

Avenues London

Neave Crescent

Inspection report

73A-B Neave Crescent
Romford
Essex
RM3 8HN

Tel: 01708370048
Website: www.avenuesgroup.org.uk






Date of inspection visit:
22 March 2016
23 March 2016

Date of publication:
27 May 2016

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

This inspection took place on the 22 and 23 March 2016 and was unannounced on the first day. At our previous inspection in March 2014, we found that the provider was meeting the regulations we inspected.

Neave Crescent is registered to accommodate ten people with profound and multiple learning and physical disabilities. People are accommodated in two adjacent bungalows which are purpose built. At the time of our inspection the home was providing care and support to ten people.

The provider of the service is an organisation (The Avenues Group). The home had 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.

People were safe at the service and were cared for by staff who were knowledgeable about safeguarding people. They knew how to report concerns.

However, we had concerns that medicines at the home were not managed safely. Protocols were not in place for the safe administration of medicines to be administered when required (PRN) for the people concerned. There were no records of regular effective systems in place to monitor and check safe medicines practice within the home.

Not all care plans we looked at included specific risk assessments which identified risks associated with people's care. They did not sufficiently guide staff about how to minimise risks in order to keep people safe.

Staff were supported through regular supervision, and the provider is in the process of ensuring that systems were in place to ensure staff received an annual appraisal of their practice and performance.

There were sufficient qualified and experienced staff to meet people's needs. Staff received the support and training they needed to provide an effective service that met people's needs. The staffing levels were flexible to support with planned activities and appointments.

The recruitment process was robust to make sure that the right staff were recruited to keep people safe. Staff confirmed and personnel records showed that appropriate checks were carried out before they began working at the home.

Staff had received Mental Capacity Act (2005) training and understood the systems in place to protect people who could not make independent decisions. The service followed the legal requirements outlined in the MCA and the Deprivation of Liberty Safeguards (DoLS).

People were supported to have a nutritionally balanced diet and had adequate fluids throughout the day to promote their health and wellbeing.

People were supported to see specialist healthcare professionals according to their needs in order to ensure their health and well being were adequately maintained.

People were looked after by staff who understood their needs, were caring, compassionate and promoted their privacy and dignity.

We found that not all care plans were based upon people's specific individual needs and wishes. They were not regularly reviewed and updated according to people's changing needs.

A pictorial complaints procedure was available. People's relatives were made aware of the complaints procedure and they knew who to speak with if they had any concerns.

Systems were in place to evaluate and monitor the quality of the service. However, improvements were needed to ensure there was continued monitoring of the progress made where actions were identified.

At this inspection 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 the 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 consistently safe.

Medicines were stored and administered safely but not always managed safely.

Up to date risk assessments were not always in place to ensure people's safety and well-being.

Staff had received training with regard to keeping people safe and knew the action to take if they suspected any abuse.

There were safe staff recruitment practices in place and sufficient numbers of staff on duty to ensure people were safe.

Is the service effective?

Good 

The service was effective.

People were supported by staff who had the necessary skills and knowledge to meet their needs. Staff were supported through regular supervision.

People were supported to maintain good health and had access to health and social care professionals when required.

There were processes in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves.

Is the service caring?

Good 

The service was caring.

Caring relationships had developed between people who used the service and staff. Staff treated people with kindness and compassion.

People were treated with respect and dignity.

People were supported to maintain relationships with relatives

and friends.

Is the service responsive?

The service was not always responsive.

People's care was not always reviewed and updated in response to their needs. Sufficient care and support plans, were not in place to guide staff.

People were supported by staff to participate in activities of their choice.

People and their relatives were provided with information about how to make a complaint and felt confident to do so.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

People and their relatives were asked to give their views about the service through meetings and surveys.

Relatives, professionals and staff said communication was good.

Staff felt supported and able to express their views.

Quality assurance systems were used to identify shortfalls in the service which needed to be followed up to ensure action identified was undertaken to make improvements.

Requires Improvement ●

Neave Crescent

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 planned 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 was unannounced on 22 March and announced on the 23 March 2016. It was carried out by one inspector. This service was last inspected in March 2014 when they met the regulations we checked.

