HC-One Oval Limited

Avon Court Care Home

Inspection report

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Date of inspection visit:
24 September 2019
25 September 2019

Date of publication:
05 December 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Avon Court is a residential care home providing personal and nursing care for up to 60 people. At the time of this inspection 46 people were living at the home. People lived across two floors, the upper floor was for people living with a diagnosis of Dementia and also had ten intermediate care beds. These were short stay admissions to the service, for people who required time to rehabilitate following time in hospital.

People's experience of using this service and what we found
Pain management medicines had not been managed effectively, palliative medicines had not been followed up as a priority or administered to provide effective pain control.

Learning from incidents and accidents had not been embedded in the service to drive improvements for people.

Risks were not safely monitored or managed in order to avoid harm. Staff did not effectively communicate to ensure people received consistent and safe care.

People were not always supported appropriately with food and drink. The chef was unaware of some people's specific dietary requirements including their allergies. This put people at increased risk.

People were not always supported to have maximum choice and control of their lives. Staff tried to support them in the least restrictive way possible and in their best interests; the policies and systems in the service however did not always support this practice.

Although staff were kind in their direct interactions with people, when communicating with other staff they did not always maintain this respect.

Monitoring records in place were not completed correctly. It was unable to be established from the lack of recorded documentation how many times people had received the required care needed.

The service had not always managed people's palliative care needs appropriately or sensitively. The Care Quality Commission is currently reviewing information in relation to a potential specific incident concerning end of life care.

The provider had taken minimal action to address issues that had been raised in previous inspections, but any improvements had not been sustained and people had not received a good service.

We observed some of the events from the programme of activities that people had the opportunity to be involved in. These were well attended, lively and enjoyed by people.

Everyone we spoke with felt that the new registered manager was a welcome addition to the service. People and their relatives praised his friendly and approachable nature.

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

Rating at last inspection (and update) The last rating for this service was requires improvement (report published 05 October 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection, enough improvement had not been made and the provider was still in breach of regulations. The service is now rated Inadequate.

Why we inspected
This was a planned inspection based on the previous rating. The inspection was also prompted in part by notification of a specific incident. The information CQC received about the incident indicated concerns about the management of palliative and end of life care. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches of regulations in relation to safe risk management, maintaining people's dignity, nutritional management, person centred care and the governance of the service at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement

Avon Court Care Home

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.

Inspection team
The inspection team consisted of two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Avon Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
The inspection visit lasted two days. The first day of inspection was unannounced.

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

During the inspection
We spoke with 17 people who used the service and ten relatives about their experience of the care provided.

We spoke with 12 members of staff including the registered manager, deputy manager, nursing staff, team leaders, care workers, housekeeping, maintenance staff and the chef.

We reviewed a range of records. This included twelve care plans and associated records and 38 medicine records. We looked at five 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 continued to seek clarification from the provider to validate the evidence we found. We looked at training data and quality assurance records. We contacted four professionals following this inspection to request their feedback.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection in June 2018 the home had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always safely managed. At this inspection not, enough action had been taken to improve this and the service remained in breach for a third consecutive time.

● At our last inspection we found there were gaps in the medicine administration records (MAR) for topical medicines, such as creams or lotions. This meant the service could not be sure people were receiving their required creams and lotions as prescribed. We found that action had been taken to address this, but further improvements were needed to make sure information was available and accurately recorded about where creams were to be applied.
● People's medicines were not always available. We saw seven examples where a medicine had run out and there was a delay before a new supply was available. Staff had made peoples' GP aware, however this indicated poor oversight of stock management and could harm people's health or well-being.
● One person told us they were in constant pain. We saw they should have their pain levels monitored regularly, however the pain record to do this was completely blank. This person's pain relief medicine had been increased by the GP, however the MAR had not been updated to reflect this and there was no instructions that this had been increased. One of their regular medicines had run out and another medicine had also been increased in dose, but also run out. The person has not received this within the timeframe prescribed.
● Pain management medicines had not been managed effectively, palliative medicines had not been followed up as a priority or administered to provide effective pain control.
● Medicines were stored securely, however there were gaps in the temperature records for the medicines' refrigerator. This meant staff could not always assure themselves that these medicines had been stored correctly and were safe to use.

The failure to manage medicines safely is a breach of Regulation 12 (1) (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Protocols were available to help staff give 'medicines as required' correctly. Staff recorded the medicines they had given.
● Covert medicines were appropriately managed. This is when staff have permission to disguise a medicine to make sure the person will take it. The deputy manager told us on the second day of our inspection that

they had revamped the medicines trolley and medicine administration records.

Learning lessons when things go wrong

● Incidents and accidents were recorded and reviewed by the registered manager. Information recorded was at times limited. We saw that one person had presented with unexplained bruises on three occasions. Staff had recorded the bruises on a body map but there was no further information on what action had been taken or information in the care plan. The registered manager said they were aware, and they had taken action but understood there was a lack of recording to evidence this.

