Tricuro Ltd

Avon View

Inspection report

Loring Road
Christchurch
Dorset
BH23 2GZ

Tel: 01202485170

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Avon View is a residential care home for 81 older people. The home provides care over three floors. The top floor provides nursing care, the middle floor provides residential care to frail older people and the ground floor provides residential care to people living with a dementia. At the time of our inspection there were 81 people receiving care at Avon View.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People received safe care. Staff had completed training on how to recognise potential abuse and understood the actions they needed to take if abuse was suspected. People were protected from discrimination as staff had completed equality and diversity training and demonstrated a respect for how people chose to live their lives. People had their risks assessed and regularly reviewed. Staff understood the actions they needed to take to minimise risks of avoidable harm including the risk of avoidable infections. People had been involved in how risk was managed and had their freedoms and wishes respected. When things went wrong systems and processes were in place that provided opportunities for reflective learning, staff training and the reviewing of risks.

Staff had been recruited safely including checks to ensure they were suitable to work with vulnerable adults. Staffing levels and the mix of staff skills meant that people were supported by enough staff to meet their needs and choices. Staff had completed an induction and on-going training that enabled them to carry out their roles effectively. Clinical training opportunities were provided to nursing staff. Staff received regular supervision and support and had opportunities for professional development.

People had their medicines managed safely and when errors occurred actions had been taken to establish why and reflect on any practice issues to avoid a repeat of the error. Protocols were in place for medicines prescribed for as and when required ensuring people received these medicines appropriately.

Assessments had been completed prior to people moving to Avon View. These had captured peoples care needs, any specialist equipment needed and reflected people's life style choices. The information had been used to create individualised care and support plans. People had their eating and drinking needs understood and met and were provided with a range of choices each meal time. People were involved in reviews of their care and had access to healthcare professionals when needed. People's end of life wishes which were known by the staff team and respected. Avon View had received a national accreditation for their end of life care.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice. A complaints process was in place that people were aware of and felt able to use. When complaints had been received they had been dealt with in line with Avon Views policy and shared appropriately to drive improvements and staff learning.

People and their families described the staff as kind and caring. People told us staff respected their dignity and privacy. We observed staff involving people in decisions, explaining actions and giving people time. A dignity audit had been carried out and an action plan had been implemented including a dignity day promoting discussion about what dignity meant to people and how Avon View placed importance upon it. Dignity champions had been appointed from the staff team who worked alongside staff identifying good practice and addressing any areas were practice needed to improve.

The service had an open and positive culture and had systems in place to engage and involve people, their families and staff in service delivery. Leadership was visible and promoted teamwork. Staff had a clear understanding of their roles and responsibilities and described the home as organised and well led. Audits and quality assurance processes were effective in driving service improvements. Partnerships were in place with other agencies promoting learning and innovation in service development. The service understood their legal responsibilities for reporting and sharing information with other services.

Further information is in the detailed findings below.

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 remains 'Good'.	**Good**
Is the service effective? The service remains 'Good'.	**Good**
Is the service caring? The service remains 'Good'.	**Good**
Is the service responsive? The service remains 'Good'.	**Good**
Is the service well-led? The service remains 'Good'.	**Good**

Avon View

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 checked 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.

The inspection began on the 16 July 2018 was unannounced and the inspection team consisted of two inspectors. It continued announced on the 17 July 2018 with one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. The two experts both had experience of services with older people.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also contacted local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually 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 our inspection we spoke with fourteen people who used the service and four relatives. We spoke with a deputy manager, nurse manager, two nurses, nine care staff, two activities staff and a cook. We reviewed eight peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After our inspection we spoke with the registered manager as they were not available during our inspection.
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Good

Is the service safe?

Our findings

People and their families described the care as safe. One person said "I feel confident in there (staff) care". Another said "I feel very safe here; I don't even have to lock my door". People were supported by staff that had completed safeguarding training and understood how to recognise signs of abuse and the actions needed if abuse was suspected. The deputy manager explained "Safeguarding is on the agenda of every resident and relative meeting to enable discussion and transparency". People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

People were protected from avoidable harm because assessments had been completed that identified risks people experienced. When a risk had been identified actions had been put in place to minimise the risk and were reviewed at least monthly. Some people had a risk of skin damage and had specialist equipment to help protect their skin. Staff were aware of actions they needed to take which included regularly helping people change their position, applying creams to dry skin and encouraging enough fluids and diet.

The management of risks had included seeking specialist support when appropriate. Some people had a risk of choking and assessments had been completed by a speech and language therapist (SALT). Safe swallowing plans were in place and implemented by the care and catering teams. Risks associated with health conditions were assessed, monitored and reviewed by nursing staff who liaised with clinical specialists when necessary. One person had a post-operative wound and nurses had liaised with a specialist tissue viability nurse and the orthopaedic team to safely manage risks associated with the wound.

