Premiere Care (Southern) Limited

The Avenues Care Centre

Inspection report

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Date of inspection visit:
09 December 2020

Date of publication:
05 February 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Avenues Care Centre is a residential care home, providing personal care to 42 older people at the time of the inspection. Some people were living with dementia or mental health conditions. The service can support up to 62 people.

People's experience of using this service and what we found
Most people told us they were happy at the service and felt safe. However, we found people were not always safe.

The provider's processes had not been used to correctly identify how many staff were required to meet people's needs. There were not always enough staff on duty and people had to wait for their care. New staff had been recruited safely.

People's medicines were not managed safely. Stock balances and records for some medicines were incorrect and we could not be assured people had always received their medicines. Action had not been taken to ensure the safe administration of covert medicines or pain relief patches.

Risks to people had been assessed but care had not always been planned to mitigate risks. Most risks, including risks of falling or developing skin damage had been assessed and mitigated.

Checks and audits completed by the provider and staff had not always identified shortfalls and driven improvements at the service.

There had been inconsistent leadership at the service. The provider had taken action to address this and leadership had improved. Staff were motivated and felt supported. They were clear about their roles and had been held to account when things went wrong.

People and their relatives had not formally been asked for their feedback of the service. However, everyone we spoke with was confident to raise any concerns they had and these had been acted on. This was an area for improvement.

Lessons had been learnt when things went wrong at the service and action had been taken to prevent them from happening again. Following our inspection, the provider sent us evidence to demonstrate they had acted on the concerns we identified during the inspection.

People were protected from the risk of abuse. The service was clean and we were assured infection prevention and control measures were in operation to manage the risks of Covid 19.

The provider and staff worked with other professionals, including health staff to meet people's needs.

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 20 March 2019). The service remains rated requires improvement.

Why we inspected
We had concerns in relation to inconsistent leadership at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines management, staff deployment, risk management and governance at this inspection.

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

Follow up
We will continue to monitor information we receive about the service. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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.

The Avenues Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 two inspectors and an assistant inspector.

Service and service type
The Avenues Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is 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
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with eight members of staff including the acting manager, operations manager, maintenance manager, senior care workers and care workers. We reviewed a range of records. This included multiple medication records, and records relating to the safety and cleanliness of the building. We looked at five staff files in relation to recruitment.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, and governance processes. We spoke with nine relatives about their experiences of the service. We also spoke with five care staff, the provider, area manager and operations manager.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People's medicines were not managed safely. Some people had pain relief patches. Records of patch administration showed staff were not changing the position of the patch on each application. There was a risk using the same administration site on each application would reduce the effectiveness of the medicine.
- Previously we found some people had not received their blood thinning medicine as prescribed. Effective action had not been taken to address this. People's medicine continued to be prescribed according to blood test results. The dose was recorded in a 'yellow book', which staff should use when administering the medicine. For one person, the doses recorded in the medicine administration records (MAR), matched the 'yellow book'. However, the amount held in stock, 27 tablets, did not match the recorded stock balance of 23 tablets. We were not assured the person had received their medicine as prescribed.
- Records of high risk medicines were not correct. For example, two staff had checked one medicine in and signed to confirm it was correct. However, the stock balance did not match the records. Other entries in the records were unclear, where staff had over written incorrect entries or used correction fluid. Good practice is to draw a line through the incorrect entry and entre the correct information. Records of other medicines were also inaccurate and the stock balance did not match the records.
- Some people continued to receive their medicines without their knowledge, these were crushed and disguised in food, known as 'covert medicine administration'. Shortly before our January 2019 inspection the community pharmacist had been asked for their advice on how to safely hide the medicines in people's food or drinks. This guidance had not been received and no guidance had been provided to staff about how to administer person's medicines safely. The acting manager requested this guidance again following our inspection.
- Some staff who administered medicines had not completed training with the community pharmacy. They had completed on line training and their competency to administer medicines had been assessed. This process had not been effective and not all staff had the skills and knowledge they needed to administer medicines safely. Following our inspection, the provider stopped some staff from administering medicines. They also arranged face to face training from the community pharmacist for all senior care staff.
- The provider required checks of medicines were completed monthly but was unable to demonstrate this had occurred in November 2020. Audits from other months had found no concerns. Following our inspection, a full medicines management audit was completed and action was taken to address the shortfalls found. This included refresher training for staff and additional checks and audits. Further investigations were planned to fully understand what had gone wrong.

The provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People, their relatives and staff told us there were not enough staff on duty at times and people had to wait for their care. One person's relative told us, "There isn't always enough staff to look after [my relative] properly". A staff member told us, "There isn't enough staff. Some people get angry and take it out on us when we take a long time to answer their call bells for the toilet".

●Call bells rang for long periods of time during our inspection and people in their bedrooms were waiting for support. Some people became distressed when they had to wait for their care. Staff told us they were often very busy and did not have time to spend with people. One staff member told us, "We can only provide basic care. We can't spend time with people and offer them company and emotional support when they cannot see their relatives". On occasions people had to wait to get up or have a bath or shower.

