Potensial Limited

Avondale Lodge

Inspection report

6-7 Nelson Terrance
Redcar
Cleveland
TS10 1RX

Tel: 01642494509
Website: www.potensial.co.uk

Date of inspection visit:
19 December 2017

Date of publication:
06 March 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 19 December 2017. This meant the provider, peripatetic manager, staff and people using the service did not know that we would be carrying out an inspection of the service.

When we completed our previous inspection on 15 and 18 August 2017 we found concerns relating to all areas of the service and multiple breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. The service was rated to be inadequate.

After that inspection we received concerns in relation to the safety of people using the service and the overall quality of the service. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (Avondale Lodge) on our website at www.cqc.org.uk.

Avondale Lodge provides care and accommodation for up to 12 people who live with a learning disability. At the time of our inspection there were 10 people using the service. The service consists of two Victorian houses which have been adapted to become one service and is situated in a residential area of Redcar, close to the sea front and local amenities. People have their own bedrooms and access to several communal areas. There are gardens to the front of the service and two small courtyards to the rear.

The registered manager has been registered with the Care Quality commission since 1 October 2010; however had not been working at the service for at least the last month. 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 peripatetic manager was in place to oversee the running of the service and had commenced working at the service the week before this inspection.

Care plans and risk assessments had been updated since the last inspection in August 2017, however the information contained in them was not always accurate and did not reflect the current needs of individual people. Key information was missing from the records. Staff did not carry out safe practices when they were providing care and support to people. Staff did not always respond appropriately to incidents when people hit staff, as they ignored the event and had not always recorded or reported them.

Prior to this inspection Cleveland fire brigade had carried out a visit to the service to complete a fire safety audit. This audit identified failures in the fire safety provisions under the Regulatory Reform (Fire Safety) order 2005. Cleveland fire brigade put an immediate action plan with deadlines for completion in place and plan to visit the service again in January 2018 to check the service have made the improvements needed.

We carried out checks of water temperatures and found the water temperatures ran below the recommended level of 43 degrees Celsius, as the maximum achieved was 40 degrees Celsius. From a review of the records we found people had been bathed in temperatures as low as 35 degrees Celsius. No concerns had been raised by staff and these records had not been checked during audits and quality assurance monitoring by the provider.

It was unclear whether people were receiving their planned one-to-one hours. This is because the one-to-one hours did not correspond with staff rotas and the care we observed being delivered. The provider needed to be clear on what one-to-one care consisted of and what people should expect to happen during these times. We noted that there was a lack of meaningful interaction and activity during planned one-to-one hours. Also staff rotas had not been kept up to date.

There were insufficient staff on duty at night to provide safe care and support to people. When we arrived at 06:30 there were two staff on duty. We noted three people had been supported with personal care and were receiving their breakfast. Hourly health and safety checks of people at 06:00 had not been completed. One staff member was dispensing medicines to people and another staff member had been providing personal care to a fourth person but needed to leave them to answer the front door and allow us to access the service. We found that two members of staff would struggle to safely evacuate ten people during the night, of whom six people required assistance with their mobility.

Medicines were not appropriately managed. Some medicines were not available for people and there were gaps in medicine records. Care plans and risk assessments for medicines did not match up with medicines records. One of the two medicines treatment rooms was exceeding safe temperature limits.

Since the last inspection, the provider had made changes to the management team responsible for the service. A peripatetic manager and an external consultant had been in post for one week and they understood expected best practice when working with people with learning disabilities had already started to ensure staff changed their practices. They had implemented new procedures and provided informal feedback to staff. An additional area manager and regional director were awaiting start dates to commence their employment with the provider.

Further improvements were needed to all areas of the service. Staff did not always provide person-centred care and support. Staff had not considered the least restrictive options for people and had a limited understanding of the Mental Capacity Act 2005. This meant best interest decisions had not always been carried out. Staff were not aware that best interest decisions were needed to determine if people required an influenza vaccination or to be supported on a one-to-one basis. Where best interest decisions had been carried out we found they were not decision specific.

A training programme was in place; however staff continued to require further support. Staff did not always adopt the practices outlined in this training and no competency assessments had been carried out in light of continued poor staff practices. The provider was aware that the level of improvements expected had not been achieved. We recognise that changes to the staff team at all levels had occurred and the service were working with an external consultant to make the improvements needed. This includes continual monitoring and assessment of the service, as well as action plans and support for staff.

We found continued breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, consent, safe care and treatment, good governance and staffing. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures.'

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service remained unsafe.

From our observations, discussions with staff and reviews of the records it was difficult to determine whether people were receiving their planned one-to-one hours.

The risks to people and staff were not appropriately managed or assessed. Staff failed to follow their training and implement appropriate strategies when supporting people.