People were involved in how their risks were managed. One person had been involved in a review of their moving and transferring care plan. They felt they would like to try and start standing again and staff had contacted a physiotherapist for advice.

Records showed us that equipment was serviced regularly including the lift, boiler, fire equipment, and hoists. People had personal emergency evacuation plans (PEEPs) which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People told us there were enough staff to provide safe care. One person told us "Staff are available when I need them; I am never rushed and they have time to deal with me". Staffing levels were reviewed regularly and changed to reflect the changing needs of people. An example had been a second nurse each afternoon to provide additional clinical support and complete care records. Staff had been recruited safely. Relevant checks had been undertaken before people started work. For example references obtained and checks made with the Disclosure and Barring Service to ensure that staff were safe to work with vulnerable adults. Nurse's registrations had been checked with the Nursing and Midwifery Council.

People had their medicines ordered, administered, recorded and disposed of safely. Staff understood the actions needed if an error occurred. One person had requested an increase in a prescribed medicine. A

nurse had contacted the GP surgery requesting a change to the person's prescription. The increased dose was given before the GP had confirmed they would prescribe an increased dose. We discussed this with the nurse who was the clinical lead who agreed this was not safe practice and during our inspection investigated why this had happened. On the second day of our inspection the amended prescription had arrived from the GP. When people had medicine prescribed for when required (PRN) protocols were in place. These provided details of what the PRN medicine had been prescribed for and how it should be administered. Body maps had been completed for people indicating where topical creams needed to be applied. Records showed us these had been applied in line with people's prescriptions.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers and moisturisers available at points throughout the building. All areas of the home were clean and odour free. One person told us "The place is spotless; very clean indeed".

When things went wrong timely actions had been taken, lessons had been learnt and appropriate reporting to external agencies had taken place. Accidents and incidents were analysed monthly and both actions and lessons learnt shared with the appropriate staffing teams.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and choices. Care plans had been developed in line with current legislation, standards and good practice guidance and including people's diversity. When specialist equipment was required this had been organised prior to admission.

Staff had completed an induction and on-going training that provided them with the skills to carry out their roles effectively. A nurse told us "I've recently completed wound care and pressure care training. When you have supervision training is always discussed". A care worker had completed dementia training and explained "It's helped me understand what's happening (to a person). Why people say certain things. It's helped with communication". Staff told us they felt supported in their role and had regular supervision. Staff had opportunities for professional development. This included diplomas in health and social care and also clinical courses for nursing staff such as managing specialist medicine administration equipment.

People had their eating and drinking needs met. Both care and catering staff were aware of people's likes, dislikes, allergies and any special diets. Menu's offered a choice of well-balanced options and people were able to have their meals where they chose. One person told us "I have expressed my likes and dislikes and they have respected them". People told us the food was good, there were always choices and snacks were always available. Some people required soft textured diets and thickened drinks to aid swallowing and we observed these being provided in line with their care plans. Adapted plates and cups had been provided to enable people to maximise their independence with eating and drinking.

Working relationships with other organisations supported effective care outcomes for people. Examples included the involvement of a specialist diabetic nurse and a specialist wound care nurse. People had access to healthcare and records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, community mental health team and dieticians.

The environment provided opportunities for people to access communal areas, private areas and accessible outside space. A quiet room had been created as a place for personal reflection, meditation and prayer. One area of Avon View specialised in caring for people living with a dementia. To aid orientation and a feeling of belonging people had memory boxes outside their doors which included favourite pastimes, interests, hobbies and photographs. Each door resembled a street front door and had a photograph of the person and their door number. Decoration provided opportunities for reminiscing and conversation such as old pictures of the local areas, old adverts and household items from times gone by.

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. The application procedures for this in care homes and hospitals are 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 were being met.

We saw that people had MCA assessments in place and that these were decision specific and provided evidence about how the decision had been made. When people had been assessed as unable to consent to their care DoLs application had been made to the local authority. Staff were aware of people with a DoLs in place and any conditions that had been applied. One person told us "The staff always seek my consent before carrying out any treatment". Another told us "The staff would ask my consent before doing anything to me".

Good

Is the service caring?

Our findings

People and their families described the staff as kind and caring. One person told us "The staff are very supportive and caring towards me". Another said "They (staff) are helpful and caring. All very respectful; they use our first names always". Another said "They go the extra bit to help you".

We observed a relaxed and friendly rapport between people, their families and the staff team. We observed staff providing emotional support. Examples included a member of staff kneeling down next to a person and reassuringly holding their hand. The person reacted with a huge smile and said "I love you; I do". Another person was tearful. A care assistant immediately approached them; the person was pleased to see them and said "You're my friend".

Life histories had been completed with people and provided information in word and pictures. Staff had a good knowledge of people, their families and people important to them. One person's family lived abroad and staff had helped familiarise them with skype so that they could see and chat with them. Staff understood people's communication needs. A care worker told us "One person is deaf and we use hand gestures, body language and keep good eye contact. Another is blind and when I take their meals I explain it on a clock plate; like potatoes at 3 o clock".

