Christchurch Housing Society

Avondene Care Home

Inspection report

171 Stanpit
Christchurch
Dorset
BH23 3LY

Tel: 01202483991

Date of inspection visit:
16 December 2020

Date of publication:
07 January 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Avondene Care Home is registered to accommodate up to 11 people. At the time of our inspection there were 11 older people living in one adapted building in a residential area of Christchurch. Avondene care home does not provide nursing care.

People's experience of using this service and what we found
People told us they were happy living at Avondene Care Home. However, we identified several shortfalls and governance systems were not robust enough to keep people and staff safe. Infection control procedures were either not in place or robust enough to fully protect people.

Potential risks to people's health and welfare had not been consistently assessed. There was not always guidance in place to support staff to reduce those risks. Records of the care people received were not always accurate or complete. Medicines were not always managed and stored safely.

People and their relatives thought they were treated with dignity and respect and people told us they were happy. We observed many kind interactions throughout the inspection. Encouraging independence was important to staff.

There were enough staff on duty and people told us they attended to their needs promptly. Staff told us they were happy working at the home and had confidence in the registered manager. Staff were recruited safely, and the necessary checks had been made. Safeguarding procedures were in place and followed; staff told us they were confident the manager would follow up on concerns raised.

Staff, people and their relatives felt involved in the home. However, this was limited throughout the pandemic and alternative arrangements had been made for contact and visiting. The home had links with various organisations; the manager said this had reduced during the year but was hoping to build on these in the future.

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 31 October 2019).

Why we inspected
We received concerns in relation to infection control, medicines, dignity and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, caring 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 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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 Avondene Care Home 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 the safe care and treatment of people and the management of the service at this inspection.

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
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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Avondene Care Home

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 was carried out by two inspectors and an Expert by Experience. 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
Avondene Care Home 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the safeguarding team. 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.

During the inspection
We spoke with two people who used the service and eight relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, registered manager and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We made general observations throughout the inspection.

We reviewed a range of records. This included 11 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further information from the manager and provider, and this was supplied to us promptly. We sought feedback from health and social care professionals who work with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People did not always have risk assessments in place to ensure they were kept safe. Where people had an identified high risk of falls there was not always a risk assessment for the management of falls or their mobility. Staff were directed to review these documents to reduce the risks to the person, but they were not always in place. There were not always risk assessments for people with underlying health conditions who may have been at a higher risk of serious effects from Covid-19.
- Risk assessments that were in place were not always up to date. For example, assessments were not reviewed monthly as per the home's policy.
- Some risks in the environment had either not been recognised or not robustly assessed. For example, we found a window on the first-floor landing which was not restricted and opened fully; this meant people were at risk of serious harm. We alerted the registered manager and they arranged for this to be restricted.
- Accidents and incidents were recorded. However, analysis and review of these had not taken place since December 2019. This meant that a pattern had not been recognised for a person and could have increased their risk of harm, for example, where they had multiple falls.

Systems were either not in place or robust enough to demonstrate risks to people were identified, reduced and effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included completing an assessment of risk for people's mobility and falls.

Preventing and controlling infection

- We were not assured the provider was preventing visitors from catching and spreading infections. The registered manager told us there was a process in place to welcome visitors to the home. This included wearing personal protective equipment (PPE), temperature checks and health screening questions. However, when we arrived, we were not subjected to any of these safety checks and equipment to carry out the checks was not in the entrance.
- Response to outbreaks of infection was not robust. The nominated individual told us that the home was experiencing its third outbreak of Coronavirus. However, they had not made improvements to their procedures for infection control or increased cleaning within the home.
- We were not assured that hygiene practices at the home were contributing effectively to the control of infection. The registered manager told us that the home was cleaned three times a week and was increasing to four times from the end of the week. Cleaning schedules were not in place and the registered manager

could not tell us which parts of the home had been cleaned and when.
● Staff did not always use PPE correctly. We observed one member of staff routinely wearing their PPE incorrectly throughout the day, by exposing their nose from their face mask and one member of staff who had removed their mask completely. We observed this practice around the home and when staff were attending closely to people's needs.
● The registered manager told us there was a designated place for staff to get changed, check their temperature and apply PPE. However, this was on the first floor and staff had to enter and walk through the home to get to this room before they were adequately protected. This meant that staff were a risk to others in the home as they were not fully protected and checked at point of entry.
● The home had a monthly infection control audit check in place, but this had not been completed since 21 January 2020. The registered manager told us they were behind with the checks.

We found no evidence that people had been harmed; however, systems were either not in place or robust enough to demonstrate infection prevention and control was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included ensuring equipment was available at the entrance of the home and increased cleaning within the home across seven days.

● The home had a process in place and were participating fully in whole home testing of people and staff.
● The home had an infection control policy in place, and this was up to date.

Using medicines safely
● Medicines were not always stored safely. The medicines fridge had a broken display and had been recorded as not working since 29 October 2020. Staff were unable to determine what temperature the medicines were stored at. This meant the effectiveness of the medicines could be affected. The registered manager told us they had planned to get someone to look at the fridge.
● Medicines that required stricter controls by law were stored in a separate cupboard and a stock record book was completed accurately. However, these medicines were frequently recorded as stored above the maximum temperature for safe storage.
● Where people were prescribed medicines that they only needed to take occasionally, guidance was not always in place for staff to follow to ensure these medicines were administered in a consistent way. This meant that there was a risk a person may not receive their medicines when they needed them.

