Coate Water Care Company Limited

Avebury House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Avebury House is a residential care home providing regulated activities accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury to up to 41 people. The home is set over 2 floors with access by lift and stairs. There are communal rooms and garden for people to use. At the time of inspection there were 34 people living at the home. Some of the people had dementia and others were in discharge to home beds; these are beds commissioned by the local authority to support people who are ready to leave hospital but need some more support before returning to their own homes.

People's experience of using this service and what we found
Medicines were not always managed safely. Whilst we observed a member of staff administering medicines safely, not everyone had "as needed" (PRN) protocols in place for pain management. Staff did not follow professional guidelines on when to administer medication.

Not all risks people faced had been identified, assessed or mitigated, which did not promote safety. People were placed at increased risk of harm by care plans which lacked detail and which some staff did not always follow. This was particularly an issue with pain and pressure management.

People were not supported in a person-centred way and the care was process driven rather than person driven.

People told us that they were often thirsty and that when they asked for drinks they were not brought to them or were left out of their reach. People told us that their call bells were not easily within reach, so they were unable to seek assistance if required.

People were at increased risk from the spread of infection because infection prevention and control measures were not always implemented. The house was not clean and there was damage to parts of the house which could encourage viruses to develop. Staff told us that the provider failed to keep an adequate stock of Personal Protective Equipment (PPE) and after the inspection we were told there was a period of time where no gloves were available to staff, however the provider told us that whilst stock was low they did have some available.

Staff were being recruited safely but some lacked the depth of knowledge needed to support people safely. The morale of the staff was low, and we were told this was due to lack of staff and lack of management in the service.

The provider failed to have oversight of the quality of care and safety. This was something that the area manager had noted and was in the process of addressing by introducing new systems for auditing and assessing competence when we inspected.

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 and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 May 2022)
We carried out an unannounced comprehensive inspection of this service on 15 March 2022 and 29 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements and to follow up on concerns received about medication management and risks to people that had been brought to our attention. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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

Enforcement and Recommendations
We have identified breaches in relation to Regulations 12 and17 at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Avebury 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
The inspection team consisted of 2 inspectors and a pharmacy inspector

Service and service type
Avebury 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. Avebury 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 the registered manager had left the post but had yet to submit the appropriate deregistration forms to the Commission. A new manager had been appointed but had not yet started. An

acting manager and the area manager attended both days of the inspection.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 12 December and ended on 9 January 2023. We visited the location's service on 12 December and the 17 December

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed the last inspection report and the improvement plan. 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 to the acting manager, the area manager, 7 members of staff, 4 family members 10 residents and 2 professionals. We reviewed the improvement plan the previous registered manager had written, we looked at medication records, care plans, daily records, cleaning rotas and maintenance records. The area manager also sent us information to review after the visits.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant that people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider failed to manage and store medicines safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not safely managed. Medicine records showed PRN medication protocols were not in place for everyone.
● One person had specific medical needs; there was little information in their care plan on how to manage their condition. The nurse on duty did not follow medication administration guidance, and when we asked why they did this they could not give us a rationale for this decision. They told us they had used their judgement to not administer medication. however, this put the person at risk of becoming quickly unwell and needing medical support.
● One person was prescribed "as required" (PRN) pain relief 2 tablets up to 4 times a day but was only being administered 1 tablet at lunchtime each day. When asked why the nurse told us they were not aware they had been prescribed more tablets than the lunchtime dose. This meant they were at risk of poor pain management.
● One person had an eye infection, when we reviewed the care plan there was no protocol to tell staff how to support the person appropriately.
● The provider failed to ensure the safe management of pain patches. Staff had not recorded where patches were placed, checks they were still on and in place or records of removal of patches. It is important to know where patches are placed so they can be rotated when next applied. If a patch had come off without being noticed by staff people would not have received their prescribed medicine
● We found pill cutters that were not clean and had a lot of debris on them. This could lead to cross contamination of medication.

The provider had not ensured the safe management of medicines. This was a continuing 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 had systems in place to protect people from the risk of abuse.
● Staff had received safeguarding training and could tell us what process they would follow if they had safeguarding concerns.
● People and their relatives that we spoke to felt that people were supported safely.
● One person had bruising on their hand. When asked, staff said they thought the person may have hit their hand against something during personal care but there was no evidence of records on their care notes or an investigation.

