The registered manager was also registered manager of the neighbouring service. A manager from another nearby service provided management cover on three days of the week. Comments from staff included, "There are some issues where different managers want different things" and "The home needs consistent management. The current system is not working."
- The provider was actively recruiting a new manager for the service.

● Staff demonstrated a good understanding of most people's individual needs and a commitment to provide person-centred care.
● The management team had a good understanding of their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service had held meetings for people and their relatives to provide feedback about the service. This feedback was used by the provider to develop the service improvement plan.
● Relatives we spoke with were happy with the way the service had involved them and kept in contact with them.
● The provider was a member of relevant industry associations to ensure they were updated in relation to any changes in legislation or good practice guidance.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of all incidents that affect the health, safety and welfare of people who use the service. Regulation 18 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess and mitigate risks to the health and safety of people using the service. People were not always supported to apply their prescribed topical medicines. This placed people at risk of harm. Regulation 12 (2) (a) (b) and (g).