Care Network Solutions Limited

Avon Lodge and Avon Lodge Annex

Inspection report

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Date of inspection visit:
28 June 2023
29 June 2023

Date of publication:
09 October 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Avon Lodge and Avon Lodge Annex is a residential care home providing accommodation and personal care for up to 12 younger adults and older people who may be living with mental health needs, a learning disability or autism. Accommodation was provided over 3 floors of an adapted house in a residential area.

The service is also registered to provide domiciliary care to people living in their own homes or 'supported living' settings, so that they can live as independently as possible. With supported living people's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living.

At the time of our inspection there were 7 people receiving residential care. The service was not providing a domiciliary care service and whilst people were living in supported living accommodation next door to the residential care home, they were not receiving support with personal care at the time of our inspection. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's legal rights were not protected. Records were not available to show staff had followed an appropriate process to decide someone lacked mental capacity or to make decisions on their behalf.

People did not have free access to any safe outside space.

Right Care:
People were at increased risk of receiving ineffective or unsafe care. Their care plans and risk assessments were not always detailed and person-centred. They did not always show people's needs had been thoroughly assessed or that robust plans were in place to guide staff on how best to meet their needs whilst minimising risks.

People were not protected from the risk of avoidable harm. A robust system was not in place to ensure accidents and incidents were appropriately recorded and responded to.

We could not be certain staff deployed had been safely recruited or that they were safe to continue working at the service. The provider had not ensured agency staff had received a suitable induction and had the information they needed to work safely at the service.

Areas of the service were not clean. There were issues with the maintenance and upkeep of the environment and management of risks. Some areas of the service were not warm and welcoming and felt impersonal.

Medicines were mostly managed safely. However, there were some issues with records and guidance for topical medicines and medicines taken 'when required', which increased the risk people would not receive their medicines consistently.

Right Culture:
There remained widespread issues with how the service was managed. Risks and issues had not been adequately addressed to improve the quality and safety of the service. Audits had not been used effectively to identify and drive improvements since the last inspection.

Whilst there was generally positive feedback about the new manager and the changes they had made, overall leaders and the culture they created did not assure the delivery of high-quality person-centred care.

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 15 May 2023) and there were multiple breaches of regulation. We issued a Warning Notice following the last inspection in relation to Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider remained in breach of regulations. This service has been rated requires improvement or inadequate for the last 2 consecutive inspections.

Why we inspected
We undertook this focused inspection to follow up on action we told the provider to take at the last inspection and to check whether the Warning Notice we served in relation to Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at previous inspections to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to the safety of the service, the environment and the provider's

oversight and governance arrangements 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Avon Lodge and Avon Lodge Annex

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by 2 inspectors, a pharmacist specialist 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
Avon Lodge and Avon Lodge Annex is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Avon Lodge and Avon Lodge Annex is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is also registered to provide domiciliary care to people living in their own houses and flats as well as personal care to people living in 'supported living' settings, so that they can live as independently as possible. In supported living, people's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and

safety of the care provided and compliance with regulations.

At the time of our inspection there was a new manager in post who was in the process of applying to become the registered manager.

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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from Healthwatch, the local authority and professionals who worked with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people and 5 of their relatives about their experience of using the service. We received feedback from 3 health and social care professionals who worked with the service. We spoke with 8 members of staff including the manager and support workers.

We reviewed a range of records. This included 6 people's care records and 5 people's medicine administration records. We looked at 4 staff files in relation to recruitment, training and supervision. A variety of other records relating to the management of the service, including audits and policies and procedures were also reviewed.

We used technology including electronic file sharing to enable us to review additional documentation following our site visits.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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 people could be harmed.