Assessing risk, safety monitoring and management
At our last inspection the provider failed to assess and manage risks safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks people faced were not appropriately identified, assessed or monitored and enough action had not been taken to mitigate them.
● Records showed one person had been assessed to be at high risk of falls and required a pressure mat to be placed by their bed. On each inspection visit the mat was not plugged in and was under their bed. Without the pressure mat staff would not be alerted to the person moving around. This would increase the risk of the person falling and sustaining a possible injury.
● Care plans did not reflect the support people needed to maintain healthy skin. Care charts did not demonstrate people had been repositioned in response to their assessed needs. We observed people were in the same position during the inspection. This meant that people were at higher risk of acquiring pressure sores.
● One person had information about a pressure sore recorded on their care plan, but staff told us they didn't know about it. This meant the they were not being supported in the right way to help them recover. We observed this person in the same position during the inspection and their care charts demonstrated they was not being repositioned regularly.
● People had had their nutritional needs assessed, but there was limited guidance for staff about the support needed to manage any risks. People who were assessed as being at high risk of malnutrition had no clear guidance about how to encourage weight gain.
● The records for people at risk of malnutrition of food intake did not have enough detail about what people had eaten. People's records showed what they were offered to eat but not the quantities of food they had eaten or any snacks they had been offered and eaten.
● We reviewed one person's records who was at risk of malnutrition. Records showed they were asleep at breakfast time and lunch time. There were no records to show that staff offered them anything to eat between these times.
● Three people told us they were thirsty because they could not reach the drinks in their room, 1 person told us that when they asked for a hot drink nothing came. Fluid monitoring records did not show people had regular fluids. Each had a recommended daily intake of 1500mls. However, this was not being consistently offered or reached with some people.
● A hydration station that the provider's action plan stated would be available for people at all times was

not there on the morning of the first day of inspection and was put in place at lunchtime.
● One person was identified by the provider as being at increased risk because they were trying to climb over their bedrails. No steps had been taken to mitigate that risk.
● People could not always reach their call bell. We helped 1 person to ring their call bell which was out of their reach.
● We observed one person who refused lunch being offered alternative choices they were supported positively with this and when they chose to have a sandwich a selection of sandwiches were offered to them.

The provider did not have effective systems to assess a mitigate risks to people. This was a continuing breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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)

● The service did not always work within the principles of the MCA.
● When we spoke to 3 staff about people asking to be repositioned we were told because people lacked capacity they were repositioned every 4 hours "in their best interests". This is not within the principles of the MCA which guides care staff to ask people if they need support rather than determine what people need without involving them.
● Appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
At the last inspection we recommended that the provider reviews staffing numbers on a regular basis to include listening and using the feedback from people about their experiences of care. At this inspection we found that the house still did not have adequate staffing levels.

● There were not enough staff on duty on the first day we visited, this meant that call bells rang in the house for most of the day. On the second visit the area manager informed us they had reviewed staffing and had increased the staffing levels during the day to 2 registered nurses and 8 care workers during the day including 2 senior care workers. They had not increased the night staff of 1 registered nurse and 3 care workers.
● Staff did not respond to call bells promptly, 1 person waited over 12 minutes for a response from staff. Another person was waiting for over 11 minutes for their bell to be responded to. One person told us "They're short staffed. You just need to wait. They're always busy" or "They'll say they'll be back in 10 minutes, 20 minutes but they don't come back". This meant that we could not be sure peoples care needs were being met in a timely way. We observed the bells rang less on the second day of inspection.
● Staff told us the increase in staff had a positive impact on their ability to support people during the day, but they also said there were still not enough staff to support people during the night shift to ensure all people could be supported in line with their needs.
● Staff were recruited following safe recruitment guidelines.

● The area manager recognised some of the staff needed further training to ensure they were delivering a good level of care to people.
● Staff morale was poor, with staff telling us they did not feel listened to and there were not enough staff for them to do the job they wanted to do. One member of staff told us "we work well as a team but just don't feel supported by management".
● Relatives we spoke to told us that told us that people were happy. One person said "[relative] is really happy there" another told us the staff were "kind and lovely".

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were not assured that the provider was using PPE effectively and safely. Staff told us there was a period of 3 days after the inspection where they had no gloves. The provider told us that they did have a stock of gloves for staff to use, and when they ran low the home manager brought additional stock to the house.
● We were not assured that the house was maintained in a way that would help to prevent infection. We observed missing tiles in the first floor sluice room, gaps in the flooring in a toilet on the first floor and chipped paint on the handrails. These all lead to an increase in the chances of staff being unable to manage infection which can be harboured in damaged equipment and facilities.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People had visits from family and friends in line with government guidelines.
● Relatives told us they could visit whenever they wished.