We found no evidence that people had been harmed; however, systems were not effective to ensure medicines management was safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included arranging for the radiator to be fixed and reviewing the guidance for staff.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe with the care at Avondene Care Home. Some of the comments included: "They keep my loved one [name] very safe and supported whilst allowing them to do whatever they can to keep their independence" and, "Our loved one is safe, and they are really well looked after".
● The home was working with the local authority on ongoing safeguarding enquiries. All relevant

information and alerts had been shared with the safeguarding team as necessary.

● The nominated individual told us they were the safeguarding lead for the home and visited twice weekly. They spoke with staff and people and did not have any concerns that had been brought to their attention. They told us if they did, they would take immediate action.

● Staff had received training in safeguarding people. Staff told us how they would recognise signs and symptoms of abuse and who they would report them to both internally and externally. Staff told us they would not hesitate to report concerns and had confidence in the registered manager to follow them up.

Staffing and recruitment

● There were enough staff on duty. People and their relatives told us: "I think there are definitely enough staff to keep people safe", "Whenever I press my call buzzer, they come pretty much instantly" and, "There appears to be plenty of staff whenever I go".

● The home completed a dependency assessment of each person. This helped them to calculate the staff needed to meet people's needs. The registered manager told us they currently had vacancies for senior staff which they hoped to fill as soon as possible.

● The home had a recruitment process and checks were in place. These demonstrated that staff had the skills and knowledge needed to care for people. The registered manager told us staff always had a period of shadowing with an experienced member of staff.

● Staff had appropriate checks, such as references, health screening and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with people in a care setting.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People and their relatives told us staff were kind and caring. Comments included: "The staff are excellent. They [staff] are very polite and conscientious, and I have very high regard for them", "The staff are warm and friendly and just very nice people. They do a jolly good job" and, "They [staff] really are loving towards my relative [name] and treat them as though they are their mum or gran".
- People's cultural and spiritual needs were respected. People were asked about their beliefs and practices during their assessment. These were recorded in their care plans. There were specific examples of people's choices and the way they wished to live their life in care plans for staff to support them.
- Staff received training in equality and diversity. Staff told us they would care for anyone regardless of their background or beliefs.
- People were able to spend their day as they chose. Due to the pandemic visits with family were restricted and at times not permitted. People were supported to maintain contact with them through telephone calls.
- Avondene Care Home had received compliments about the care they provided. We read: "Thank you all for your excellent care through this difficult year" and, "Thank you for all you did to make our loved one's life so comfortable and happy".

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

- Staff told us it was important for them to support people with choices. We observed staff encouraging people to make choices for different aspects of their day and care.
- The registered manager held regular meetings and are continually asking for feedback from people. Relatives told us communication from the registered manager is excellent when there are changes or concerns.

Respecting and promoting people's privacy, dignity and independence

- Staff treated people with dignity and respect. Relatives told us; "The carers are really good and have a lot of respect for my loved one [name]". "Staff treat my loved one with dignity and respect". We observed many kind and respectful interactions between people and staff.
- People were supported to be as independent as they could be. Staff told us it was important to support people with their independence for as long as possible. A member of staff said, " We encourage them to try and do things for themselves. This then makes them feel they still have skills".

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 good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance systems did not always operate effectively. Audits were not present, complete or robust. These systems had not identified the shortfalls found during the inspection. For example, none of the six audits to be completed by the registered manager each month had been completed since January 2020.
- Medicines should have been checked weekly and monthly. However, these checks had not been completed since January 2020. The registered manager told us they had got behind with the audits and checks.
- Additional provider checks had not been completed at all during 2020. The nominated individual told us that they had not done the checks and audits they would normally have done due to the Coronavirus pandemic. This meant that the provider did not have oversight to have identified the shortfalls found during the inspection.
- People's care records were not always up to date or complete. This meant they could not be sure that people were receiving the care they needed.

We found no evidence that people had been harmed; however, the provider had failed to ensure governance systems were operating effectively to ensure risks were managed, people were protected from harm and the service improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included, completing risk assessments for those at highest risk of falls.

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

- Staff told us they were happy working at Avondene Care Home. Some comments were, "It feels amazing now, everyone gets along", "I love it there" and, "The place is very calm and peaceful".
- People, staff and residents were complimentary about the management of the home. Some of their comments were: "The registered manager [name] is approachable and kind. They are wonderful with the residents and sorts things out when needed", "I always feel the registered manager gives support, they are a good manager" and, "The registered manager [name] is brilliant at supporting us".

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 registered manager understood the requirements of the duty of candour, that is, their duty to be honest, open and apologise for any accident or incident that had caused or placed a person at risk of harm. They told us the circumstances in which they would make notifications and referrals to external agencies and showed us records where they had done this.

● The home had made all statutory notifications as required by law. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People, their families and staff told us they felt involved in the service. A relative told us, "I feel involved as much as I need to be." The involvement had been reduced somewhat considering the Coronavirus pandemic with limited visiting and at times closure of the home.

● The home had regular staff meetings and daily handovers. Staff told us they gave them a good understanding of what people needed for the day.

● The home had links with various organisations but due to the pandemic had not interacted with them as they once did. The home had received a delivery of Christmas 'thank you' gifts for people and staff from local high street shops.

● The registered manager told us that they had a good working relationship with health professionals and records showed regular. We did seek feedback from health and social care professionals but did not get a response.

This section is primarily information for the provider

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 Systems and processes were not in place to provide safe care and treatment to poeple in regards infection control, medicines and risk management.

The enforcement action we took:

Served a warning notice telling the provider where they had breached the regulations and by what date they must be compliant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were either not in place or robust enough to have oversight of the service.

The enforcement action we took:

Served a warning notice telling the provider where they had breached the regulations and by what date they must be compliant.