People felt involved in decisions about their care and treatment and able to express their views. One person said "The staff are quite receptive if I want things doing differently". People told us they chose when they got up and when they went to bed, whether they had a shower or bath or if they wanted to join in activities. People who needed an independent representative to speak on their behalf had access to an advocacy service.

Throughout the inspection we observed the majority of staff respecting people's dignity, involving people in decisions, explaining their actions to people, giving people time and listening to what they had to say. However we observed some examples of staff providing care without engaging with the person. Also some people told us they preferred female care staff and this didn't always happen. We discussed these issues with the deputy manager who provided information about dignity actions Avon View had implemented. These included dignity champions in the staff team who worked alongside staff and were able to promote good examples of respecting dignity and address poor practice. A dignity day which promoted discussions about dignity and a dignity audit. They told us "Its important residents understand how important we view dignity". The issues we had identified had also been feedback in a recent survey completed by people and an action plan was in place. A residents committee meeting had been held in May 2018 and dignity and respect had been discussed. The minutes read that everybody felt treated well and staff were very good.

People had their privacy respected. We saw staff checking with people whether they wanted their room door left open or closed. Staff respected people's private time with family and friends when visiting or having a telephone conversation. Confidential information was stored in a locked cupboard or stored on password protected computers.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. One person told us "The nurse comes with forms to sign to do with care and talks to you about your care". Another told us "I have a care plan and staff discuss this with me and my daughter". Care staff were able to tell us about their role in supporting people with their care needs and choices. At the beginning of each shift staff attended a handover which kept them up to date with any changes to peoples care.

Care plans reflected people's diversity and described how people had chosen to express their sexuality, religious and cultural beliefs. This included dietary requirements linked to a person's religion and providing opportunities both in the home and community for people to attend religious services.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The registered manager provided one example where a consent form had been changed to include pictures to help people with a cognitive impairment understand how their information may be shared.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. We observed people enjoying a music entertainer; people were dancing together and staff had organised ice cream cones. Some people had enjoyed a holiday at a local beachside lodge and friends and family had been able to join in for days out and meals. People had requested chickens and these lived in the garden and provided a source of interest and conversation. One person told us "I had a birthday tea in June. They gave me a very nice day". We spoke with a person who was cared for in their bed. They had always worked with animals and delighted in showing us photographs of a Shetland pony visiting them in their bedroom.

When people chose to spend time in their rooms this was respected. One person told us "I'm not interested in activities. I like my books and the TV". One to one activities included hand massages, reading poetry and looking at photographs of family, friends and past events.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. Avon View had received a national accreditation in end of life care. A care worker explained "End of life care is so much better; so much more dignity, so much more choice that people have made and you can provide exactly what they want even if they don't tell you personally".

Good

Is the service well-led?

Our findings

People, their families and the staff team spoke positively about the visible leadership and open culture at Avon view. One person told us "The manager drops in and talks to me". A care worker said "We're encouraged to say what we think; we're not just a carer". We're the ones with the residents. You feel appreciated by the manager. They are very good if you need them in an emergency they would help". A nurse said "(Registered manager) I feel is approachable. We get verbal feedback about any complaints and also we see positive feedback from audits. Always telling the staff you have done good or you can do better".

Staff understood their roles and responsibilities. Systems and processes ensured staff understood what was expected from them each day. A board was on display which provided information about which staff were caring for different parts of the home. A visitor told us "Generally they (staff team) all get on well together; some staff have been here for years. The home is very well managed".

The registered manager had kept their skills and knowledge up to date including completing the organisations mandatory training such as moving and assisting people and safeguarding. They had also attended a locally organised strategic workshop "How to be Well-led".

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. Systems and processes had been introduced to ensure effective communication and engagement with people, their families and staff in developing the service and sharing information and learning. Resident and relative meetings were held quarterly. Minutes had included topics such as feedback from safeguardings, activities, new technology being introduced and end of life care. Residents Committee Meetings were being held and provided an opportunity for people to get involved. A big focus was fund raising for a mini bus which would enable more trips into the community. One person told us "I've been asked my opinion on things and the management do listen".

Quality assurance systems were in place and effective in capturing areas requiring improvement. Action plans were clear, provided details of accountability and timelines. Outcomes and actions were shared with staff in writing who in turn had to sign to say they had read and understood. The deputy manager explained "Accidents and incidents are audited and key points pulled out to share with seniors, staff team, people and families as appropriate. Used for reflective learning, staff training and care plan reviewing".

Partnerships were in place with other agencies that supported sharing of good practice, development of new practices and improved outcomes for people. The home had worked with the local NHS and implemented the 'Red Bag Scheme'. The scheme involved using a red bag containing information about the person that stays with them and ensures an effective transition between services. They were also involved with a local university pilot which involved testing games for people and evaluating levels of impact and fun.