The Orders Of St. John Care Trust

Avonbourne Care Centre

Inspection report

1 Mitre Way
Old Sarum
Salisbury
Wiltshire
SP4 6NZ

Tel: 01722429400
Website: www.osjct.co.uk

Date of inspection visit:
13 March 2019
14 March 2019

Date of publication:
30 April 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Avonbourne Care Centre is a care home for up to 120 older people, including those living with dementia. 51 people were living in the home at the time of the inspection.

What life is like for people using this service:
People were not always supported to take their medicines as prescribed. Some people had been supported to take more medicine than they had been prescribed. The provider had not improved the medicines management systems following the last inspection as required. The medicines systems were still not safe.

Risk assessments and plans to manage the risks people faced were not always kept up to date. Assessments had not been updated following incidents to minimise the risk of incidents happening again. Information about the support people needed to manage periods of distress was not clear.

The provider did not have effective systems to identify improvements that were needed and ensure the improvements were made. The provider had not ensured actions that were required following the last inspection had been completed.

People were supported make choices and have as much control and independence as possible.

People received caring support from kind and committed staff.

Staff respected people's privacy and dignity.

People's rights to make their own decisions were respected. People were supported to choose meals they enjoyed and access the health services they needed.

The management team provided good support for staff.

More information is in Detailed Findings below.

Rating at last inspection: Requires Improvement. Report published 30 May 2018.

Why we inspected:
This inspection was brought forward due to information of concern we received.

Enforcement:
We served a warning notice against the provider as a result of continued breaches of Regulations.

Follow up:

We will monitor all intelligence we receive about the service to inform when the next inspection should take place.

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 effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our Well-led findings below.

Avonbourne 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of 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:
Avonbourne Care Centre is a care home. People in care homes receive accommodation and nursing or personal care. 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 the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

We spoke with five people and three visitors to gather their views about the care they received. We looked at seven people's care records. We checked recruitment, training and supervision records for staff and looked at a range of records about how the service was managed. We also spoke with the registered manager, two other managers and eight care staff.

Requires Improvement

Is the service safe?

Our findings

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

Requires improvement - Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely:
• At the last inspection in April 2018 we identified improvements were needed to the way medicines were managed. Following that inspection, the provider wrote to us to say they would make improvements to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations by August 2018. At this inspection we found that medicines were still not being managed safely.

• People were not always supported to take their medicine in the way it had been prescribed. Incident records from 5 February 2019 to 13 March 2019 included 14 medicine errors. Of these errors, there were 10 occasions when people were not supported to take the medicine they had been prescribed, two occasions when people were supported to take a higher dose of medicine they had been prescribed. There were also two occasions when staff had not kept a record of whether they had supported people to take their medicine.

• Following the medicine incidents staff had checked with the person's GP to get advice on when to support them to take their next dose. The management team had taken action in relation to individual staff members following incidents, including additional training, assessment of skills and review of medicines procedures. However, these actions had not resulted in improvements to the safety of medicines administration practice.

• This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:
• Risks people faced had not always been assessed or action put in place to manage those risks.

• One person's daily records contained an entry where they had hit and been verbally abusive towards another person. Staff recorded that they took immediate action to support people to move away from each other. The registered manager confirmed the incident had been reported to the Wiltshire Council safeguarding team. However, there was no information in the person's risk management plans setting out what action staff should take if a similar incident occurred. The person's risk management plans had not been reviewed or updated following the incident. There was no clear plan in place to keep people safe if a similar incident occurred.

• Another person's daily records contained details of incidents in which they were physically and verbally

aggressive towards other people and had left the building without staff support. Although these incidents had been recorded and the person had been moved to a more secure part of the building, there had not been a review of the measures in place to manage all of the risks they faced. The risk management plans did not contain reference to the incidents or an assessment of the risk of them happening again. There was no information for staff on the support the person needed to manage the risks to themselves and others.

• This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• The service had safeguarding systems in place and most staff spoken with had a good understanding of their responsibilities. Comments from staff included, "Action is taken to keep people safe" and "I'm confident action would be taken if concerns were reported." One member of care staff told us they were not aware of the safeguarding procedures or actions they should take if they were concerned about people's safety.

• The registered manager confirmed there was an incident that took place in January 2019 that was reportable to us and Wiltshire Council safeguarding team. This incident had not been reported in a timely way. Staff had recorded the incident on the home's incident recording system, but the registered manager said they had not been made aware of it. The safeguarding team and CQC were subsequently informed of the incident.

• The provider had worked with the safeguarding team to investigate allegations that had been raised through the safeguarding procedures.

• People told us they felt safe in the home. Comments included, "Yes, I do feel safe here, everyone is very nice to me" and "I do feel safe in this home." Visitors we spoke with also felt people were safe.