● One person had a note in their daily records that blood had been noticed during personal care. The nurse was informed but no further action was recorded as being taken in response. We saw an incident of a hot drink being spilt on a person in April 2019 in which a complaint had been raised. We could not see if any injury had been sustained or received a notification of this incident. The registered manager told us they would investigate further.

● Prior to this inspection there was an incident in which a person did not receive their end of life medicines in a timely manner. A safeguarding investigation concluded that this was substantiated, and the provider had not ensured this person received appropriate end of life care. The Care Quality Commission are currently reviewing information in relation to this to under our specific incident guidance.

● Following this incident, the provider told us they had reviewed their end of life care and medication and what needs to be in the building and put a contingency plan in place. However, during this inspection, we saw that palliative care was still not being managed appropriately. One person's medicines had been increased due to their palliative care needs and pain they were experiencing. We spoke to the nurse about this person's medicines and told us the prescription from the GP had only just come through to them and had not been sent to the pharmacy. This had only been followed up by one nurse and not recorded or handed over to anyone. The nurse then chased up the medicine again after we spoke with them. The prescription should have been obtained at the time of writing up or very soon after in order to obtain necessary medicine from the pharmacy in time. This had not been managed well and lessons from the last incident had not been embedded to prevent a similar event.

The failure to learn from previous incidents is a breach of Regulation 12 (1) (2) (b) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● For serious falls and home acquired pressure ulcers a root cause analysis would be completed. This looked at contributing factors such as the person's immediate environment. A post falls checklist would also be completed. This considered if the incident needs to be referred to external professionals, updating supporting assessments and informing the person's family.

Assessing risk, safety monitoring and management

● Risks were not always well managed. People in the home who had pressure ulcers or were at high risk of developing them were not supported safely to minimise this risk. We observed the position of one person during our inspection who was meant to receive repositioning support every four hours. This person had been supported at 7.50am and we saw that they were not supported again until 3pm, a total of seven hours and 10 minutes. This person was at high risk of developing pressure ulcers.

● One person who was admitted with a pressure ulcer had no pressure ulcer log in place. The wound was meant to be photographed and measured weekly to monitor the healing, however we saw a gap of ten days where this had not been done. This person's skin integrity care plan was blank, there were no details on the pressure ulcer, the care needed, or the person's air mattress settings for staff to be aware of and follow. This person told us they were in pain and not comfortable. We asked for staff to assist this person to change position.

● Another person had a grade three to four pressure ulcer. The records stated this person's wound should be redressed on 23 September. This had not been documented on the 24 September and was still blank when we checked again on the morning of 25 September. The wound management chart should have been recorded in daily, however the last entry we saw was 20 September. We asked a nurse to confirm if this had been changed but they were unable to answer this. We were unable to gain reassurance on if this person's wound was being managed appropriately. Following our inspection, the provider sent further evidence to show this person's wound had been redressed, but the wound chart had not been appropriately documented.

● We were unable to find one person's repositioning chart. This person should have been supported to change position four hourly. The nurse told us they should have one in place. A staff member said they didn't think they had one and they had not been supporting the person to reposition. This person had not been supported appropriately and had therefore been put at increased risk.

● One person's choking risk assessment dated 14 September 2019 detailed their food needed to be cut into small pieces and their fluids to be taken with thickener stage one. Thickener is used to reduce the risk of choking. At lunchtime they were served stringy long green beans that had not been cut up. A beaker of water was in front of them with the thickener at the bottom and the water at the top. This had not been stirred in properly. This person had been left at potential risk of choking.

● At the start of the inspection we were informed that no one in the home presented with behaviour that could challenge. However, we saw entries in one person's records of, "hitting, pinching and grabbing" during personal care. The support plan stated the person became anxious and agitated during personal care. There was a lack of information recorded around supporting this person and action taken following incidents. This did not provide clear guidance for staff to follow which could result in inconsistent support being offered.

● Staff told us "We have [person] they are so aggressive, always shouting and anxious all the time. We try to calm them down in a nice way, if they don't want to listen we get someone to replace us or leave them to calm down" and "We have a couple, one resident is agitated during personal care, but we just crack on and reassure them. It's the way you speak to them, if you do it in the right way they are more relaxed." This person was receiving support from male staff when their care plan stated they did not want male staff. This person was not being supported as per their wishes and this practice was potentially increasing their anxiety.

● Maintenance staff were employed and conducted regular health and safety checks, including fire alarm monitoring, water temperature checks, equipment and emergency lighting. We saw that doors to laundry items and storage of equipment were meant to remain locked but were frequently left open and accessible posing a risk to people.

