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 June 2017
14 June 2017

Date of publication:
19 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Avonbourne Care Centre provides accommodation and personal care for up to 120 older people. At the time of our inspection 51 people were living at Avonbourne and one side of the building was not being used. This is the first inspection since the service was registered in April 2016.

This inspection took place on 13 June 2017 and was unannounced. We returned on 14 June 2017 to complete the inspection.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. A registered manager was in post when the home opened, but they left in February 2017. A new manager had been recruited and had started work in the service three weeks before the inspection. The provider had a condition of registration that a registered manager must be in post at Avonbourne Care Centre and was therefore in breach of their conditions of registration at the time of the inspection. The new manager told us she intended to submit an application to register as the manager of the service.

People did not always receive the medicines they had been prescribed and staff supporting people to take their medicines did not always keep accurate records.

Risk assessments were not always reviewed and updated with the frequency staff had assessed as necessary.

The provider's system for receiving and acting on complaints was not always followed by staff.

Some people told us staffing levels had been low in the home, which had caused problems with them receiving care in a timely way. Comments included, "The staff can't cope. I get on well with them but they are under a lot of pressure. The staff members vary a lot now and there are lots of agency staff". Other people told us there were sufficient staff available, with one person saying, "They come quickly if I call them". We observed staff responding to some people's requests for assistance in a timely way. However, we also heard one person distressed at the time it took for staff to respond to them. One person was walking in the hallway of the home and was overheard saying, "I don't know where anyone is. The gentleman down there is crying out. There's no-one to help him". Shortly after this conversation a staff member went to help the person.

Most people said they felt safe living at Avonbourne Care Centre. Comments included "I feel safe here, no problem. I would talk to the staff if I had any concerns". One relative raised concerns about interactions between people who used the service, saying their relative felt intimidated and scared by another person. There was a system for recording these incidents and the manager had reported them to Wiltshire Council

safeguarding team where appropriate.

Most people told us staff understood their needs and provided the support they needed. However, we also received concerns about communication between the staff and people's relatives. Comments included, "When there are issues, they don't always call. With everything that has been going on we are always unsure of what we will find when we walk in, No-one is communicating", "On one occasion I arrived to take [their relative] for a blood test, she was not properly washed, her hair had not been brushed and she was not really dressed for going out" and "They take [their relative] to hospital and we don't get to know. The only way we found out was when we received an invoice from head office for a taxi. We asked what it was for and they said it was for her return trip from hospital".

Most people told us they enjoyed the food provided by the home and were able to choose meals they liked. We saw people were supported to choose their food at mealtimes. Comments included, "The food is very nice – I enjoyed my lunch today" and "I like the homemade soup and bread for supper and the rice pudding at teatime". However, we also heard that some people were not able to get their choice of food and drink.

People told us they were treated well and staff were caring. One person told us, "The staff are very nice and treat me well". Comments from relatives included, "He is very well looked after", "The care seems good" and "This is the place I would choose if I had to". Staff understood the needs of the people they were providing care for.

Staff told us they were happy with the way the manager and deputy manager were managing the service, but said the frequent changes in management of the service had been difficult for them. Comments from staff included, "We need stability. Sometimes you don't know whether you're coming or going" and "It has been like being on a rollercoaster". The staff were very positive about the support they were getting from the new manager and deputy manager. Comments included, "I feel [the manager] will give clarity of expectation. She will tell people what to do and be clear about it. She will be fair and will be very good for us" and "[The manager] is realistic and has bought people on-board. We can see improvements, for example staffing, and I'm very optimistic. She's direct, honest and doesn't stand any nonsense".

The new manager assessed and monitored the quality of care provided at Avonbourne Care Centre and had developed an improvement plan to address shortfalls that had been identified.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People did not always receive the medicines they had been prescribed and staff supporting people to take their medicines did not always keep accurate records.

Risk assessments were not always reviewed and updated with the frequency staff had assessed as necessary.

People did not always feel there were sufficient staff to meet their needs.

Systems were in place to ensure people were protected from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Some relatives did not feel the staff communicated effectively with them and they were not kept up to date with changes in their relative's condition.

