HC-One Limited

Averill House

Inspection report

Averill Street
Newton Heath
Manchester
Lancashire
M40 1PF

Tel: 01616886690
Website: www.hc-one.co.uk/homes/averill-house

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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
Averill House is a nursing and residential care home providing personal and nursing care to up to 48 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 47 people using the service.

Averill House is a purpose-built care property with 3 floors. The ground floor provides residential support, and the first floor provides nursing care. Each floor has two lounges, dining room and adapted bathing facilities. The third floor has a large kitchen and laundry.

People's experience of using this service and what we found
Medicines were not always safely managed. The home took actions to rectify the issues we found following our inspection. A quality assurance system was in place and actions completed for any issues identified. However, the medicines audits had not been robust in identifying the issues we found during this inspection.

People felt safe living at Averill House. Risks were identified and guidance was in place to manage them. There were enough staff to meet people's care and support needs. Staff were safely recruited. Equipment was regularly checked and serviced in line with legal guidelines. Incidents and accidents were reviewed for any learning to reduce further occurrences. The home was clean throughout, and infection control was well managed.

Staff said the management team were visible in the home and approachable if they needed to speak with them. The home worked well with a range of professionals, including physiotherapists, GPs and district nurses.

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 and relatives said they were involved in agreeing and reviewing their care plans. Relatives said there was good communication with the staff team and any concerns they had were addressed. Staff said they enjoyed working at the home.

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 20 December 2018).

Why we inspected
We received concerns in relation to the management of medicines and people's nursing care needs. As a

result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of 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.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. Action had been taken to address the issues we identified.

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

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

Enforcement and Recommendations
We have identified breaches in relation to the safe management of medicines at this inspection.

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?

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.

Averill House

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
Two inspectors, a medicines inspector and an Expert by Experience carried out this inspection.
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
Averill House 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. Averill House] is a care home with 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 not a registered manager in post. A new 'turnaround' manager had been in post for one month and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 7 people who used the service and 3 relatives about their experience of the care provided at the home. We spoke with 12 members of staff including the manager, deputy manager, area director, regional quality improvement lead, care assistants, and the chef. We also spoke with 3 visiting professionals.

We reviewed a range of records, including 4 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment. We looked at a variety of records relating to the management of the service, including quality assurance and incident reports.

We observed the support provided throughout our inspection and viewed the environment of the home.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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 safely managed. People did not receive their time critical medicines at the right time and could experience symptoms of their condition as a result. A high-risk medicine had not been administered on 2 occasions in June for 1 person. Staff had reported 1 omission but not the other.
- Staff did not accurately record when thickener powder was added to drinks to reduce the risk of choking for people with swallowing difficulties. We saw powder being used for more than the person it belonged to.
- Some peoples records did not reflect their current needs and lacked some person-centred details.
- Staff had undergone medicines e-learning, however we saw no annual refresher as per the medicines policy and were not provided with evidence of annual administration competencies in line with national guidance.

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Action to address all the above issues were taken following our inspection.

Assessing risk, safety monitoring and management

- Risk assessments were in place, and they identified the risks people presented and what action staff needed to take to reduce risk.
- Staff knew people and could describe what action they would take to reduce the known risk, for example to manage people's skin integrity or where people were at risk of choking.
- Fire risks were assessed and included the use of phone chargers and e-cigarettes to ensure each person was safe if they were using these electronic devices in their bedrooms.
- Where necessary referrals were made to external agencies so additional advice and support could be provided, for example the speech and language team (SALT) and district nurses.
- Equipment was regularly checked and serviced in line with legal guidelines.

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.
● Capacity assessments were completed and where people lacked the capacity to make decisions about any restrictions, an application was made to deprive the person of their liberty.
● Staff had received training in in MCA and DoLS. We observed and heard care assistants asking for people's consent before providing support. Staff explained how they offered people day to day choices.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff felt comfortable to raise any concerns they had and had completed training in protecting vulnerable adults from abuse. One staff member said, "100% I wouldn't hesitate, we are their (people living at the home) voice."
● People and relatives thought they were safe living at Averill House. One person said, "I feel like I'm being looked after well."
● Staff knew how to report and record any incidents or accidents. Incidents were reviewed, and risk assessments updated where appropriate to reduce the risk of a reoccurrence. Any incidents were discussed during the daily 'flash' meetings with nurses and team leaders.