● During our inspection we noticed that one person's air mattress machine did not appear to be working. We asked the nurse to look at it and they confirmed that it had been discovered to not be working two days ago. The person was currently not on an air mattress but a high grade foam mattress until the new one arrived. This person already had a pressure ulcer but there was no increased monitoring put in place to safeguard this person whilst a new mattress was sourced. The nurse further told us this person had developed a 'redness' on their sacrum. This was not recorded anywhere and may have developed into a pressure ulcer due to the inconsistency of re-positioning and monitoring. This person who was already a high risk of pressure ulcers had not been safely cared for to prevent further incidents. The registered manager told us on the second day of our inspection that all pressure mattress had been addressed and were now in working order.

● We saw that people had a transfer plan in place which held important information about them should they need to go to a hospital or other setting. However, these had not been completed properly and did not contain essential information including support needed to eat and drink, if they had capacity or any preferences around care. This meant people were at risk from inappropriate care if they had to transfer into a new setting quickly.

The failure to assess, monitor and protect people from increased risks is a breach of Regulation 12 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection in June 2018 the home had been in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because sufficient numbers of staff were not deployed to meet the needs of people. At this inspection we found improvements had been made and the service were no longer in breach of this Regulation.

● The registered manager had worked hard to recruit permanent members of staff and reduce the levels of agency staff used commenting, "We had such a good recruitment drive so agency is massively reduced." Although on the first day of our inspection the team were down by two staff due to sickness, the recruitment of new staff had been successful. People and their relatives told us they had seen an improvement to the staffing levels commenting, "Now in the last three months it is better, before then it was tight, but they coped. I have even known the manager to come and make a bed" and "My relative has a call bell, they do use it and I have seen the response and it is quite good."
● During mealtimes because of the numbers of people requiring support, this did put a stretch on staff resources at this time. Staff told us this was hard saying, "The kitchen assistants used to dish up when there was more of them, it is awkward as takes a person off the floor" and "It's difficult to balance people, ICT (Intermediate care beds) is very demanding and leaves little time to our residents. We struggle to get people to the toilet over mealtimes, we are always behind." The registered manager told us they were looking to increase kitchen staff to provide further help serving the meals at this time.
● Staff told us recruitment and levels of staffing had definitely improved, they were still using agency staff, but it had greatly reduced. The registered manager had also been able to recruit nurses which was having a positive impact. One staff commented, "The staffing has got a lot better, if I went back early this year we had a lot of agency and it was hard. We have recruited quite a lot of staff the last few months, it's just getting them up to the standard." One health and social care professional commented, "There are periods when agency staff come in and we lose the continuity of care that would mean that constant monitoring of things like medication can be better."
● Safe recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.
● Potential staff received a 'carer competence and value based' interview to identify character and natural caring capabilities and determine if they were right for the role.

Preventing and controlling infection
● The external grounds were not as well maintained. The service had experienced an issue with pest control during the warmer months which had been managed and was no longer a concern. However, we saw that outside the kitchen loose rubbish had been thrown on the ground and was a potential infection control risk.
● The clinical waste bins were overflowing, and staff continued to use these which meant the lids could not be closed due to the amount in them. This meant the bins were not being used in the manner intended and posed an infection control risk. We checked with a member of staff and there were two other spare bins, but these were not being used.
● The interior of the home was kept clean. A housekeeping team maintained cleanliness of people's bedrooms and communal areas each day. Staff had access to a supply of protective equipment in the home,

such as gloves and aprons. One person told us, "It is spotless every morning."

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at Avon Court. One relative said, "It is a happy place now. Because at the end of the day we would rather have [relative] home. But they can't be, and I can't look after [relative] the way I needed too. They are safe here and happy, and that makes me so too."

● The service had safeguarding systems in place and staff spoken with were confident action would be taken if they reported any concerns. Staff told us, " I have not seen anything that warrants concerns. I would report it straight away, if anything is threatening the safety of the residents you can't ignore that" and "Never had concerns. I know to report to the nurse or go higher if they won't listen."

● The registered manager was confident staff would take appropriate action stating, "If anyone feels something is going on they would come to me or the deputy manager. If anything comes to me it's fully investigated. Staff know if they are not happy with my practice they can go to my manager and have those details."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always supported appropriately with food and drink. On the first day of the inspection the lunchtime experience for people on the first floor was not well managed. Staff were short by two members that day and nine people needed support to eat their meal. Although lunch was served at 12.45pm some people did not receive their meal until 1.50pm. This meant people were waiting for a long period of time observing other people having their meal which could increase their anxiety.

● We observed that most people had drinks in accessible reach. A drinks trolley was observed going around mid-morning and afternoon to refresh people's drinks. One person had not been supported to change their position in order to easily reach their drink. We asked staff to assist them.

● One person had a glass or orange in front of them at 10am. We saw that this was not touched and was still untouched at 1.50am. This person's care plan recorded in several places that they did not like cold drinks. This person's wishes had not been respected and because of this they had not had a drink all morning. This person was on a fluid record and had not been supported appropriately to ensure they were drinking enough. We immediately raised this with staff to ensure this person was given a drink of their choice.