There were insufficient staff on duty at night to safely carry out the duties expected of them and to evacuate people in an emergency.

We could not improve the rating for the safe question from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Inadequate

The service was not well led.

The provider had made changes to the senior leadership team. Some had been in post for one week and others were due to start their positions.

The peripatetic manager had started to implement changes at the service. There was evidence of small improvements at the service; however continued improvements were needed across all aspects of the service.

Staff were failing to adopt appropriate practices and follow correct procedures. Best interest decisions had not always been carried out. Those in place were not decision specific.

We could not improve the rating for the well-led question from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Avondale Lodge

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 checked 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.

We undertook an unannounced focused inspection of Avondale Lodge on 19 December 2017. We received information of concern and wanted to check that people were safe and that improvements had been made to the quality of the service since the last inspection in August 2017. The inspection team reviewed the service against two of the five questions we ask about services: is the service safe and is the service well led.

No additional risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

During this focused inspection, two adult social care inspectors and a pharmacist inspector attended the service. The two adult social care inspectors attended at 06:30 because they wanted to review the arrangements in place for night duty and to review the day to day running of the service during the day. The pharmacist inspector reviewed medicines management at the service.

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by the CQC. Notifications are reports about changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with Redcar local authority local authority contracts, commissioning and safeguarding teams, South Tees clinical commissioning group and Cleveland Fire service. We used this feedback as part of our inspection planning process.

The provider was not asked to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

During the inspection we spoke with four people. We also spoke with the operations director, external consultant working with the service, peripatetic manager, acting manager and five care staff.

We reviewed all ten care records and personal emergency evacuation plans. We reviewed the training summary records for all staff. We also reviewed records relating to the day to day running of the service.

We looked around the service and we visited the communal areas. We carried out observations of practice and conducted a short observational framework for inspection (SOFI) to capture the experiences of people who may not be able to express themselves or communicate with us.

Inadequate

Is the service safe?

Our findings

At the last inspection in August 2017, we identified that people were not receiving safe care. Risks to people had not been appropriately managed. Staff had carried out actions which were known to trigger behaviours which may challenge in the people they supported. Staff had failed to manage situations appropriately when people caused harm to themselves, other people and staff. There was a lack of staff on duty and people did not always receive their planned one-to-one care. Fire procedures and the management of medicines needed to be improved.

At this inspection we found that many of the same concerns remained. Action had been taken to improve the quality of care records since the last inspection in August 2017; however further improvements were needed. The information contained within care plans was lengthy and at times was inaccurate. Risks and safeguarding concerns identified as current concerns were no longer concerns because risks had been reduced or eliminated. Risk assessments did not include the measures staff needed to take to reduce the risk. For example, one person was at risk of falls, but the assessment did not include prompts such as making sure the environment was free from objects which might cause a fall or telling the person to slow down. The records stated that staff needed to 'link arms' with the person when they were walking. We saw that staff did not carry out this practice because it was not practical within the environment. This meant staff had not accurately considered the risks to people and how to minimise the risk of harm.

For one person who had difficulty mobilising and lived on the first floor there were two risk assessments around action to take in the event of a fire. One stated staff had to support the person to get downstairs and this may take some time because of their mobility difficulties. Another stated the person would be encouraged to go across to the other side of the service and wait for assistance. Neither detailed how the risk was being managed by the action being taken and the second plan did not explore the fact that the corridor to the second half of the service went across the kitchen and laundry. Both these areas are the most likely to be the centre for a fire.

Care plans were not written in a way which promoted people's independence. For example, a care plan for daily living for one person stated they were unable to carry out household chores, but liked to be involved when they were in a 'good mood.' The records stated this person needed to access the kitchen to develop their skills through baking and preparing sandwiches, however there was no evidence to show that these activities were occurring. From our discussions with staff we determined that they had not been carrying out the activities identified within this care plan.

Staff did not follow the guidance in people's care records, particularly in relation to positive behaviour support. This meant people did not receive person centred care and at times their privacy and dignity was compromised. Staff were failing to carrying out safe practices when they and other people were assaulted. These incidents were not always reported or recorded and staff continued to accept these incidents as normal behaviour. During our observations we saw one person continually hit a member of staff. The member of staff did not ask the person to stop and did not speak with them about their behaviour. We saw this staff member walked away from the person and they were left alone in the lounge, despite having one-

to-one care from the staff member. On another occasion this person spat at another staff member who failed to respond to the situation. On this occasion, the peripatetic manager intervened and spoke to the person about their behaviour.

There continued to be no consideration given to whether the police should be notified of these matters or the Health and Safety Executive, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDORS) under the Health and Safety at Work Act 1974. These regulations mean employers and responsible persons in the workplace are responsible for ensuring the safety of staff employed at a service and report specific incidents and accidents in the workplace.