Learning lessons when things go wrong:
• Systems were in place for staff to report accidents and incidents. Staff were aware of these and their responsibilities to report events. However, these incident reports had not always been reviewed by the Registered Manager. Action was not always taken to reduce the risk of similar incidents happening again.

Staffing and recruitment:
• There were sufficient staff to meet people's needs safely, although we did receive feedback from some staff that they sometimes felt rushed. They said there were enough staff scheduled on the rotas, but problems arose when staff called in sick at short notice. The management team was taking action to address sickness levels with individual staff where necessary. Staff told us that despite their concerns, they were able to provide safe care to people.

• People told us they thought there were enough staff to meet their needs. Comments included, "The staff seem to have plenty of time to deal with me, I am never rushed" and "The staff come if I call them, they are very helpful to me".

• Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with

vulnerable people. Recruitment records showed that staff were thoroughly checked before they started providing care to people.

Preventing and controlling infection:
• All areas of the home were clean and smelt fresh. There were systems in place to prevent cross contamination, which we observed staff following. There was also a system in use to ensure soiled laundry was kept separate from other items. There was a supply of protective equipment in the home, such as gloves and aprons, and staff were seen to be using them. One person commented, "This home is kept very clean, no complaints on that score."

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good - People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's needs were assessed before receiving care to ensure they could be met. People and most relatives told us staff understood their needs and provided the care they needed.

• Staff had worked with specialists where necessary to develop care plans, for example social workers, occupational therapists and speech and language therapists. The provider employed a team of Admiral Nurses, to provide specialist advice and support in relation to care for people living with dementia.

Staff skills, knowledge and experience:
• Staff told us they received regular training to give them the skills to meet people's needs. This included a thorough induction and training on meeting people's specific needs. New staff spent time shadowing experienced staff members and learning how the home's systems operated.

• Staff completed assessments to demonstrate their understanding of training courses. Staff told us the training they attended was useful and relevant to their role in the service. The management team had a record of all training staff had completed and when refresher training was due. This was used to plan the training programme. Staff were supported to complete formal national qualifications in social care.

• Staff said they received good support. They told us they had regular meetings with their line manager to receive support and guidance about their work and to discuss training and development needs. The management team kept a record of the supervision and support sessions staff had attended, to ensure all staff received the support they needed.

Supporting people to eat and drink enough to maintain a balanced diet:
• People told us they enjoyed the food provided by the home. Comments included, "The food is nice and I get a choice of what I want. Snacks and drinks are always available. The staff are available to help me at meal times" and "The food is very nice here and they give us choices."

• People chose to eat their meals in a variety of locations. Staff showed people plated meals to help them make their choice. This was helpful for people living with dementia who may not be able to express their choices verbally. Menus were also provided in large print and with pictures to help people make their choice. Staff supported people to eat their meals where needed and ensured people had a drink. One person had a soft diet due to the risk of choking. They also had fluid thickening powder added to drinks to prevent choking. The person had been assessed by a speech and language therapist and staff followed the recommendations they had made.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
• People could see health professionals where necessary, such as their GP, specialist nurse or attend hospital appointments.

• There was information about multidisciplinary meetings held between the service's staff and other community based professionals. Staff made detailed notes when people had contact with other health or social care professionals. For example, we saw notes about interaction with social workers, GPs and an advocate.

Adapting service, design, decoration to meet people's needs:
• Technology and equipment was used to meet people's care and support needs. This included sensor alarms to alert staff that people may be at risk of falling.

• The service was modern and purpose built. The building was accessible for people who used wheelchairs throughout.

• Bedrooms and communal spaces were large and unobstructed, which meant that manoeuvring of moving and handling equipment was easier.

• There was directional signage in most parts of the home. There were no signs at the end of corridors leading to bedrooms, which meant people may not always be aware of which direction to travel to their bedrooms.

Ensuring consent to care and treatment in line with law and guidance:
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People told us staff gained their consent before providing any care. We observed staff gaining people's consent before providing any care or support.

• Applications to authorise restrictions for some people had been made by the service. People's needs were kept under review and if their capacity to make decisions changed then decisions were amended. Staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity.

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.

Good - People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• People were treated with kindness and were positive about the staff's caring attitude. People said the staff were kind to them and respected them. One person told us, "I find the staff are very caring and jolly, we all get on well together." A relative said "During my visits the staff are very caring and supportive of [my relative]."

• Staff addressed people by their preferred name and used humour with people to help them enjoy their day.