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

At our last inspection the provider had failed to assess, monitor and mitigate risks. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always protected from avoidable harm. Their care plans did provide detailed information about risks to their safety or include plans to guide staff on how those risks should be managed. For example, in relation to the management of allergies or when supporting people whose behaviour may put them or others at risk.
- People were at increased risk of harm as systems for monitoring and learning from accidents and incidents were not robust. Accidents and incidents were inconsistently or inappropriately recorded.
- There were no monitoring or analysis tools used to manage, monitor or learn from accidents and incidents that occurred. This meant we could not be certain about what had happened or whether appropriate action had been taken to ensure lessons were learned.
- Incidents of anxiety or distress were not always analysed in detail to help identify how staff could change or develop their approach in future to better meet people's needs.

The failure to assess and do all that is reasonably practicable to mitigate risks was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Areas of the service were not clean and showed evidence of ingrained dirt.
- Maintenance and storage issues impacted on the ability to hygienically clean some areas of the service.
- Records in relation to cleaning and the monitoring of infection prevention and control practices did not support effective oversight or show a robust approach to ensuring the cleanliness of the environment.

The failure to ensure the premises was clean and properly maintained was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were at risk of harm because appropriate action had not been taken to make sure staff were safe

to work at the service.
● The manager told us no staff had been recruited since the last inspection. However, records in relation to staff already employed did not show they had been safely recruited or that they were safe to continue working at the service.
● There was not always evidence staff's identities or right to work in the country had been checked. Checks had not been completed to explore whether there were any health conditions which might impact on staff's ability to work safely.
● The provider's audits identified these concerns in February 2023, but they had not been adequately addressed at the time of our inspection.

The failure to establish and operate an effective systems to mitigate risks to the safety of service users was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave generally positive feedback about staffing levels, and we observed sufficient staff were deployed during our site visits. Comments included, "It seems to be better with staffing and I usually see the same people now" and, "It depends what time of day, but it does seem quite well covered now."
● Care staff were responsible for cooking, cleaning, laundry, activities and supporting people with personal care. We identified issues with the cleanliness of the environment and people told us staff were sometimes "Too busy". A member of staff explained, "Sometimes it is stressful to handle all the things we need to do. I feel we need more staff."
● We spoke with the provider about developing their approach to monitoring staffing levels to ensure sufficient staff were deployed at all times.

Using medicines safely

At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12 in relation to the management of medicines. However, some issues remained in relation to record keeping.

● Medicines were mostly managed safely and there was no evidence people had been harmed. However, records were not always in place to support the safe administration of topical medicines. Guidance available to staff was not clear on how often creams should be applied and some records were missing.
● Some people were prescribed medicines to be taken 'when required' or with a variable dose. Guidance for how these medicines should be administered was missing for some people. The reason for taking a 'when required' medicine or the outcome was not always recorded to review effectiveness. This meant there was a risk people would not receive their medicines consistently. We have addressed concerns in relation to medicine records in the Well-Led domain.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to report safeguarding concerns. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

- Staff had completed training to help them identify and respond to any safeguarding concerns.
- Safeguarding concerns had been reported to the local authority safeguarding team.

Inadequate

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

At our last inspection the provider had failed to maintain complete and contemporaneous records in relation to the MCA. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's legal rights were not always protected. Records did not always evidence how or when people's mental capacity had been assessed or best interests' decisions were made.
- The service had not obtained copies of Powers of Attorney to check and make sure the right person made decisions on people's behalf.

The failure to maintain complete and contemporaneous records of decisions was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were observed offering people choices and encouraging them to make decisions. For example, about how they spent their time.
- Applications had been made to deprive people of their liberty where staff felt restrictive practices were necessary to meet people's needs.
- Where people had mental capacity, staff had sought their consent to the care and support provided.

Adapting service, design, decoration to meet people's needs

At our last inspection the provider had failed to ensure a person-centred environment. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider was not in breach of Regulation 9, however, there remained concerns about the environment.

● The design and layout of the service did not always support the delivery of person-centred care.
● There remained issues in relation to the maintenance and upkeep of the service. The provider had developed a renovation plan, however, at the time of our inspection this work had not been completed.
● Areas of the service were cluttered, unclean or in need of maintenance and repair.
● People did not have independent free access to a secure outside space.
● Some areas of the service were sparse and impersonal. It did not provide a warm, welcoming and homely space for people.
● Environmental risks were not always effectively managed. For example, bedrooms used for storage were left unlocked.