Cleveland fire brigade had carried out a visit to the service prior to this inspection to complete a fire safety audit. This audit identified failures in the fire safety provisions under the Regulatory Reform (Fire Safety) order 2005. Cleveland fire brigade put an immediate action plan in place which included deadlines for completion and planned to visit the service again in January 2018 to check the service have made the improvements needed.

In their report they identified that the fire risk assessment did not accurately reflect the risks and control measures within the premises, that the emergency evacuation plan was unsuitable for the nature of the undertaking within this premises and at the time of the audit, no planned drills had taken place using night time staffing levels. They also found that the current evacuation plan did not sufficiently detail what actions staff needed to take in order to evacuate people. Not all smoke alarms were working and not all doors were 30 minute fire resistant and fitted with cold smoke seals, intumescent strips and a proprietary self-closing device. Monthly checks of emergency lighting had not been carried out.

We identified that staff training in fire safety was up to date and staff working during the day had participated in a planned fire drill. However staff working at night had not participated in a fire drill, despite feedback from the last inspection and Cleveland fire brigade about fire safety and staffing levels at night. Both had highlighted the need to ensure night staff practiced evacuating the building in order to provide assurance that this was achievable with two staff.

Personal emergency evacuation plans (PEEPs) are used to inform staff about the support people need to leave the building in an emergency such as a fire. These records should be stored in the entrance to the service; however we found them on the floor in the registered manager's office. This meant they would not be easily found in an emergency.

We found there were insufficient staff on duty at night. We determined that two members of staff would struggle to safely evacuate ten people during the night, of whom six people required assistance with their mobility and many of which would not respond to or acknowledge the fire alarm. The PEEPs stated that staff would need to stay with these six people once they were outside.

Also when we arrived at 06:30, three people had been supported with personal care and were receiving their breakfast. Hourly health and safety checks of people at 06:00 had not been completed. One staff member was dispensing medicines to people and another staff member had been providing personal care to a fourth person but needed to leave them to answer the front door and allow us to access the service. From our observations, we saw that the two members of staff were struggling to carry out all of the duties expected of them.

Staff rotas had not been kept up to date. This meant the staff members on duty did not always correspond with the staff rota. It was unclear whether people were receiving their planned one-to-one hours. This is

because one-to-one hours did not correspond with staff rotas, care records and the care we observed being delivered. The care records for one person stated that the staff member should be solely for that person during their one-to-one hours and the staff member should be working to the actions in the support plan. We observed that the staff frequently changed during the one-to-one time and meaningful activity was not provided whilst they were at the service. On another occasion we saw three staff members had supported four people to attend an activity in the local community. Three people were receiving one-to-one support at the time. Staff had failed to recognise that the person not receiving one-to-one support required a staff member for general support and to ensure they remained safe. The provider needed to be clear on what one-to-one care consisted of and what people should expect to happen during these times.

We carried out checks of water temperatures in the ground floor bathroom and found they only achieved a maximum of 40 degrees Celsius. We checked bathing temperature records and identified people had been regularly bathed in temperatures as low as 35 degrees Celsius. No concerns had been raised by staff and these records had not been checked during audits and quality assurance monitoring by the provider. We also saw that the flooring in this bathroom had not been replaced and posed a trip hazard for staff when they were supporting people to bathe.

We looked at the systems in place for medicines management. We assessed ten medicines administration records (MARs) and looked at medicines storage, handling and stock requirements. We found that the arrangements for managing medicines did not always keep people safe.

We observed that medicines were stored in two small treatment rooms on the ground floor. Room and medicines fridge temperatures were recorded daily. The smallest treatment room was not fit for purpose and the temperature had exceeded the recommended temperature on two occasions in December 2017. This is not in line with national guidance and actions had not been documented. No controlled drugs were stored at the home however, facilities were available if controlled medicines were to be prescribed.

The MAR charts were printed by the community pharmacy. We checked the processes in place for maintaining stock balances and ordering of medicines. Medicines were ordered on a monthly basis however, stock levels were not always sufficient to last to the end of the month. Carried forward balances, which are used at the start of the medicines cycle to ensure consistent records of stock levels, were completed accurately. Staff used a communications book to record when actions regarding medicines were needed.

We reviewed records for administration of a transdermal patch and found that the MAR did not reflect the transdermal patch record. We found one person's patch had been used a day early. This meant this person was at risk of running out. We brought this to the attention of staff to ensure the MAR could be reviewed and further supplies could be ordered.

There was a system in place to ensure that specific requirements regarding medicines for example early morning doses or those that required administration 30 minutes before food were adhered to.