● The provider had a process in operation to assess how many staff were required to meet people's needs. The process used a formula to assess people's needs in different areas of their care and determine how many staff were required to meet them. Staff told us one person required a lot of staff support but their assessed needs did not reflect this. The member of the senor management team told us, "The process is only as good as the information you put in it" and agreed the person's needs had not been assessed correctly.

● The provider had identified one person required additional staff support. However, despite identifying more staff were needed and requesting additional funding, more staff had not been deployed. At the time of our inspection no staff were self isolating because of Covid 19. Following our inspection, the provider employed agency staff to ensure all shifts were covered. They also told us they would review the dependency assessments to make sure they were accurate.

The provider had failed to ensure enough staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Checks on staff's character and previous employment, including dates of employment and reasons for any gaps in employment, had been obtained. Criminal record checks with the Disclosure and Barring Service had been completed.

Assessing risk, safety monitoring and management

● Care had not always been planned to keep people as safe as possible. One person told us they were in pain when being hoisted on occasions. Staff confirmed the person had complained of being in pain. Detailed guidance was not in place about how to move the person safely, including the equipment to use and how to position the sling correctly. There was a continued risk of the person being in pain.

● At our last inspection we found risks to three people who had recently moved into the service had not been assessed. At this inspection risks to one person who had moved in October 2020 had been assessed, but staff had only been given very brief information about how to mitigate the risks. Very high risks to the person included the risk of falling and developing skin damage. However, staff supported the person to move regularly to keep their skin healthy and safety checks were completed. There remained a risk the person would not receive consistent care to keep them safe.

● One person had fallen on the morning of our inspection. They told us they had fallen because the toilet frame, which they used to help them remain independent, was not secured and had moved. An assessment had not been completed to ensure a freestanding frame was the most appropriate piece of equipment to meet the person's needs. Free standing toilet frames can move if they are not used in accordance with the manufacturer's instructions.

The provider had failed to ensure all risks to people were assessed and mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Other risks to people had been assessed and guidance had been provided to staff about how to keep people safe. This included the action to take if people had epileptic seizures. Previously we found guidance had not been provided to staff about how to use pressure mattresses safely. At this inspection guidance was in place and staff checked they were at the correct setting.
● Checks had been completed to ensure the building and equipment was safe. This included checks of mains services and firefighting equipment. Following a serious incident during our last inspection, action had been taken to prevent a similar incident occurring again. The fire service had visited the service since our last inspection and the provider had acted on their advice and recommendations to make sure fire risks were mitigated.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe at The Avenues. One person told us they had been concerned about their finances. Staff had reassured them their money was safe and the person felt protected. Another person told us, "It makes me feel safe knowing I have someone at the end of the call bell to help me".
● Staff knew how to protect people from the risk of abuse. Staff had completed safeguarding training and knew how to blow the whistle to the local authority safeguarding team and the Care Quality Commission.
● Staff were confident to raise any concerns they had with the acting manager, operations manager and provider. They were confident any concerns would be addressed. There had been a delay in the provider and safeguarding team being informed of one safeguarding incident in April 2020. The provider had reminded all staff of the notification process and timescales and there had been no further delays.
● The provider and acting manager had shared safeguarding concerns with the local authority safeguarding team, so they could be investigated. They had acted on recommendations to improve staff practice and concerns had not reoccurred.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● Accidents and incidents were reviewed and action was taken to reduce the risk of them happening again. This included supporting people to use alert mats to inform staff when people were at risk of falling. One person told us they had fallen out of bed soon after the moved in to the service. They had discussed this with the acting manager who had arranged for a bedrail to be fitted to their bed. The person was reassured and had not fallen again.
● The acting manager looked for patterns and trends in accidents and acted to reduce them. For example, one person had fallen twice in September 2020. Equipment was put in place to reduce the risk of the person

falling and protect them if they fell. The person fell again in December 2020. The equipment was reviewed and some was removed as it may increase the risk to the person. Alternative measures were put in place including lowering their bed to reduce the risk of injury if they fell out of bed.

● Before our inspection a health care professional had raised concerns when there was a delay in staff informing them someone had not been to the toilet. Detailed care had been planned in response to the concern, including how to monitor the person, when to raise concerns and who was responsible for doing this.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

● Checks on the quality of the service had not been effective in identifying shortfalls. The provider and operations manager had not visited the service frequently during the Covid pandemic. This was to reduce the risk of bringing Covid 19 into the service. They continued to review checks and audits electronically but had not checked these against practice or evidence at the service. They were not aware of the shortfalls we identified in relation to medicines management, staff deployment and risk management. Action was taken following our inspection to address these shortfalls.

● At our last inspection checks and audits had not been completed in line with the provider's schedule. At this inspection most audits had been completed monthly as required. However, the medicines audit for November 2020 could not be found. This task had been delegated and had not been checked by the acting manager or area manager to ensure it was completed and accurate.

● Some audits had identified issues but there was not always a clear plan to show how issues would be addressed. Other records and staff confirmed action had been taken to rectify the shortfalls. A consultant continued to complete regular reviews of the quality of the service the last review had been completed in August 2020. They had identified some shortfalls around medicines management which had been addressed.