● The chef did not have important dietary information available for everyone living in the home. We saw only one person's food allergy was recorded. We informed the chef that there was a further two people in the home with serious food allergies. The chef had not known this information. The chef was also unaware that one person was a diabetic which was diet controlled. There was no information available in the kitchen about the diets of people who lived on the first floor. The chef said they marked down what the nurses told them. We immediately raised concerns with the registered manager who spoke with staff to put this information in place. People had been put at unnecessary risk due to poor communication within the staff team.

● People chose their meal choice the day before. For people with dementia this may be hard to retain this information so far in advance. We spoke with the registered manager who informed us they had trialled it another way but there had been too much food wastage. If a person wanted a different option, this could be catered for. We saw that people were not always shown the meal choice or informed. The menu was not available in a pictorial format to remind people of the choices should they need this format. The registered manager said they would review the menu process to consider making it more home specific.

● We observed one person in bed trying to eat their meal of meatballs. They were unable to get the food onto their fork so gave up and began to eat their banana mousse with their fork instead. We alerted a staff to assist this person and the staff told us they did not need help as ate independently. We asked staff again to go and support this person. We saw this person's care plan stated they required assistance to eat their meals. Staff were to encourage to take small bites and allow enough time to chew and swallow. This person

did not receive this level of support during our inspection and therefore may have been put at potential risk.

The failure to ensure people's nutritional and hydration needs were met is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us the food was tasty and the portion sizes were generous. Comments from people included, "They know I like my breakfast in my room and that I love Kit-Kats", "If you dislike the food they bring you something else. The chef sometimes pops in and says, "I have a chocolate biscuit for you" and "The new chef is gradually improving the choice and quality of the food. Just recently the Chef popped in and said to me, is there anything else you want to eat, and they went out and bought me two pizza's, it was wonderful."
● The chef was passionate about wanting to cook things people enjoyed, one family had brought in trout for their relative and the chef cooked it commenting, "You can change the moment for someone. It's like cooking for my family."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● At our last inspection in June 2018 the home had been in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always involved in decisions in a dignified way. This breach is now assessed and discussed in the Caring key question of the report.
● We saw that where restrictions were in place to protect people the appropriate applications had been made to the authorising body to approve. Evidence of capacity assessments and best interest meetings were in people's care plans and recorded why the decision was necessary. We discussed with the registered manager that there needed to be more evidence that restrictions put in place were being reviewed to ensure they remained the least restriction option.
● We saw there was some conflict around consent forms for things including permission for photos to be taken and access and agreement to care plans. This consent had largely been given by relatives where a person was unable, however some of these relatives did not have the legal authority to be able to consent on behalf of the individual. We raised this with the registered manager to take the appropriate action.

Adapting service, design, decoration to meet people's needs
● The home was in need of attention to the décor and repair and maintenance in some areas. The registered manager told us that contractors had assessed and given quotes for work to be done.
● Some communal bathrooms had been left inaccessible as they were used as storage places for wheelchairs and laundry trollies. We saw that in a staff meeting on 17 September the registered manager has raised the clutter in bathrooms with staff and reminded them it limited their use. However, this had still not been followed.

● The upstairs décor had not been considered in terms of creating a dementia friendly environment for people. There was a lack of signage to navigate people around the corridors. The walls and doors were all one colour and made it hard to distinguish one room from another. There was a lack of stimulus along the corridors or objects of interest for people to engage with. Memory boxes were in people's rooms, however the one's we viewed were empty and these were placed inside people's rooms rather than outside to orientate them to their room.
● The registered manager agreed the environment was not conducive to people's needs and was making changes. Two registered mental health nurses had been employed and they had been asked to observe what was needed to change the environment for people. The registered manager spoke of painting individual doors, more sensory equipment and brightening up the spaces.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to see health professionals where necessary, such as their GP, specialist nurse or attend hospital appointments. A record was kept when people had contact with other health or social care professionals. One health and social care professional told us, "The managers and staff are approachable when problems arise. In the experience of our team any situations that come up have been sorted out as quickly as they are able."
● For people staying in the Intermediate Care beds there was access to physiotherapy care and occupational therapists on site. We saw people from ICT beds being encouraged to get up and walk and do exercises as part of their rehabilitation plan.
●● People's oral health care was not always maintained. We saw one person's oral health assessment scored one. This meant their mouth should be cleaned frequently. We looked at their personal hygiene record and saw this had not been recorded as being followed. Another person had a score of two which indicated frequent cleaning and any concerns should result in a dentist referral. We saw that for September there was not one recorded attempt or offer to give this person the mouth care they needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had an assessment of their needs prior to any service being offered. Assessments covered people's health, physical and social needs.
● The registered manager told us he monitored staff practice through his daily observations when spending time around the home commenting, "I watch their practice, I am on the floor, if there is poor practice I pick it up or work with staff. This will also be captured in supervision going forward."