Supporting people to express their views and be involved in making decisions about their care:
• Staff supported people to made decisions about their care, and knew when people wanted help and support from their families. We heard people being asked about their preferences and choices for various decisions. They were encouraged to make decisions for themselves. Where they couldn't independently decide, staff prompted them and guided them with the decision-making.

• Staff had recorded important information about people; for example, personal history, plans for the future and important relationships. Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided.

• People's communication needs were assessed and recorded. Staff were seen to be following these plans, and communicating with people in their preferred way.

Respecting and promoting people's privacy, dignity and independence:
• We observed staff working in ways that respected people's privacy and dignity. Staff were discreet when discussing support people needed with their personal care. Staff maintained confidentiality when discussing sensitive information about people. Confidential records were locked away when staff were not using them. Comments from people included, "The staff are very much protecting my dignity at all times" and "I do think the staff encourage me to be independent."

• People's diverse needs, such as their cultural or religious needs were reflected in their care plans. People said staff supported them to meet these needs.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Requires improvement - People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• At the last inspection in April 2018 we found improvements were needed in the frequency people were supported to have a bath or shower, to meet their individual choices. At this inspection we found that information was recorded about people's choices regarding personal care support and people received the support they needed. People told us they were happy with the support they received to have a bath or shower.

• Care plans did not always contain detailed information about how to support the person. One person had experienced periods of distress and anxiety. Their emotional well-being care plan stated they would "calm down with some reassurance", but did not include any information about how staff should provide reassurance or what strategies had worked in the past. Another person had periods of distress recorded in their daily records. Their care plan stated they could become "verbally agitated" at times, but did not include information about the support they needed. Despite the lack of information in the care plans, staff demonstrated an understanding of people's needs and how to support them. Other care plans we saw were detailed, with clear information about the support people needed. The management team were aware that work was needed to the care plans and this was included in the home's service improvement plan.

• People were supported to take part in a range of activities they enjoyed. There was a planned schedule of group and one to one activities. One relative commented, "[Person] likes the activities, she likes music and dancing." Other people said they were happy to spend time on their own or socialising with friends. There were regular visiting entertainers and trips out to places of interest.

Improving care quality in response to complaints or concerns:
• People told us they knew how to make a complaint, and were confident any concerns would be dealt with. Comments included, "If there were a problem we would talk to a senior carer or the manager." Records demonstrated complaints were investigated and the complainant was provided with a response, including an apology where appropriate.

• Records of meetings for people and their relatives showed complaints were regularly discussed and people were reminded how they could raise any concerns. The complaints procedure was available in a large print version and displayed in the home.

End of life care and support:
• People were supported to make decisions about their preferences for end of life care. Where appropriate, people had resuscitation decision forms at the front of their care folders. These informed staff whether to perform resuscitation in the event of a person's cardiac arrest. There was evidence the person, relatives and

healthcare staff were involved in the decision-making.

• Staff understood people's needs, were aware of good practice and guidance in end of life care. People's religious beliefs and preferences were respected and included in care plans.

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.

Requires improvement - Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care:
• This is the third inspection since the home opened in 2016. Each of these inspections has rated the service as Requires Improvement and found breaches of regulations. The provider has taken action to address issues that have been raised in inspections, but any improvements have not been sustained and people have not received a consistently good service.

• The provider had made recent changes to the management structure at the service. The home had been divided into two sides, with the registered manager overseeing one side and another manager overseeing the other. An area manager was present in the home on one or two days a week. The provider informed us they intended to apply to change their registration, with each side of the home registered as separate locations and each with a registered manager.

• The provider had quality assurance systems in place, however, they had not resulted in sustained improvements to the service. The systems included reviews of care records, medicine records, care plans, staff files and quality satisfaction surveys. The registered manager submitted monthly assessments of the service to senior managers. An area manager was present in the home on one or two days each week and also assessed the service being provided. The management team had developed a service improvement plan.

• Despite the actions taken by the management team, the service continued to place people at risk of harm through poor medicines management and lack of action to manage risks following incidents.

• This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• Staff were generally positive about the management of the service and confident improvements would be made. Staff felt they were able to have open conversations with the management team and agree how to move the service forward.

• The management team were aware of their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The service involved people, their families, friends and others effectively in a meaningful way. The management team responded to issues raised in quality surveys and let people know what action they had taken.

• Staff told us they felt listened to, valued and able to contribute to the running of the service.

Working in partnership with others:
• The management team worked well with the local health and social care professionals. Where concerns had been raised the management team worked with other professionals to plan how improvements could be made.

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 registered provider had not ensured risks to the health and safety of service users were assessed and action taken to mitigate those risks. Regulation 12 (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (2) (a).

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 The registered provider had not ensured there were safe systems to support people to take the medicines they had been prescribed.

The enforcement action we took:

We served a warning notice on the provider.