Support for people to eat their meals was not always provided effectively and some people were not able to have food and drink of their choice.

Staff had a good understanding of the Mental Capacity Act (2005) and there were systems in place to make decisions when people did not have capacity to consent.

Staff had suitable skills and received training to ensure they could meet the needs of the people they cared for.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and the care they received. This was supported by what we observed.

Care was delivered in a way that took account of people's individual needs.

Staff provided care in a way that maintained people's dignity and upheld their rights. People's privacy was protected and they were treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider's system for receiving and acting on complaints was not always followed by staff.

People were supported to make their views known about their care and support. People were involved in planning and reviewing their care.

Is the service well-led?

Requires Improvement

The service had not been well-led.

There was no registered manager in post and there had been regular changes in the management of the home.

Staff were positive about the new management team and felt they received the support they needed.

Systems were in place to review the quality of service provided, to help identify any themes, trends or lessons to be learned. These were used to develop an improvement plan for the service.

Avonbourne Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 June 2017 and was unannounced. We returned on 14 June 2017 to complete the inspection.

The inspection was completed by one inspector 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. Before the inspection we reviewed all information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. This was the first inspection of the service since it was registered in April 2016.

During the visit we spoke with the manager, deputy manager, 13 people who use the service, six relatives, five care staff and the area manager of the provider. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for six people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

People did not always receive the medicines they had been prescribed and staff supporting people to take their medicines did not always keep accurate records.

One person continued to have a prescribed medicine for seven days after their GP said it should be stopped. Following the discovery of this incident, staff consulted the GP, who was satisfied this had not caused harm to the person. The deputy manager reported this was due to an error on the part of staff administering the medicine and the instruction to stop the medicine had not been clearly communicated. In another incident, a person did not receive the medicine they had been prescribed for three days. The deputy manager reported that this was due to an error in the ordering of medicines. Action was taken to consult with the person's GP when the error was discovered and to obtain the missing medicine.

Staff did not always accurately complete the medicines administration record when they supported people to take their medicines. This is a record that shows what medicines people had been supported to take, including the time and dose taken. We found that the medicines administration records had a significant number of gaps in them, where staff had not recorded whether they had supported people to take their medicine. For example one person had six gaps in their record between 9/6/17 and 14/6/17. Another person was prescribed a medicated topical cream to be applied to their skin. The medicine administration record for this person had not been completed in approximately 50% of the occasions when it should have been applied. The deputy manager told us she thought people had received their medicine on these occasions and the error was that staff had not recorded on the medicines administration record.

The deputy manager told us the problems with the support people received to take their medicines and for staff to keep an accurate record had been identified by the management team and action was being taken to ensure people received safe care. Improvements to the medicines system were part of the home's improvement plan that had been developed by the management team. Care staff confirmed that action was being taken to address issues with the safe administration of medicines. This included additional training for staff responsible for administering medicines and clear instruction from the management team about their responsibilities and the expectations they needed to fulfil. Some staff had been removed from supporting people with their medicines until they could demonstrate that they were able to do it safely.

Risk assessments were in place to support people to be as independent as possible, balancing protecting people with supporting them to maintain their freedom. These assessments contained detailed information on how to manage the risks people faced. However, they were not always reviewed and updated with the frequency staff had assessed as necessary. Of the six people's records we inspected, three had risk assessments which stated they must be reviewed each month but had not been reviewed since February 2017. A fourth person had a risk assessment in relation to falls completed in April 2017 which stated there was no history of falls. The person had two falls during May 2017, and information was added to their assessment about the support they required. However, the initial assessment had not been reviewed and was still available in the person's file to direct staff on the support they required. If the risk assessment tool in place had been reviewed, the identified level of risk would have increased from low to medium. This

meant staff had conflicting information on the risks people faced and the support needed to manage those risks.

Although some of these records had not been reviewed with the frequency assessed to be necessary, staff demonstrated a good understanding of people's needs and the support they required. The deputy manager told us they had identified that some records needed to be reviewed and this was part of the home's improvement plan that had been developed by the management team.