Staff support: induction, training, skills and experience
● Staff received a six day induction when they started at Avon Court prior to 'hands on working'. One staff told us, "The induction was very helpful, I got into it and was helped all the way through it."
● The registered manager had an online training matrix to monitor when staff training had been completed or was due to be renewed. We saw some gaps around safeguarding, safe people handling and nurse competencies around medicines. Training had been booked and the registered manager told us "A team leader has done train the trainer in manual handling and will be responsible for training and refreshers for staff as well as audits on equipment, slings and hoists."
● Staff spoke positively about their training and opportunities. The registered manager was happy to support any further development staff wanted and was currently sourcing end of life training for staff commenting, "I would like palliative care training as a priority. It is not in place as yet. There is a 'touchstone' module about dying and Dorothy House have been to the home to advise and have been invited to a team meeting" (Dorothy House is a hospice focusing on quality of life, so patients can live well and die well. They provide support to people and their families).

● Formal documented staff supervisions had not been happening in line with the provider's timeframes. The registered manager confirmed, "Supervisions is an area we need to get to grips with, a lot of work with team leaders about their role is happening and supervisions is an area they should be doing. All team leaders now have a list and know who they are supervising."

● Staff had access to informal guidance and meetings with the registered manager and an 'open door' policy was adopted. Staff felt confident that they could approach the registered manager at any time if needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At our last inspection in June 2018 the home had been in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. At this inspection not enough action had been taken to improve this and the service remained in breach for a second consecutive time.

● At this inspection we observed some examples of undignified practice. We walked past a person lying in their bed with their door open and saw their covers were off and they partially dressed. The accompanying staff member acknowledged the person but did not attempt to cover them up. As the staff went to walk away we had to ask that they assist the person to preserve their dignity.
● Although staff were kind in their direct interactions with people, when communicating with other staff they did not always use respectful terminology. For example, we heard one staff walk along the corridor calling to another staff member, "Room [number] wants soup and room [number] is on the toilet."
● Staff worked in ways that appeared task focused and left little time for meaningful interactions. Staff told us, "I feel we get to spend time with people. When you give personal care it's quality time and when feeding them" and "We get time to chat with them during meal time." At lunchtime one staff was heard saying about five people in the dining room "Let's get these [people] in here done first." These conversations did not evidence a person-centred approach.
● People were not always asked where they would prefer to sit for mealtimes. Some staff bought people into the dining room in wheelchairs and placed them at the table. One staff said "I'm going to bring the others in." They returned with one person and said "[person's name] can sit here." Another staff intervened and quickly said "Where would [person's name] like to sit."
● People's confidential information was not always kept securely. People's room folders and intermediate care beds support plans were at times left on the railings outside of their rooms and were easily accessible to others. These contained information including if the person had a DNAR in place, medical history and care needs.
● We saw on two occasions the nurses administering medicines would walk away from the trolley and leave the MAR records open which contained private information about people's medicines. We stayed with the trolley until the nurse returned and raised this concern with the registered manager.
● In the dining rooms folders were accessible which contained personal information about people's dietary needs and other details. We raised this with the registered manager who told us this information would be

removed to a secure location.

The failure to ensure people were treated in a dignified approach was a continued breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we saw that people were supported to wear clean clothes and their personal appearance was maintained throughout the day by staff. One relative told us, "I remember a time when at the beginning [relative] would not allow herself to be washed. They found a way to do it by placing a sheet over her legs to protect her dignity and it worked and [relative] became relaxed. They are thoughtful and have attention to detail."

Ensuring people are well treated and supported; respecting equality and diversity
● All the people we spoke with told us the staff were well meaning and showed them kindness when they supported them. Comments included, "It is like a large family and they always have a smile on their face and make you welcome", "They do everything you want them too. There isn't one that isn't helpful in some way" and "Staff are lovely. It's been a lovely place to recover."
● The registered manager was a very visible presence around the home and people demonstrated they were used to seeing a lot of him and he knew them well. One relative told us "My relative has been here over three years and this is the first time, since the new manager has been here, that we are treated with respect and thoughtfulness."
● Relatives praised the relationships staff had built with people and told us they were always welcomed to the home with a friendly smile. Relatives said, "They are wonderful to [relative]. My relative can be difficult. They know them so well, so much so that know when they are able to be taken out of bed without upsetting them" and "You pick up vibes that people care. They are friendly to [relative] and look after me too. They are a generally a very caring group of staff."
● The manager told us they worked to show awareness and promote people's different backgrounds, cultures and beliefs commenting, "We always ask what people want, we meet religious needs, dietary needs, depending on their culture we will adapt things. We have staff of different faiths and we support any staff disabilities and give support." One staff told us "I like talking to the different residents and finding out their stories, listening to what they have done with their lives. We have a good relationship with the residents."
● Staff all wore badges with their name on and a personal statement about themselves. Staff told us this was chosen by them when they started, and the aim was to encourage conversations with people from this. Staff told us this worked really well and allowed connections to form as people were able to learn things about the staff too.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