The provider had failed to ensure checks and audits and the service were effective and drove improvements at the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had a clear vision for the service which included supporting people to be independent and treating them with dignity and respect. This was shared by the leadership team and the staff. People told us they were supported to continue to do things for themselves. The provider had not identified when the service was not provided to the standards they required. A greater oversight by the provider, operations manager and management team was required to ensure care was always planned and delivered to the standards they expected.

● All the staff we spoke with said the provider, operations manager and acting manager were approachable and listened to any concerns or suggestions they had. Staff told us they felt supported by the leadership team. Staff had been offered counselling during the Covid pandemic to support them with the additional

pressures of their role. Some staff had taken this up and told us it had been very helpful.
● Staff told us the acting manager gave them their work rota four weeks in advance which was an improvement. They knew when they were working and were able to plan and cover additional shifts if they wanted to. One staff member told us, "I now know what is going on and can plan child care". Another said, "The acting manager has been very fair when allocating time off over Christmas".
● Staff felt appreciated by the provider and acting manager. They were thanked regularly for their hard work and had received financial rewards. During the pandemic, when food stocks were short, the provider had ordered food for staff to ensure they always had enough to feed their families and were not putting themselves at risk at the shops.
● During the Covid pandemic the provider had introduced staff welfare checks. These were discussions with staff on an individual basis to check their wellbeing and offer support. These had been affective and staff morale was good. Staff were positive about the actions they were taking to keep people and themselves safe.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There had been a number of changes in leadership at the service since September 2018. The last manager had left in October 2020. In response to this the provider had appointed an acting manager from within the management team. An experienced registered manager from another of the provider's services, was mentoring and supporting them in the role. An application for an interim registered manager had been received. Since our last inspection the provider had appointed two heads of care to strengthen leadership at the service.
● The changes in management had unsettled the staff team, as each manager changed systems and processes. Staff told us the appointment of the acting manager had given them some stability as they knew the staff and systems well. One staff member told us, I'm glad it's someone who knows the people, staff and processes and there are no more changes". A relative said, "They have had a change of management recently, they seem much more on the ball".
● Staff were clear about their roles and were reminded at staff meetings. Systems were in place to make sure all staff were informed immediately of any changes or reminders. Staff worked together as a team across the service, this included day and night staff who appreciated each other's role and were mindful of each other's workload. One staff member commented, "We work as a team and it makes it easier for everyone".
● Since our last inspection there had been a delay in the Care Quality Commission being notified of some important events that had happened at the service. On occasions the inspector had prompted staff to submit notifications. The provider had addressed this shortfall and the acting manager knew when they needed to notify us of significant events. They had sent notifications without delay and these contained all the information we needed to understand what had happened and the action taken.
● The provider and staff understood how to maintain people's confidentiality and only shared people's information with their consent. If people wanted, their relatives could view electronic records of their care and support to see how they were doing. The provider had recently stopped using radios to aid staff communication around the building because others outside the service could listen to them. Staff understood and supported the provider's decision, despite it hindering communication across the large building. A new secure radio system was being purchased.
● When responding to complaints the manager had been open and transparent about what had gone wrong.

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

characteristics

● There was an open culture at the service and acting manager encouraged people and staff to share their views of the service. Staff were able to raise any concerns they had anonymously using the 'Get it off your chest' box. Staff told us the acting manager had addressed their concerns quickly and this had improved the service. The acting manager spoke with people regularly to find out their views. Everyone had been involved in choosing the new name for the service.

● People and their relatives had not been formally asked for their views of the service, in line with the provider's policy. However, everyone we spoke with told us they were confident to raise any concerns with the staff and these had been addressed. This was an area for improvement.

● The manager had responded to and investigated complaints. Action had been taken to improve the quality of care following complaints.

● Relatives had been kept informed of changes within the service by letter. These included information on the changing visiting arrangements during the Covid pandemic. Each letter invited relatives to raise any concerns they had with the provider, operations manager or home manager and included their contact details.

● People's relatives told us they were kept informed of what their loved one had been up to, including any accidents or illness. They found this reassuring and told us they were able to contact staff and their relatives by phone and video call and some had visited safely. Monthly newsletters were sent to relatives sharing what people had done each month and included photographs, updates on the management team and visiting arrangements.

Working in partnership with others

● Staff worked with external stakeholders including the local authority safeguarding team and other health care professionals to provide people's care. They followed professional's advice to keep people safe and meet their needs. For example, an occupational therapist had visited the service to review people's mobility and advise about chair heights.

● The acting manager and area manager were part of the local manager's Covid support group. They used the group to share information, give and obtain support and keep up to date with local changes.

● The acting manager discussed any changes in people's health weekly with a clinical nurse specialist for older people. Plans were agreed to support people and any specialist or rapid response support was obtained. This ensured people always head the health care they needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were managed safely. The provider had failed to ensure all risks to people were assessed and mitigated. 12.(1)(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure checks and audits and the service were effective and drove improvements at the service. 17(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure enough staff were deployed to meet people's needs. 18.(1)