When 'as required' medicines where given outcomes were not always recorded as per the home's policy. This meant staff were unaware of the effectiveness of treatments. In addition, one person was prescribed an anxiety medicine with two different doses. The care plan, and as required plan were not clear to guide staff when to administer which dose or how this was to be given. We brought this to the attention of staff. Medicines which were prescribed with a variable dose did not always have the amount administered recorded so staff could not be sure of the total quantity administered. We also looked at two bowel chart records and found that these had not been completed to assist staff making a judgement as to what

variable dose of laxatives to administer. This increases the risk of a person receiving an overdose and meant records did not accurately reflect the treatment people had received.

Topical medicines were not always administered as prescribed. Topical medicines application charts were not always available for prescribed creams and some of the records were not completed in full.

We reviewed three care plans specifically for medicines. We found that the care plans lacked detail for people with complex medicines needs. For example, we looked at one person's care plan for thickened fluids and found this lacked detail regarding dosages or fluid consistency to ensure the person was not at risk of choking.

We looked at medication audits carried out by the home. Audits were completed weekly and a full review audit was completed monthly. The audit template lacked detail and required a review to ensure audits were able to drive improvements.

We recommend the service seeks guidance on the writing of medicines care plans and take action to update their medicines care plans accordingly.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection, in August 2017, we identified that improvements were needed in all areas of the service. Staff were not carrying out the duties expected of them and the management of records needed improvement. Staff were not working within the principles of the MCA (2005). Quality assurance checks had failed to highlight the concerns which we did and the provider had not recognised that people were not receiving safe care and support.

At this inspection, we found the service was still not working within the principles of the MCA and did not know whether people had any conditions on their authorisations to deprive them of their liberty. Best interest decisions had not been carried out for four people who had receiving an influenza vaccination between September and November 2017. Staff had not recognised or understood why a best interest decision was needed for these four people who did not have capacity to make the decisions themselves. The acting manager told us that they thought each person's GP made the decision about this vaccination. Also despite people being deemed to lack capacity no 'Best interests' decisions were in place to show that one-to-one support had been deemed appropriate to meet people's needs and the least restrictive option. This goes against the principles of the MCA (2005).

This was a continued breach of Regulation 13 (Safeguarding people from harm or abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that there was a lack of meaningful interaction and activity during planned one-to-one hours. Care records regarding activities did not correspond with one another and no records had been completed to show that people had planned and carried out the activities which they had enjoyed. We saw that a family expressed their wishes for one person to go swimming because it was an activity which they enjoyed. A risk assessment had been carried out; however staff had not taken action to arrange to take this person swimming. From our discussions with staff, we identified no planned dates were in place and arrangements made with regards to staffing to take this person swimming. We found that the provider's system for monitoring adherence to care plans had not identified the lack of meaningful activity or that people were not being supported to take up activities they enjoyed.

We found that care records were confusing and inaccurate. One person's care records stated they could not always communicate with others, as they had no verbal communication skills, used two Makaton signs and would lead people to the items they wanted. No communication care plan was in place to show how this person could be supported to communicate or if additional aides such as pictures had been tried. However further on in their records it stated the person could ask to go to a local club and could ask to leave the building. It was asserted in the records that this meant the least restrictive options were used but nowhere in the records was it recorded how this person could ask for these activities. Staff could not explain how the person would ask to go to the local club. We found that the systems for monitoring the system had not identified this discrepancy.

A training programme was in place for staff to carry out their roles and to drive improvement. However, we

could see from our observations that staff continued to require further support to improve their practices when providing care and support to people. No competency assessments had been carried out in light of continued poor staff practices. We observed the peripatetic manager provide informal feedback to staff during their interactions with people with the aim of improving their practice. However, they had only been in post for a week so these interventions were in the early stages and therefore it could not be determined if these would ensure changes in practice were made and sustained.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection changes to all levels of staffing had taken place. A peripatetic manager, with experience of supporting people living with a learning disability was in place to oversee the day to day running of the service. We could see they understood best practice guidance and although they had only been in post one week, there was evidence of change taking place at the service. New procedures had been put in place. An external consultant was working at the service to drive improvements. An area manager and regional director were awaiting start dates to commence their employment with the provider.

The operations director told us that they had held discussions with staff about the last inspection of the service in August 2017 and had held regular meetings since to keep staff updated with the changes taking place. From speaking with staff, we understood that they had experienced difficulties keeping up with the changes taking place, however they were supportive of them and the management team.

An improvement plan was in place which showed the provider had listened to feedback from the last inspection. There was evidence that some changes had occurred, however the provider was aware that the level of improvements expected had not been achieved. We also recognised that significant improvements were needed, that changes to the staff team at all levels had occurred and the service were working with an external consultant to make the improvements needed. This includes continual monitoring and assessment of the service, as well as action plans and support for staff. This meant we could see the provider was taking the action needed to drive improvements at the service and to ensure people received safe care.