Staffing and recruitment
● There were enough staff on duty to meet people's needs. This was confirmed by people, relatives, and the staff we spoke with. Agency staff usage was low. The provider aimed to over recruit in all their homes to cover annual leave, sickness and training. This meant staff from other of the provider's local homes were able to cover shifts where appropriate.
● People's dependency levels were reviewed monthly to calculate the staffing levels needed at the home. Rota's showed consistent staffing throughout the week.
● Staff were safely recruited, with all pre-employment checks completed prior to the new member of staff starting work. Staff completed a 3-day induction before doing 2 or 3 shadow shifts to get to know people, their needs and routines.

Preventing and controlling infection
● The home was clean throughout.
● We were assured that the provider was admitting people safely to the service. Staff used PPE effectively and safely.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed and the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives were freely able to visit the home and stay for as long as they wished to.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Continuous learning and improving care

- A quality assurance system was in place, with a schedule of audits. Actions were identified and signed off when completed. However, the medicines audits had not identified the issues we found. Staff didn't fully utilise the electronic medicine administration system and were unaware of some administration issues. Systems to mitigate errors from reoccurring were not always evident.
- The provider's central quality team provided a clinical indicator report which enabled the manager to monitor trends and patterns for a range of areas, for example falls, skin integrity and infections. The manager reviewed all incidents to identify any trends or patterns and ensure appropriate actions were in place to reduce the risk of any reoccurrence.
- The area director and regional quality improvement lead could view all incident reports, audits, and clinical reports remotely. The area director completed a monthly visit report.
- A monthly organisational report was used to share the lessons learnt from any of the provider's homes to all homes in the group. We were told the issues we found with the medicine administration at Averill House, and the actions taken, were shared with all the provider's homes.

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

- The manager was new to the home and was a temporary 'turnaround' manager. They were in the process of registering with the CQC, whilst a permanent manager was recruited.
- The manager was supported by an area director and regional quality improvement lead, who both new the home well. The manager could also request support from the provider's central teams, for example human resources, learning and development team, nursing standards team.
- The deputy manager, nurses and team leaders were established members of staff, with clearly defined roles and areas of responsibility. A new nursing assessor had been appointed for the provider's Greater Manchester homes. They would support the home with nursing assessments and reviews for people moving to or already living at the home to ensure all needs were identified and could be met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People said the staff were kind and caring. One person said, "The staff all know me, they go out of their way to accommodate me." A relative told us, "We've had a good experience. The staff are always friendly and very helpful. [Name's] never wanted for anything." We observed positive interactions between people

and care staff throughout our inspection.
● Relatives said the communication with the home was good, and they were involved in agreeing and reviewing their relatives' care plans. One relative said, "Staff give me feedback about how [name's] been. I'll get a phone call if there's any changes and the nurse will go over stuff with us."
● A relative's survey was underway at the time of our inspection. The results would be collated, and the manager would follow up any issues raised.
● Staff felt supported by the managers, nurses, and team leaders within the service. There had been multiple changes of managers over the last 5 years, but staff told us the transition had been smooth, with some of the ex-managers still visiting the home in their new role within the provider's central management team. The managers were visible in the home, completing daily walk round checks.
● Staff said they felt well supported, with up-to-date training, regular supervision meetings and staff meetings. Information about people was regularly shared at handovers and daily flash meetings to ensure staff had the most up to date information about people and their needs.

Working in partnership with others
● The home worked closely with physiotherapists and rehabilitation specialists supporting people discharged from hospital for assessment. A physiotherapist said, "We work well with nurses; they have all the information we need and feedback how people have been to us. Staff will support people's rehabilitation by encouraging them to mobilise and engage activities. We see people become more independent."
● The home worked with a range of professionals, including the GP, speech and language team, podiatrists, and district nurses.

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 manager knew their responsibilities under the duty of candour. They had policies in place to ensure they were open and transparent when things went wrong. Complaints were investigated, lessons learnt actions completed and information shared as required with other agencies.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed. Time critical medicines were not administered at the correct time, a high risk medicine had not been administered as prescribed on 2 occasions, records of thickener added to drinks were not accurate, staff annual refresher training and competency assessments were not always completed.