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

Some people told us staffing levels had been low in the home, which had caused problems with them receiving care in a timely way. Comments included, "The staff can't cope. I get on well with them but they are under a lot of pressure. The staff members vary a lot now and there are lots of agency staff". Other people told us there were sufficient staff available, with one person saying, "They come quickly if I call them". We observed staff responding to some people's requests for assistance in a timely way. However, we also heard one person distressed at the time it took for staff to respond to them. One person was walking in the hallway of the home and was overheard saying, "I don't know where anyone is. The gentleman down there is crying out. There's no-one to help him". Shortly after this conversation a staff member went to help the person.

Staff told us the staffing levels had been a problem, but said they were starting to see improvements. One member of staff told us, "Staffing is getting better. There are enough staff on duty, but the number of agency staff makes it difficult at times. I don't feel there is a big impact on residents" and "We are able to do what's needed, but more staff would be nice. We would be able to stop and have a proper conversation with people. It can be hard with the number of agency staff – it is difficult to go through the induction process [with new people]".

The manager told us staffing was a key part of the home's improvement plan. They had identified that staffing levels needed to be increased due to increased needs of people using the service and there had been a recruitment drive. At the time of the inspection, 11 new staff were completing their induction process and due to start providing care to people in the following week. The manager said the Operations Director for the provider had visited the service and asked the management team to put together a plan to address staffing in the home. The management team were confident their plans to increase staffing levels in the home would address the problems that had been experienced.

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. We checked the records of two recently recruited staff and found the organisation's procedures were being followed and staff had been thoroughly checked before starting work.

Most people said they felt safe living at Avonbourne Care Centre. Comments included "I feel safe here, no problem. I would talk to the staff if I had any concerns". One relative raised concerns about interactions between people who used the service, saying their relative felt intimidated and scared by another person. There was a system for recording these incidents and the manager had reported them to Wiltshire Council safeguarding team where appropriate. Action had been taken to support people to feel safer around each other and prevent further incidents. However, the manager concluded they were not able to meet the needs

of one person at Avonbourne The manager had worked with the person and their social worker to support them to move to a service where their needs could be met.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. They said they would report abuse if they were concerned and were confident the manager or senior staff in the organisation would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with.

Requires Improvement

Is the service effective?

Our findings

Most people told us staff understood their needs and provided the support they needed, although we also received concerns about communication between the staff and people's relatives. Comments included, "When there are issues, they don't always call. With everything that has been going on we are always unsure of what we will find when we walk in, No-one is communicating", "On one occasion I arrived to take [their relative] for a blood test, she was not properly washed, her hair had not been brushed and she was not really dressed for going out" and "They take [their relative] to hospital and we don't get to know. The only way we found out was when we received an invoice from head office for a taxi. We asked what it was for and they said it was for her return trip from hospital".

Staff had not been having regular meetings with their line manager to receive support and guidance. However, this was improving after being identified as an issue by the manager. These meetings were used to support staff and to discuss training and development needs. The manager told us these meetings were now getting back on track and she and the deputy manager were monitoring them to ensure they happened. Staff said they felt they received good support from the new manager and the deputy and were able to raise concerns.

Staff told us they received regular training to give them the skills to meet people's needs. Staff told us the training they attended was useful and was relevant to their role in the home. The manager had a record of all training staff had completed and when refresher training was due, which was used to plan the training programme. Staff were supported to undertake formal national qualifications in health and social care. The provider employed Admiral Nurses to provide specialist dementia support to help staff develop strategies to meet people's specific needs.

Most people told us they enjoyed the food provided by the home and were able to choose meals they liked. We saw people were supported to choose their food at mealtime. Comments included, "The food is very nice – I enjoyed my lunch today" and "I like the homemade soup and bread for supper and the rice pudding at teatime". However, we also heard that some people were not able to get their choice of food and drink. One person told us their favourite meal was "Egg and chips, but they don't do it here". When asked, the person said they had asked if they could make it but the answer was no. A relative told us, "Mum likes weak black tea but it seems impossible to get that here. They offer her squash but she doesn't like it"

During the inspection we observed some staff providing good support to eat for people who needed it. Staff encouraged people to be as independent as possible and some people were supported to use adapted cutlery and crockery to help them. However, we also saw that some people in one area of the home did not receive the support they needed due to a lack of organisation. Two people received a chicken kiev with only a fork and a spoon to use to eat it. A visiting family member found a knife and cut up the chicken for people. The staff in this area of the home were busy and support for these two people was not provided effectively. This was not reflected in the support provided to people in other parts of the home.

Staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA). The 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 legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments had been carried out to determine whether people had the capacity to make certain decisions. For example there were assessments in relation to people's capacity to make decisions relating to management of health conditions, administration of medicines and whether to live at Avonbourne Care Centre. Where people did not have capacity to make decisions, best interest decisions had been made following involvement of the person and others involved in their care, including their family, staff at the service, social workers and health professionals. The management team had submitted DoLS applications for people where appropriate. There was a record of all DoLS applications that had been made, which were kept under regular review to ensure they were supporting people in the least restrictive way possible.

People said they were able to see health professionals where necessary, such as their GP, specialist nurse or speech and language therapist. People's care plans described the support they needed to manage their health needs. There was information about monitoring for signs of deterioration in their conditions, details of support needed and health staff to be contacted.

Good

Is the service caring?

Our findings

People told us they were treated well and staff were caring. One person told us, "The staff are very nice and treat me well". Comments from relatives included, "He is very well looked after", "The care seems good" and "This is the place I would choose if I had to".

We observed care staff interacting with people in a friendly and respectful way. Staff respected people's choices and privacy and responded to requests for support. We observed staff responding to people in a caring and respectful way. Staff took time to help people understand where they were in the building and find the place they wanted. They asked people whether they needed any assistance. Staff made sure they were at the same level as people who used a wheelchair and made eye contact with people before speaking to them. Staff were friendly and spoke about people in a respectful way. Staff were also respectful of people in the way they wrote in their care records.

Kindness was shown by other staff who worked in the home as well. Housekeeping staff had developed positive relationships with people and we observed them interacting with people in a caring way. Whilst putting people's laundry away housekeeping staff explained what clothes they were returning and asked people where they would like them. Housekeeping staff also took the time to chat with people while they were carrying out their job.

Staff had recorded important information about people, for example, personal history, plans for the future and important relationships. People's preferences regarding their daily support were recorded. Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided, for example people's preferences for the way staff supported them with their personal care needs. This information was used to ensure people received support in their preferred way. There was a notice board for family members on the ground floor, which included an offer from the activities coordinator to work with family members to create a life story book.

People were supported to contribute to decisions about their care and were involved where possible. Details of these reviews and any actions were recorded in people's care plans. Most people and their relatives told us staff consulted them about their care plans and their preferences. However, one relative told us they had received a letter informing them that a care plan review was due, but this had not happened.

Staff received training to ensure they understood the values of the organisation and how to respect people's privacy, dignity and rights. This formed part of the core skills expected from staff and was mandatory training for everyone working in the service.

Requires Improvement

Is the service responsive?

Our findings

The provider's system for receiving and acting on complaints was not always followed by staff. People told us they knew how to complain and would speak to staff if there was anything they were not happy about. The service had a complaints procedure, which was provided to people when they moved in and was displayed in the home. Two complaints had been recorded in the home's records. One had been fully investigated and a response had been provided to the complainant. The other complaint had been received through the provider's call centre and had not been entered on the home's electronic system to track complaints. There were notes in the file of investigations into the complaint, but it was not clear whether a response had been provided to the complainant. The manager and area manager told us they were not aware whether the investigation covered all elements of the complaint or whether a response had been provided.

The daily records for one person contained details of a fall they had sustained. The person told staff they had been waiting too long for staff assistance. This was recorded as an incident on the home's recording system, but the complaint they made about staff availability was not included. There was no record that this complaint from the person had been investigated and a response provided to them.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people about support provided to keep in contact with friends and relatives and to take part in activities they enjoyed. One person explained "I used to write letters to my friends but I find it more difficult now. I don't think I can ask for anything. There used to be two activity ladies but now there is only one. They used to bring DVDs to watch and help me write the letters but they don't have time anymore". Another person told us, "I can't read what's on the activity sheet and they don't tell me so I miss things. I can't ask them because they go by so quick". The activity programme was set out as a full monthly calendar in small font.