Learning lessons when things go wrong
● There were records of accidents and incidents, however there were no records of lessons learnt. This is something that the previous registered managed had planned to implement after the last inspection but had not completed. The area manager stated that this was now being introduced by the management team.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection we found the provider failed to have systems in place to assess, monitor and improve the quality and safety of the service and to mitigate the risks in the service placed people at risk of harm. This was a breach of Regulation 17 (good governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Quality systems were not effective.
- The provider had not followed their improvement plan. We found actions the provider had said they would take to rectify issues identified in the commission's previous inspection that had not been completed. The area manager told us she would be completing a whole system audit to address the quality performance issues.
- Managers lacked oversight about people's care. Regular walk around's by management to observe staff practice and welfare of people had not happened. We were told this had recently been reinstated, although some people looked dishevelled. For example, people's hair and teeth did not look clean. This had not been identified in the manager's walk around.
- Management did not check that tasks assigned to staff on the electronic care system were completed in a timely manner. For example, we were shown the oral hygiene record for a person who had not had his morning teeth cleaning completed until after 12pm.
- Regular management reviews of pressure sores had not happened as planned, which led to people being at higher risk of harm from poor pressure sore management.

● Managers could not provide us with evidence that care workers had been supervised in the last year. Staff told us they were getting no support from management. The area manager told us she had implemented a supervision plan for 2023 which meant carers would be receiving regular supervisions.
● The acting manager had not ensured that "as required" (PRN) protocols for medicines were in place which meant people did always not receive their prescribed medicines as needed.
● Auditing system were not being used to identify when things were good or when they went wrong. This meant that lessons could not be learnt.
● Systems were not being used effectively to ensure that people had adequate fluid intake. Three people told us they were thirsty when we spoke to them and fluid charts did not demonstrate people had been offered enough to drink.
● Systems were not in place for kitchen staff to know if people needed different textured food, what food allergies they had and what people liked and disliked to eat. When this was raised with the area manager they ensured the information was made available to the cook.
● We were shown a cleaning rota, but the manager could not evidence that there were any checks being completed to ensure the cleaning was robust, and we found parts of the home to be dirty. The lift had debris on the floor, there were cobwebs in light fittings and dirt on the over tables and walls in peoples rooms.

The provider did not have effective systems to assess, monitor and improve the service provided. This was a continued breach of regulation 17 (safe care and treatment) 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
● Inspectors observed staff not engaging with people when they were spoken to. We observed 2 staff talking about their next job whilst supporting someone. One member of staff was observed by 2 inspectors engaged in an argument with a person in a corridor.
● People told us staff did not always listen to them and walked away when they were trying to speak to them and that there was not much to do during the day.
● Staff told us that they always tried to support people as best they could, but this was difficult when they did not have enough staff.
● One professional told us that they felt the nurses were not aware of all that was happening in the home.

Continuous learning and improving care
● Staff training was by an online system, the area manager had identified that some training needed to be face to face and had plans in place to start this. The previous registered manager had identified some training needs for staff in relation to dignity and oral care, which had been included in the improvement plan, but the provider had not delivered these as planned.
● Two members of staff told us that they did not feel the present training system was adequate to meet all their training needs. For example, 1 member of staff said that dementia training was not effective.
● We could not find evidence that staff had been trained to support people appropriately if they had specific support needs. For example, on person had a diagnosis of schizophrenia but the acting manager told us that no one had been given any training on this.

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 area manager and the manager were aware of their duties and responsibilities to be transparent and open. There were systems in place to ensure duty of candour was appropriately followed.
● Relatives told us that communication between staff and them was good, one person told us

"Communication is good, they call when they need to relay information"

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

● At the last inspection, systems for seeking feedback from people to improve the service were not robust. At this inspection, we found no change.

● The previous registered manager had planned to introduce a nutrition and hydration steering group, but this had not happened. The area manager told us she will be creating a resident's survey to include nutrition and hydration needs.

● Relatives told us they were invited to family and friends' meetings and that communication from the home was usually good.

Working in partnership with others

● We spoke to 2 professionals who told us that communication with the home had been good when the previous registered manager had been in post.

● One professional told us that since the previous registered manager had left partnership working had been "a struggle". They had found difficulty in getting information from the acting manager.

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
Treatment of disease, disorder or injury	The provider failed to ensure people were protected form avoidable harm. The provider failed to ensure medicines were always managed safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to operate effective governance systems to accurately monitor the quality and safety of care and drive improvement.

The enforcement action we took:

Warning notice