Before the inspection, we reviewed the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the other information we held about the service, including previous reports, complaints and notifications. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We met all the people who lived at the service during the inspection. However, most people were unable to speak with us directly about their views of the service. We therefore observed the care and support provided to them by the staff and briefly spoke with two people. We also spoke with two members of staff, and three professionals who visit the home. We also spoke with the manager and the deputy as well as two relatives of people who use the service.

We looked at three people's care records and a range of records relating to how the service was managed. These included training records, duty rosters, documents relating to the provision of the service, medicine records, quality monitoring records as well as policies and procedures.

Is the service safe?

Our findings

People were relaxed and comfortable with each other and in the presence of staff who knew their needs well. Relatives told us they were happy with their family member's care at Neave Crescent. Both commented "Yes I think he is safe." Health professionals told us that they did not have any issues with this service generally and staff sought advice when needed. However we found that people's medicines were not managed safely.

We looked at medicines records and Medication Administration Records (MAR) for people using the service. Photographs of people using the service were in place to help staff identify them when administering medicines. People's MAR outlined the medicines prescribed, details of people's GP and information about any known allergies they may have. Staff told us they had received medicines training. The manager and the deputy manager had checked that staff who administered medicines were competent to do so. Medicines were stored in medicines cupboards in the manager's office. As far as possible they were administered from specific medicine administration aids filled by the pharmacist to lessen the risk of an error being made. Two staff members on each shift were responsible for administering medicines. We discussed and observed the procedure with them and saw that they followed it in a safe way. Medicine administration records (MAR) were signed with no gaps in the recording.

Senior staff and the registered manager had responsibility for checking stocks, re-ordering and returning medicines to the pharmacy.

We checked how controlled drugs were administered with in the home. These were stored in a locked cabinet within a large cupboard in the manager's office. We found that for one medicine, the number of patches (for pain relief) differed from the stock found in the cupboard. There was a surplus of one patch left over from December 2015 which had not been returned to the pharmacist. The strength of the patch had been increased by the GP from 5-10 mg. The person received appropriate pain relief from the correct strength of the patch, this information had been updated on the person's MAR chart to enable all the staff to be fully aware of the current requirement.

We found that people were in receipt of PRN medicines such as paracetamol. However, there was no protocol in place for the administration of these medicines and the circumstances under which these medicines are to be administered. We also found homely remedies such as ibuprofen and an antacid solution for heart burn. However, there was no protocol in place for the administration of these medicines for the people concerned.

There were no records available of regular medicines audits in place at the service to identify and address any issues or concerns relating to medicines management. The registered manager and staff at the service conducted medicines stock counts on a daily basis but these were not documented and only checked against people's MARs.

All of the above meant that medicines were not consistently managed and people may be at risk of unsafe

medicine administration as there were no safe and effective systems in place to monitor and check safe medicines practice within the home.

Although there were some risk assessments in place, they were not sufficiently individualised, or detailed and did not take account of each person's specific needs. For example, for the administration of rectal diazepam or risks associated with the management of percutaneous endoscopic gastronomy (PEG) feeding (receiving nutrition via a tube in to the stomach) as a result of people's health condition. There was insufficient guidance given to staff about the steps to be taken to manage the risks associated with this process for example, documented clear guidance for staff on managing and maintaining good catheter care. It was unclear from the records seen, whether any risk assessments were regularly reviewed and up dated. Therefore, people were not fully protected from the risks associated with unsafe care and treatment. Both of the above areas of concern, in relation to safe medicine management and appropriate risk assessments were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding adults training. They were aware of the signs of abuse and were clear about their responsibility to ensure that people were safe. They were aware of their responsibilities to raise concerns about suspected abuse and the records they needed to keep. Staff told us that they were confident that the manager would take appropriate action in response to any concerns raised. Staff were aware that they could also report any concerns to external agencies such as the local authority and the Care Quality Commission. Staff were also aware of the provider's whistle blowing procedure and how to use it.