At our last inspection in June 2018 the home had been in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care provided was not always appropriate and reflective of people's preferences. At this inspection the service had failed to take the required action to address these concerns and remained in breach for a third consecutive time.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Monitoring records in place were not completed correctly, or in line with people's assessed care needs. It was unable to be established from the lack of recorded documentation how many times people had received the required care needed, or if staff had not documented the care given.
- Personal hygiene records indicated that people did not always receive support to wash. For example, one person's record documented a gap of six days where nothing was recorded. Their hair was recorded as not having been washed for a month. One hygiene record showed that a person had nothing recorded for the month of September up until 20 September. This person was not absent from the home, so they should have been receiving support with personal care. We asked a staff member about this and was told "It was probably not recorded." We are not reassured that people were receiving care as they should be.
- Some people had food and fluid charts in place to record their daily intake. However, these were not being used effectively. Fluid charts did not always record the intended target people needed to drink and the amounts were not totalled up. There was no oversight to ensure people were consuming the required amounts in order to take swift action if there were concerns.
- One person's fluid chart recorded they had received support to drink at 9am, 11am and then not again until 22.10pm. Staff were unable to confirm if this was a recording issue or if this person had not received appropriate support. Another person had support to drink on one day at 1.45pm and 15.45pm and 21.50pm. These were the only entries recorded and totalled just 220mls for that whole day. It was not able to be ascertained if people had actually gone without fluids for these amounts of time or staff had not been effectively recording.
- People who required support to change their position regularly to prevent pressure ulcers were on a repositioning chart. We found numerous gaps on the documentation indicating that people had not received their care in line with their required need as stated in their care plans. It was unable to be ascertained how many people had not been supported correctly and how much was a recording issue. We were informed that everyone on the top floor was on four hourly repositioning regardless of their skin viability risk. Staff were unable to explain the rationale for this. The registered manager suggested it was a historical practice that needed review.
- One person on four hourly repositioning support had gaps of six, seven and eight hours where

repositioning was not recorded in line with their care plan. One person had a gap of 15 hours and 35 minutes where they had no documented support. Staff were unable to confirm if this person had actually received support within this time. For two people in June 2018 who obtained pressure ulcers whilst living at Avon Court had the root cause documented as not having received repositioning care in line with their care plans.

● We saw at times there was incomplete or inconsistent information recorded in care plans. For example, one person's Malnutrition Nutritional Screening Tool (MUST') to identify adults, who are malnourished, at risk of malnutrition or obese had been incorrectly scored. They were documented as a low risk, but they were actually a medium risk which required a different set of actions and could potentially have delayed action being taken. We saw that actions recorded in people's daily records were not always followed up. For example, one person was recorded as being sick and supported to change their bedding and clothes. However, there were no actions on what had happened or if this had been reported to the nurse to monitor.

● One person who was at risk of falls and had shortness of breath told us they had asked for a folding chair or stool for their bathroom, so they could sit whilst washing independently. Both nurses we spoke with did not know anything about this request. This person's mobility care plan recorded they were independently mobile with a Zimmer frame. This did not reflect their current needs in order to ensure this person was supported appropriately.

● All these concerns were raised during our inspection to staff and to the registered manager. The registered manager was aware that documentation was not being completed correctly.

● Communication between the staff team was not always effective. This was evident in staff knowledge around who should be receiving palliative care, sourcing medicines when the supply had run out and communication around pressure care management. Documented communication was also not effective in order to provide effective and consistent care to people.

● Staff told us that communication was an area that needed improvement, so they were all aware of changes within the home. Staff told us, "Sometimes in handover the communication needs improvement so we definitely know what's going on and who has received personal care" and "It is hard as there have been new staff and they are learning how to do things in this type of environment. For instance, for the new admission yesterday the paperwork about registering them and their medicines was all left in an envelope under some papers."

●We attended the daily meeting with the heads of department. No care staff or nurses attended this meeting. A nurse appeared at the end of the meeting but did not ask if there was anything they should be aware of. The registered manager told us they normally attended but had been busy that morning. This was not effective in ensuring communication was shared across the home. Following this inspection the registered manager informed us that they spoke with a nurse to share information from the meeting.

● The registered manager had completed a night visit the night before our inspection due to records not being completed by staff appropriately. The registered manager told us they were disappointed this was still ongoing and would continue to address with staff. The registered manager told us they were introducing a key worker system in which people would have a named member of staff, they hoped this would improve communication.

The failure to ensure people's care and treatment was appropriate and met their needs is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person had a care plan in place which recorded the support they needed to ensure their needs were met. A profile had been created to show things that were important to people and a photo of them if they wished.