Other people we spoke with were more positive about the opportunity to take part in activities they enjoyed. One person told us they were making mats for a fete the home was holding the following weekend. Another person had some flowers growing in pots on their windowsill. They explained "they are sunflowers, I asked the chap that does the medicines if they were dry and he said they were. He helped me give them some water using my glass". Two people described Christmas with two trees of different colours in the lounges, carols and a visit from reindeer and penguins. "The penguins were very funny, they pooped everywhere".

There was a programme of planned activities, which included arts and crafts activities, visiting singers, a coffee morning games and exercises. During the inspection there was an activity by 'Zoolab', who visited with a number of different animals, including a bearded dragon, a stick insect, a snail, a cockroach, a snake and a rat. People were told what animals would be involved before they decided whether to attend the activity. 14 people and a couple of family members attended and were given an opportunity to hold the creatures or have them placed on their hands. The entertainers explained a bit about each creature and

where it comes from. The people who chose to attend the session appeared to enjoy it and we heard conversations about their experiences later in the day.

People had a care plan which was personal to them. The plans included information on maintaining health, daily routines and support needed to maintain skills and maximise independence. Care plans set out what people's needs were and how they wanted them to be met. The plans included a one page profile, in which people and those who know them well had set out details of what is important to them and how they want care to be provided. This gave staff access to information which enabled them to provide support in line with people's individual wishes and preferences. The plans were regularly reviewed with people and we saw changes had been made following people's feedback. Staff demonstrated a good understanding of people's needs and how they should be met. Staff said the plans were updated promptly as people's needs changed and they were informed of any changed through the handover process.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. A registered manager was in post when the service opened, but they left the service in February 2017.

A new manager had been recruited and had started work in the service three weeks before the inspection. The provider had a condition of registration that a registered manager must be in post at Avonbourne Care Centre and was therefore in breach of their conditions of registration at the time of the inspection. The new manager told us she intended to submit an application to register as the manager of the service. We will monitor this and will consider enforcement action if the service continues to operate without a registered manager.

Staff told us they were happy with the way the manager and deputy manager were managing the service, but said the frequent changes in management of the service had been difficult for them. Comments from staff included, "We need stability. Sometimes you don't know whether you're coming or going" and "It has been like being on a rollercoaster".

Staff were very positive about the support they were getting from the manager and deputy manager. Comments included, "I feel [the manager] will give clarity of expectation. She will tell people what to do and be clear about it. She will be fair and will be very good for us" and "[The manager] is realistic and has bought people on-board. We can see improvements, for example staffing, and I'm very optimistic. She's direct, honest and doesn't stand any nonsense".

The manager and deputy manager completed a number of audits to help assess how the service was operating and plan improvements. These included different aspects of the service being provided, including medicines management, care planning, catering, health and safety and the environment. The results of these audits had been used to develop a service improvement plan. This set out all of the identified shortfalls and actions that were needed to address them. Actions had time-scales for completion and a lead member of the management team who were responsible for completing them. In addition to these reviews by operational staff, the organisation had a central quality team, who completed comprehensive audits of the service. The service also worked with external auditors to assess aspects of the care provided, for example, their supplying pharmacist.

The home had a system of obtaining people's views through short surveys on specific areas of the service provided. These surveys were sent to a sample of people and the results used to identify areas for improvement. These had not been completed since November 2016 and the manager told us she was keen to re-start this to ensure people were fully involved in the quality assurance process.

The manager told us she was focussed on improving the leadership at the service, and empowering staff to

do their jobs effectively. The manager was aware of the work needed when she took on the role and said her vision was to enable the service to operate in a more person-centred way. The manager said there needed to be a greater focus on involving people in all aspects of how to home operated. The deputy manager was clear about the improvement plan and actions that were needed to address shortfalls in the service.

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 the proper and safe management of medicines or taken action to assess the risks to the health and safety of people using the service. Regulation 12 (2) (a) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had not ensured their system to identify, investigate, record and respond to complaints was operated effectively. Regulation 16 (2).