The organisation's human resources (HR) department had a robust staff recruitment system. The human resources administrator at the Avenues group, confirmed to us via e mail and we saw that all the required staff checks were carried out before they began work for the organisation. They informed us that references were obtained and criminal records checks were carried out to check that staff did not have any criminal convictions. This assured the provider that employees were of good character and had the qualifications, skills and experience to support people who used the service. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom. People were protected by the recruitment process which ensured that staff were suitable to work with people who need support. Staff told us that they were not allowed to begin work until all the checks had been completed.

Staff rotas we looked at confirmed that the numbers of staff on duty ensured that people received safe and effective care. One staff member said, "Yes there are enough staff to look after people." We observed that staff responded promptly to people's needs and spent time with them encouraging them to take part in activities and doing things they enjoyed. Staffing levels were reviewed regularly and adjusted when people's needs changed. Staff told us that absences were covered by them and bank staff, most of whom were familiar with people's needs, to ensure they received consistent care. This meant that people received consistent support from staff they knew.

The provider had appropriate systems in place in the event of an emergency. For example, there was a file containing details of action to be taken and who to contact in the event of an emergency. A fire risk assessment had been completed and fire alarms were tested weekly. Staff confirmed that they had received fire safety and first aid training and were aware of the procedure to follow in an emergency.

Most people living at the service required specialist equipment such a ceiling hoist and bathing aids. These were routinely serviced and maintained to ensure they were safe to use. Gas, electric and water services were maintained and checked to ensure that they were functioning appropriately and were safe to use. A yearly health and safety audit was carried out. We observed the home environment was clean, free from

odours and was appropriately maintained.

Is the service effective?

Our findings

Staff had the appropriate skills and knowledge to meet people's needs. They supported people to have a good quality of life. We observed that people who used the service received the care that they needed. People smiled affectionately when asked if they felt well cared for by the staff. A health care professional told us "Very impressed with the care they provide. Staff understand what people's needs are, they are professional and friendly."

The relatives we spoke with told us that they felt confident in the ability of the staff in the home to care for the people who lived there. There was both praise and appreciation for the way staff assisted people with very complex needs. Staff used their skills to engage in different ways with people of varying abilities and communication. For example, we observed that when a person was asked to choose the type of drink they wanted at lunch time, a staff member showed them two drinks from which they choose one. Use of technology such as tablet computers was also made for some people who had received training and were able to recognise and identify items/activities they wanted to undertake. This enabled them to express their wish and make a choice. Relatives told us they thought staff were skilled and well trained. One relative said, "The staff are very good and understand [my relative's] needs very well." However a professional expressed concern about the skills and ability of new staff and their competence to meet some complex care needs, in view of recent staff changes. The manager explained that new staff undertake training in the care certificate which extends over a number of weeks as well as specialist training. Staff we spoke with confirmed that they received the training they required to carry out their roles.

Staff were supported through regular supervision with a senior person and the deputy manager. However, the service did not have systems in place to ensure that staff received an annual appraisal of their practice and performance. The registered manager told us that staff development plans were implemented from supervisions that had been conducted. However, they were unable to show this at the time of our inspection. The manager recognised the need for a formal appraisal system to enhance staff learning and identify development needs which they agreed to implement.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We were told that all the people living at the home had been assessed under the MCA and had been determined as not having the capacity to make certain decision for themselves. We were informed that DoLS applications had been made for all ten people living at the home. We found that only two had so far been returned by the supervisory body (local authority) and the conditions were met for these to be

approved.

Staff told us that they had received training in the MCA and were familiar with the principles of the DoLS arrangements, understood that where decisions were taken on behalf of a person who did not have mental capacity, these should be taken using best interest principles. We checked the records of staff training and the staff confirmed that they had attended training in topics such as safeguarding vulnerable people, epilepsy management, autism, infection control, fire safety, emergency and first aid and moving and handling. The matrix allowed the registered manager to identify when refresher training was required and we saw that most staff were up to date with this.

We discussed the concern expressed by a health professional regarding training received by new staff. They informed us that all new staff attended induction which followed the structure of the care certificate. Staff we spoke with confirmed that they had been provided with this induction on starting their employment with the provider and were at various stages in completing this. Further specialist training was provided to all staff following this and new staff always shadowed and worked with experienced colleagues.