The failure to ensure the environment was properly maintained and suitable for the purpose for which it was being used was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People raised concerns about noise within the service impacting on their quality of life and ability to sleep.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care plans were not always detailed, holistic and person-centred. They did not include enough information about people's needs or to support staff to provide effective care. For example, in relation to the management of constipation or to support people with medical conditions.
● People's needs were not always reviewed and reassessed when their needs changed.
● People did not have detailed and up-to-date health action plans to ensure they and health and social care professionals had a clear picture of the support needed to live healthily.

The failure to assess people's needs and put plans in place to meet those needs and manage risks was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information about any input from health and care professionals was recorded in people's daily notes. This made it difficult to get a clear oversight of the professionals involved in people's care and any advice or guidance they had given. A professional told us, "The staff have always been friendly and helpful to me as a professional, but it sometimes feels a bit disorganized."

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always receive effective support to help monitor and make sure their nutritional needs were met.
● Detailed and clear plans were not in place relating to the support people required with their nutritional needs.
● Robust systems were not in place to monitor and evaluate changes in people's weight to ensure

appropriate action was taken.

The failure to monitor and mitigate risks relating to people's nutritional needs was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People gave mixed feedback about the skills and experience of staff. Comments included, "They do their best to try and do a good job".
- Staff completed a range of training, but records did not always show a robust system was in place to monitor staff's ongoing performance or competence following the completion of training and to ensure they understood and continued to follow best practice in their support.
- The provider had not ensured agency staff received an appropriate induction before starting work at the service. This meant there was a risk agency staff might not understand how to support people in a safe and effective way.
- Clear information was not available to understand what specialist training staff had received to support people with complex behaviour that may challenge.

The failure to establish and operate effective systems and processes to monitor the quality and safety of the service was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there remained widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to operate effective systems and processes to assess, monitor and improve the service. This was a breach

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

● There remained widespread issues with the provider's oversight and management of risks. Risks had not always been thoroughly assessed and detailed plans were not always in place regarding how risks should be managed.
● Clear and complete records were not available. For example, in relation to records of staff employed, people's consent, or regarding the management of medicines and accidents and incidents. This meant there was a lack of clarity about risks and issues and how these were managed.
● Audits had been ineffective in identifying issues and driving necessary improvements.
● Concerns identified at our last inspection had not been addressed. The provider had not met CQC's Warning Notice issued following the last inspection.

The failure to establish and operate effective systems to assess, monitor and improve the quality and safety of the service, mitigate risks and to ensure complete and contemporaneous records was a continued breach of Regulation 17(1) 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
● People had not always had a good experience of using the service and the support provided did not consistently achieve good outcomes.
● Whilst some improvements had been made, issues in relation to how people's needs were assessed and the planning of their care increased the risk they would receive unsafe or ineffective care.
● People gave generally positive feedback about the new manager and the changes they were trying to make. Relatives told us, "It seems a lot calmer now. I am pleased with the progress in the last few months" and "It has improved a little bit since [Manager's name] started."
● The manager showed us work planned to renovate and redecorate the environment and told us about a

new system they planned to introduce to improve oversight of accidents and incidents.

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 manager understood their responsibility to be open and honest with people when things went wrong. They had worked with the local authority to provide information in response to a serious incident in which a service user had been harmed.

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

● People gave mixed feedback about the communication. Comments included, "I'd like to know a lot more. I used to be updated with what's going on. I have to keep asking them" and, "The communication has improved a bit, so I am a bit more confident with what they are doing."

● There was evidence of some attempts to work in partnership with people using the service through meetings and questionnaires to gather feedback, but this approach was inconsistent. It was not clear how feedback was used to drive improvements.

● Team meetings had been held to share information with staff and to provide opportunities for them to give feedback. Staff told us they felt more supported and had noticed some improvements since our last inspection. Comments included, "We have a manager who is trying to fix the home" and "It is better than it used to be a couple of months ago. It is more organised now."