Avocet Trust

Avocet Trust - 20-22 Middlesex Road

Inspection report

20-22 Middlesex Road
Hull
HU8 0RB

Tel: 01482326226
Website: www.avocettrust.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Avocet Trust 20-22 Middlesex Road is a care home providing personal care for up to eight people with autism or a learning disability. At the time of our inspection, seven people were using the service. The service is split across two houses and a bungalow adapted to meet people's needs.

People's experience of using this service and what we found
Quality assurance systems in place were not utilised effectively. The provider did not have appropriate oversight of the service provided to people.

The provider had not implemented a robust process to manage COVID.19 safely. Staff were not always wearing PPE (personal protective equipment) effectively, placing people at risk of harm.

The provider employed a sufficient number of staff to meet people's needs. However, staff were not always on site meaning that support was not always available in the event of an emergency.

Minor maintenance issues and repairs were not managed effectively. Issues identified were not always resolved in a timely manner. Staff were expected to take responsibility for minor repairs.

Staff received supervision but these were lacking in effective discussion and reflective practice.

Care plans and risk assessments were developed in a person centred way.

Medicines were managed safely.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Shortfalls in the quality of leadership and management did not support a positive culture which could empower people to lead fulfilling lives.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 14 November 2017).

Why we inspected
We received concerns in relation to the providers oversight of safeguarding incidents, infection control and overall management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Avocet Trust 20-22 Middlesex Road on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the management of infection control processes, poor record keeping, and the overall leadership and management of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
20-22 Middlesex Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with three support workers, the registered manager, and a senior support worker.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with two professionals who work with the service on a regular basis. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- People were not appropriately protected from the risk of contracting or transmitting COVID.19
- Staff did not always wear personal protective equipment (PPE) correctly. We observed staff wearing masks under their nose. Staff received training for donning and doffing (putting on and removing PPE) but were not assessed in their competency.
- The provider was unable to evidence a robust testing regime for staff. We discussed this with the registered manager who advised staff testing had increased. However, evidence of this was not available at the time of the inspection.
- Some staff were observed to be wearing false nails and jewellery against best practice guidance for infection control.
- Cleaning schedules did not cover all areas of the home. This meant staff could miss areas that could harbour harmful bacteria and viruses.
- Cleaning products did not conform to the required standards for effective cleaning and infection control management.

The failure to ensure good infection control processes were in place put people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The providers fire safety risk assessment was out of date. We spoke to the area manager who confirmed this was booked in.
- Some staff had not completed fire safety training, practice evacuations or fire drills. This meant staff may not know how to respond in an emergency.

There was no evidence that people had been harmed. The failure to assess and manage risk placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Personal emergency evacuation plans (PEEPS) were in place and contained clear instructions for staff to support people in an emergency.
- Staff demonstrated knowledge of risks associated with people's care and support.

Staffing and recruitment

● Sufficient numbers of staff were employed to meet people's needs. However, during the inspection, staff were seen leaving the site. This meant that remaining staff may not be able to seek support in the event of an accident, incident or emergency. Staff did not recognise these actions placed people at risk of harm.

Whilst people had not experienced harm, failure to monitor staff deployment meant people were placed at risk of harm. This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely and attended a programme of induction before supporting people.
● Not all staff received regular supervision. Staff supervision records, including the registered manager supervisions were of poor quality.

Learning lessons when things go wrong

● Accidents and incidents were not always properly recorded or investigated.
● The provider and registered manager did not monitor or review accidents and incidents as part of their quality assurance processes. Opportunities to learn from incidents and prevent reoccurrence were missed.

The provider failed to follow their own systems and processes, ensuring lessons learnt when things go wrong. This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff received training in safeguarding and knew how to report incidents to the registered manager.
● Accidents and incidents were recorded, however, record keeping was disorganised. Records were kept together for all locations on site. This impacted the providers ability to monitor and review incidents and carry out effective analysis.
● Relatives told us they felt the provider delivered a safe service.

Using medicines safely

● Medicines are managed safely.
● Staff received training in the safe administration of medication.
● Protocols were in place where people required 'as and when' medicine. These were reviewed regularly and supported staff to recognise when people may require their prescribed 'as and when' medicine.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 providers systems in place to monitor the quality of the service was ineffective as concerns found during the inspection were not identified. This included audit checks completed by the senior management team, including the nominated individual.
- Where audits had identified areas for improvement, no action plan was created and these areas had not been followed up to ensure improvements were made
- Accidents and incidents had not been reviewed since July 2021.
- Recording keeping was not always clear and concise. Poor record keeping was raised during a staff meeting in August 2021. No improvements had been made and the management team took no action to monitor or review this.

The failure to operate an effective quality assurance system is a breach of Regulation 17 (Good governance) 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; Continuous learning and improving care

- Areas of concern identified during inspection were suggestive of a poor culture within the service. For example, language used within some documents to record accidents and incidents was inappropriate. This had not been identified by the registered manager or provider.
- A key worker system was operated. We found key worker meetings were not taking place as directed in the providers policy resulting in missed opportunities to maximise people's opportunities to lead fulfilling lives and experiences of high quality care.
- Lessons learned forms part of the providers quality assurance processes. However, this was not always evidenced as taking place despite being signed off by the registered manager.

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

- People who used the service, their representatives and staff were not consistently asked for their feedback about the service to ensure they were included in the development of the service.
- One relative told us, "(Name) calls me at least three times a week with support from staff. Staff are brilliant

and have a good understanding of (name) needs." Another relative told us, "They kept (name) occupied throughout lockdown, they walked to meet us at the park when we couldn't visit properly."

- Staff told us they felt the manager was approachable and supportive.

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks associated with people's health and safety were appropriately assessed or managed. The provider failed to ensure that robust systems were in place to learn lessons from accidents and incidents that had occurred in the service. The provider had failed to ensure that effective infection, prevention and control measures were in place. Regulation 12 (1)(2)(a)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance The provider had not established and operated effectively systems and processes to assess, monitor and improve the quality and safety of the service or to mitigate risks. Regulation 17(2)(a)(b).