People were supported to eat and drink sufficient amounts to meet their needs and where appropriate people's food and fluid intake was monitored to ensure their well-being. People's weight was monitored to reduce physical health risks and these were documented in their health care plans. Health care plans contained guidance for staff for people who required specialist feeding regimes and where concerns were highlighted in relation to the risk of choking. Records demonstrated that the home worked closely with dietitians, nurses and speech and language therapists to ensure people received appropriate support. However recommendations and guidance made by health professionals were not always recorded within people's care plans. Although staff had been verbally informed by the manager and followed the instructions accordingly.

The manager and staff worked closely with a range of health and social care professionals in the local community such as nurses, psychiatrist, GP, occupational therapist and social workers, in order to ensure people's health care needs were met.

Is the service caring?

Our findings

We observed that staff had developed a positive and caring relationship with people living at the home. People were supported by a consistent staff team who knew them well. Staff told us about people's needs, likes, dislikes and interests. They knew people's individual routines and any signs that might indicate a change in their overall well being. There was a key worker system which meant that people's keyworkers knew them well and had overall responsibility for maintaining their health and well being.

We saw information in people's care plans about their life history and their interests. Staff could provide us with information regarding people's background, interests and needs. This ensured that staff were able to understand and form positive relationships with people. Some staff had known people for many years and spoke affectionately about them. During discussion they showed that they understood people's individual characters and needs. They understood people's individual styles of communication well enough to know their preferences and wishes.

People were supported to maintain relationships with family and friends. Relative told us that their family members were "treated really well" and that they had made progress while at the home. We saw that relatives were actively encouraged to be involved in people's care and advocate on their behalf. The manager told us that they would source independent advocates for people who did not have family and required further support to make choice about their care. People and their relatives were also notified about any significant events or visits from health and social care professionals and these were recorded in people's care plans. A relative told us "They are very good at involving me and really listen to me. They are so good with him." A response by another relative in a quality assurance questionnaire states "Brilliant team, providing high quality care, with client's best interests at heart."

Each person had their own room which had the required adaptations in place according to the person's needs. We visited two bedrooms with people's consent and saw that they were clean, well-furnished and had been personalised with people's pictures and belongings according to their preference.

Staff told us how they promoted people's privacy and ensured their dignity was respected. They explained that they knocked on people's doors before entering their rooms, ensured doors and curtains were closed when offering support with personal care. Staff respected people's confidentiality and were aware of the importance of maintaining confidentiality. Confidential information about people was kept securely in the office.

There was a well maintained garden on the ground floor and people had direct access to it. This promoted people's independence and they were able to make full use of the outdoor space during fine weather.

Is the service responsive?

Our findings

All the people we met required high levels of personal care and support with all aspects of daily living. We were not able to ask people who lived at the home about the contents of their care plan and their involvement with them because they did not communicate verbally. However, the relatives we spoke with confirmed that they were involved in the assessment process as well as the development of care plans.

We looked at two care plans in detail and found that they varied in terms of the information contained in them. They were not always reviewed and up to date in accordance with people's changing needs. Some files contained care plans which had been drawn up when people first moved to the service several years ago. It was unclear from the files we were provided with to check, when the care plans were reviewed and updated according to people's changing needs and if advice from health professionals was followed. For example, a person's collagen supplement had been changed by the nutrition support team from 100mls to 30mls. Although staff were aware of this instruction, there was no updated care plan to reflect this. We did not see an up-to-date record on their chart to show this was being completed according to the instructions.

For another person the guidelines for supporting them with nutrition had changed. The SALT team (speech and language therapist) had changed the type of thickener to be used in August 2015. Staff were aware of the change but there was no written and updated care plan or guidelines for staff reflecting this in the file used by staff which was located in the dining room. Staff told us that this file contained up to date information about each person's needs and support. However the above instruction was not contained within this. Although, this information was verbally shared with staff during handovers it was unclear where health and social care professional's advice was formally recorded and included in people's care plans to ensure that their needs were met. Therefore sufficient and easily accessible systems were not in place to ensure that all staff had current information about how people needed their support.

