Avery Homes RH Limited

Aran Court Care Centre

Inspection report

Braymoor Road
Garretts Green
Birmingham
West Midlands
B33 0LR

Tel: 01217704322

Date of inspection visit:
09 March 2016

Date of publication:
18 April 2016

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

This focussed inspection was carried out on 9 March 2016 following information we had received that people were not always safe from harm. Aran Court Care Centre was last inspected on 2 and 4 September 2015. At that inspection we judged that although no breaches of regulations were identified improvements were needed in keeping people safe and the governance of the service. At this focussed inspection we looked at specific issues relating to the safety of people and to assess their safety at the time of this inspection. We have not reassessed the ratings.

Aran Court provides accommodation and nursing care for a maximum of 86 people

There was a registered manager in post at the time of our inspection. 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 protected from the risks of harm because risks had been identified and management plans put in place.

People received support to eat when needed and food was prepared so that it was presented in a form that could be swallowed easily and safely.

Staff were aware of the actions to take in an emergency so that people received safe care. There was always at least one staff member on duty with the appropriate lifesaving skills to assist people in an emergency situation.

There were systems in place to ensure that information was passed on between staff and there was learning from accidents and incidents that occurred. There was monitoring of accidents and incidents to ensure that trends were identified and actions taken to prevent reoccurrence.

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 were always not kept safe because staff were not always aware of
suitable action needed taken when risks were identified. People were supported by staff who knew how to protect them against abuse. People were supported by a sufficient number of staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were not always safe as internal audits and monitoring systems were
not effective to ensure the environment and equipment were well maintained.
People and staff found the registered manager to be accessible and open to
comments and ideas to improve the quality of the service provided.

Aran Court 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 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 focussed inspection took place on 9 March 2016 and was unannounced. The inspection was carried out by two inspectors.

As part of this inspection we looked at the information we hold about the service. This included notifications from the home, other professionals involved in the service and people that use the service. Notifications are information about accidents; incidents and safeguarding concerns the service are required to inform us about by law.

During our inspection we spoke with the registered manager, area manager, two nurses and three care staff. We also spoke with a relative visiting the home at the time of our inspection. Many of the people living in the home were unable to tell us about their experiences of care so we observed the support people received at lunchtime. We looked at the care records of six people using the service and records relating to staff training and the exchange of information between staff and managers.

Requires Improvement

Is the service safe?

Our findings

Aran Court Care Centre was last inspected on 2 and 4 September 2015 and this section was rated as requires improvement. This focussed inspection was carried out because we had received some concerns about the safety of people that used the service particularly in respect of choking. This inspection focussed on the safety of people with emphasis on this particular issue and the rating was not reassessed.

We asked the registered manager how people at risk of choking were kept safe and what systems were in place to ensure that changes in needs were identified and managed. The registered manager told us that there was no one in the home who was known to at risk of choking because they pick up things and put them in their mouth. We were told that there were some people at risk a low to medium risk of choking due to swallowing difficulties. We looked at the care records of six people who were at risk of choking due to swallowing difficulties.

During our inspection we spent time on one floor of the home and observed interactions between staff and people that received a service and observed the midday meal. We saw that people received appropriate support to eat their meal when needed by staff that sat with them to ensure the pace of eating. Some people were able to eat and drink independently meals that had been prepared in a special way, for example, soft or pureed meals were provided. Other people needed to be assisted to eat by the staff. We saw that people enjoyed their meals. Staff were aware of who was on a soft diet and the menu choice sheet also identified this.

Risks associated with people's care had been assessed and management plans put in place to keep people safe. Staff spoken with was knowledgeable about the risks to people and how the risks were minimised. Staff explained that following an assessment was completed and referrals were made if appropriate to healthcare professionals. For example to the speech and language therapists for people at risk of choking and to the falls clinic if people were at risk of falling. We looked at the records of six people and saw that advice given by professionals had been followed. For example, we saw that people were provided with soft diets and thickened drinks as recommended.

We looked at the training staff had received in respect of providing first aid. The registered manager, and area manager, told us that plans had been put in place to provide all staff with either basic life support or emergency first aid at work training for all staff depending on their role. The registered manager assured us that at the time of our inspection there was always at least one person able to provide first aid on each shift. In addition there was always a qualified nurse on duty on each floor who had undertaken this training as part of their nurses training. The provider was in the process of providing updates on all the areas needed including moving and handling and first aid. Nurses spoken with were able to describe the actions they would take in the event of an emergency situation, including the process for accessing emergency services such as paramedics. They told us they didn't think the process was written down anywhere. Care staff told us that any changes in people's needs would be passed onto the nurse on duty. Nurses confirmed this and told us they would update the care plans, particularly if an issue was likely to occur again and ensure that staff were updated with the information during handovers.

A relative spoken with told us they felt there were enough staff available and staff told us that they felt there were enough staff to meet people's needs. Our observations showed that there were sufficient staff available to meet the needs of people during our inspection.

Requires Improvement

Is the service well-led?

Our findings

Aran Court Care Centre was last inspected on 2 and 4 September 2015 and this section was rated as requires improvement. This focussed inspection took place because we had received some concerns regarding the safety of people in the home. During this inspection we concentrated on the systems in place to ensure that information was passed on to the people that needed it, and we have not reassessed the rating.

Systems were in place to share information on a day to day basis between staff and the registered manager. The registered manager told us that there was a handover of important information about changes in people's needs between staff at each shift change. A handover record was completed twice a day and a manager's report was completed daily to ensure that the required information was passed on to the registered manager. This included information about accidents and incidents. Staff spoken with confirmed that this was the process. We looked at the handover records for November 2015 and saw that the information passed to the registered manager correlated with the information recorded on the handover sheets. However, we saw that for one shift there was no handover recorded and there was no evidence that this had been queried by any senior staff. We also saw that there was no written guidance for staff about what information was to be passed on to the registered manager. This had resulted in some inconsistencies in the information passed on from one day to another. For example, on some days the people that had been bathed was recorded but not on other days. Some days high or low blood sugar levels were recorded but not on other days.

There were systems in place to ensure that important information was passed on to staff. The registered manager told us that staff supervisions were taking place and that these were being used to discuss a recent incident in the home. The supervision matrix showed that 29 of 77 staff had had supervision since the incident (approximately six weeks earlier). In addition, a staff meeting had been held after the incident and the registered manager told us that staff not present at the meeting had seen the minutes. We saw that staff were also being monitored to ensure that they had read recent changes to work practices since the incident. Staff told us that the incident was discussed regularly and everyone was aware of the changes that had been put in place.

Systems were in place to ensure that trends were identified and the causes of any accidents and incidents were identified. Accidents and incidents were recorded and monitored on a monthly basis to identify any developing trends so that they could be addressed. The registered manager told us that an analysis of the reasons that may have led to a serious incident was taking place so that learning could take place and identify if any improvements could be made to the processes involved. The analysis of this investigation was not available at the time of our inspection.