● At a team meeting in September the registered manager told staff there was some really good care and support being given to the residents at Avon Court, what was letting them down was that staff are not

evidencing through documentation the good support they were delivering. The registered manager told us a session was planned with staff on person centred planning.
● People's care plans were reviewed three monthly or as and when their needs changed. An evaluation sheet recorded any changes and showed the person and their relatives were involved in this process.

End of life care and support
● The service had not always managed people's palliative care needs appropriately or sensitively. Pain management medicines had not been managed effectively, or followed up as a priority in order to be administered to provide effective pain control. The Care Quality Commission is currently reviewing information in relation to a potential specific incident concerning end of life care.
● We were informed at the start of our inspection that two people were receiving palliative care. When we spoke with staff including senior staff and nurses they were unable to tell us who these people were. We saw that the care plans did not have information on how they wished to be cared for at this stage in their lives or that they were receiving palliative care. One staff told us, "It depends if [person] is still on it, it was [person] but I don't know if they are still on end of life care. I think it was mentioned that [person] was end of life a few weeks ago but I can't remember."
● We spoke with one person who told us their wishes around their care. This person had a lot of questions and had not yet been offered the opportunity to discuss these with staff and information to support them had not been sourced. We saw their end of life care plan contradicted their personal wishes and had not been completed as a matter of priority. Staff told us they knew this care plan should have been reviewed more regularly and their care monitored. They were aware of the discrepancies but stated the staffing had been short and with agency staff there had been a lack of consistency with records.

The failure to ensure people received person centred end of life care is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they planned to have a meeting with this person and their family to discuss their expectations and were aware limited information around palliative care was recorded. A formal palliative care training course was being sourced for staff to give them more awareness of the importance of this stage of care.

Improving care quality in response to complaints or concerns
● Prior to this inspection CQC received six direct complaints this year about this service. The themes of the complaints were around staffing and a lack of quality care. Some of these concerns were shared with the registered manager and were investigated and a report shared with us.
● We saw 11 complaints had been raised internally, of these 11 four had been upheld and three partially upheld. These were around issues of general care, hydration, dignity and end of life care. Some of these concerns were also identified during this inspection and have been reported on throughout this report.
● People in the service had information available on how to make a complaint should they need to do so. People and relatives told us, "In the last three years being here, there has never been an incident where we thought we had to get [relative] out. The carers here are brilliant, it feels like a family" and "I have never had a complaint, but if I did I would complain." One person told us about a compliant they had made and how the registered manager had acted to put things right saying, "I was very happy how the whole process went and was handled."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People had a communication care plan in place which detailed any support or aids they needed in order to engage fully in their surroundings.

● Although the service could provide easy read documentation if people requested, it was not readily available within the home for some people who may not know or think to ask for this. The service did not currently have information in pictorial formats for people who would have benefitted from this format. The registered manager told us this was currently being considered going forward.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● We observed some of the events from the programme of activities that people had the opportunity to be involved in. These were well attended, lively and enjoyed by people. One person told us "One of the activity people is exceptional, she is gold-dust. Do you know they used FaceTime when she was on holiday, so she could talk to us and everyone. It was so special and much appreciated by everyone."

● People praised the activities in the home saying, "Activities are very varied and very good, we also go out for lunches. The entertainment is very good", "I join in things, staff know me well, they have been fab" and "They have musicians which I like. They brought in Llamas too and they do arm chair aerobics."

● The activity staff held group events and completed one to one sessions for people in their rooms when able. A lot of people spent time in bed and we saw the engagement opportunities for them were low outside of staff helping them with meals or personal care. One staff member said, "We have taken people down to the movement activity and we look at what it is and think people would enjoy it. People in their rooms have interactions when we do personal care and give them a drink. It's hard as we can't always be in two places."

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 Requires Improvement. At this inspection this key question has remained the same. 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.

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

At the last inspection in June 2018 we identified improvements were needed to the way the provider assessed the quality of the service provided and made improvements. Following that inspection, the provider wrote to us to say they would make improvements to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations by December 2018. At this inspection we found that although some aspects of the service had improved, the provider had failed to ensure people received a consistently safe and good service. The service is in breach of Regulation 17 for a second consecutive time.

● This is the third inspection since February 2017. In 2017 the service was rated as Requires Improvement under the previous provider. In 2018 the service was inspected under the current provider, HC-One Oval Limited, and had continued to be rated as Requires Improvement. This inspection has now rated the service as Inadequate. The provider had taken minimal action to address issues that had been raised in previous inspections, but any improvements had not been sustained and people had not received a good service.
● The provider had quality assurance systems in place, however, even when concerns had been identified, they had not resulted in sustained improvements to the service. A governance meeting actions in June 2019 stated that the root cause analysis of pressure ulcer incidents had identified this was due to poor documentation and a failure to follow care plans. This was an area identified on this inspection that was ongoing. Following this governance meeting actions had not been put in place at service level to make the necessary improvements.
● We reviewed a recent medicines audit and saw it had not picked up the issues of out of stock items, fridge temperature gaps, and creams not having dates of opening. The registered manager said the checking of care documentation was not routinely being done. The registered manager did it on an ad hoc basis when walking around the home but told us this was the role of the team leads. Stamps had been ordered for the team leads so when they checked paperwork they would be stamping it to evidence these checks.
● Following this inspection, the provider was asked to send immediate assurance of three key areas of concern, palliative care, pressure ulcer management and dietary needs. An action plan was submitted alongside the home improvement plan, however the actions in the plan did not alleviate concerns to a satisfactory level.