We were informed by the registered manager that following an initial assessment of a person's needs, a care plan was developed for their everyday care and support needs. The care plans were designed around people's specific individual assessed needs. We asked to see this information for people who were most recently admitted to the home. We found that a completed pre assessment form was not available for this person. There were no specific care plans in place for them. The staff were able to explain the person's individual needs and their relative told us that they were involved in developing a care plan. However, the registered manager was unable to provide this to us at the time of the inspection. We were informed by them that although the person had been residing at the home for approximately a year, they had only just begun to settle in the home and their health was now stabilised. The manager and staff were therefore now in a position to develop a personalised care plan for them.

However, assessments of people's needs upon admission to the home and subsequent development of care plans which give guidance to staff about people's specific care needs and how best to support them, are key requirements in ensuring people received care and support in accordance with their identified needs and wishes.

We saw that preferred methods of communication by individual people was not noted in the care plans we looked at. There were no guidelines in place for staff to recognise how people expressed pain, pleasure, approval or agreement with any of the tasks that were carried out by the staff. This information is required when there is a new and changing staff group as well as when people accommodated are non-verbal. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily records were kept by staff about people's day-to-day wellbeing and activities they participated in.

People had access to specialist equipment that enabled greater independence and promoted dignity whilst ensuring their physical and emotional needs were met. We saw equipment was regularly checked by staff and routine servicing when required.

People were supported to engage in a range of indoor and outdoor activities. The home had access to a vehicle that enabled people to access community services with support from staff. This included trips and meals out as well as attending local community clubs and social events. One relative told us "The staff take people out and they support him to come out with me twice a week too."

People's relatives told us they knew who to speak with if they had any concerns or complaints. There was a complaints policy and procedure in place which was on display for people and visitors to refer to. Relative told us they had been given information about how to make a complaint, although they felt there was no need to complain. A relative said, "I haven't got any complaints and feel very happy to leave my family member there after my visits." Another told us "I always talk to the manager if I have any concerns and he sorts it out. They listen to me and always keep me informed." There were no complaints logged in the complaints folder. Staff told us they would refer complaints to the manager and they immediately resolved any small issues.

Is the service well-led?

Our findings

The provider had systems and processes in place to regularly assess and monitor the quality of service people received. The organisation's business manager visited quarterly to carry out a quality audit. The registered manager showed us the audits that were conducted by the area manager, which were based around the five domains inspected by CQC.

We found that although the reports highlighted areas for actions such as updating risk assessments and care plans as well as the guidelines for specific care needs, there were no clear timescales for completion of actions to ensure areas for improvement did not span long periods. We found that records were not always up to date, systematic, accurate and easily accessible. This demonstrated that quality assurance systems were not sufficiently used to drive forward improvements to the service. We recommend that the registered manager ensures that any actions identified for improvement are acted upon so that the management systems at the service are effective and ensure that people receive safe, effective and high quality care and to ensure that the service runs smoothly.

Staff told us they felt listened to, supported and their views were respected by the manager. Staff understood the aims and objectives of the service and these were discussed at staff meetings. They felt that they were listened to and that the feedback they gave was acted upon and changes made if required. Daily handover meetings and staff meetings were used to discuss any issues and share information about any changes. The staff team worked in partnership with relevant health and social care practitioners. A staff member told us the registered manager was, "Good, I can always talk to him." Another said, "I really enjoy working here although it is hard work, I enjoy coming to work."

People's families told us that the registered manager and staff were always available and willing to talk to them about their family member's care. During the inspection we saw that the registered manager spent time talking to people and their families. They were very 'hands on' in their approach to people. Questionnaires were sent out to people's relatives/representatives for comments about the quality of service. The responses were positive. Some comments noted in the questionnaires returned were "Any issues are dealt with promptly and not dismissed until resolved", and "I am always given time to feel I am heard. What I have said is acknowledged."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider failed to develop an individual and personalised care plans which identified people's specific care needs , their preferences and how these need to be met by staff.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to ensure medicines were managed safely.</p>