The failure to assess, monitor and improve the quality and safety of the service effectively is a breach of

Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they were committed to making the necessary improvements in the service commenting, "It's a good service, yes we need to improve on areas and we are aware and that is why I came in. We are not evidencing it as well as we should, but the care and support is a lot more focused, they are more engaging, I hear a lot more conversation going on and choice given. I see happier residents and relatives they are complimentary about the way we are going."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Everyone we spoke with felt that the new registered manager was a welcome addition to the service. The registered manager had been in place for five months at the time of this inspection and people and their relatives were all aware of who he was and praised his friendly and approachable nature. Comments included, "Oh the manager is very easy to talk to. He is always moving around", "The place has really lifted up. The Manager is marvellous", "The Manager is very good at getting his hands dirty" and "The manager talks all the time, he is like one of us. If I am stuck on my computer tablet, he will sit down and help me with it."

● Staff told us they now felt supported and valued in their work and this was because of the new registered manager. Staff commented, "Manager is lovely, he has an approachable personality, he goes around and checks things are alright, he makes lots of jokes and breaks the monotony of the job", "It's a good atmosphere here, the manager is doing a good grand job" and "He is very nice. He is honest and open, he's good for the place."

● The registered manager completed daily meetings and walk arounds of the home. Staff told us they felt encouraged and part of a team from the weekly meetings the registered manager had implemented. One staff said, "It's completely flipped on its head, before the manager came it was going downhill, now everyone is perked up and we come into work looking forward to it. He gets everyone together on Fridays to check how we are. I feel supported if I go to him, it's always handled." The registered manager told us they had changed the format of meetings to follow CQC's key lines of enquiry, so staff could discuss what they needed to evidence.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibilities under the duty of candour.

● The registered manager's office was based in the reception as visitors came in. This meant they were visible and available to people and their relatives if needed. The registered manager had an 'open door' approach which meant anyone at any time was free to approach them and be listened to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their relatives were able to attend inhouse meetings to share their views and hear about events affecting he service. One person told us, "I have sometimes been to meetings, but we are always informed and get the minutes. Also, they mix the timings up so some are in the afternoon and some in the evenings. This means more people get the opportunity to attend at times that suit them." One relative said, "I am always invited and sent the minutes." An electronic interactive 'have your say' feedback system was available in the reception for people to use should they wished to provide feedback in this way.

● A feedback survey had been given to people in May 2018 but a more recent one had not yet been completed. The registered manager said they would follow this up. We saw that the service had received

compliments and praise from relatives and people thanking the staff for their kindness and care. The registered manager spoke about how they recognised and acknowledged good practice from staff and would share this with them.

● One person told us they had been part of the interview process for new staff and praised the registered manager for this initiative saying, "They take an interest in me too. The manager has involved me in three to four staff interviews in recruiting permanent staff. When it was under [previous provider] the staff were unhappy and not listened to, it could not be more different now under [registered manager]."

Working in partnership with others

● The manager worked with local health and social care professionals. They were planning to advance this further and do some partnership working with Dorothy House hospice around end of life care. One health and social care professional told us, "The managers and staff are approachable when problems arise. In the experience of our team any situations that come up have been sorted out as quickly as they are able."

● The registered manager had worked to build good relations with other professionals in managing the intermediate care beds. One health and social care professional told us, "There is a great level of understanding with the staff and they continually demonstrate high levels of manual handling and a great working relationship with the people. That said, there have been comments from people about the attitude of the night staff on some occasions."

● The registered manager received medical alerts in order to keep up to date on any changes. These alerts were then put into a folder in each nurse's station, so the information was cascaded to staff.

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 10 HSCA RA Regulations 2014 Dignity and respect There was a failure to ensure people were treated in a dignified approach. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to assess, monitor and improve the quality and safety of the service effectively. The provider had failed to ensure people received a consistently safe and good service. Regulation 17 (1) (2) (a) (b) (c) (f)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to ensure people's care and treatment was appropriate and met their needs. Appropriate records were not kept or followed. Regulation 9 (1)

The enforcement action we took:

A Warning Notice has been served against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to manage medicines safely for people. There was a failure to learn from previous incidents and take action to minimise a reoccurrence. There was a failure to assess, monitor and protect people from risk which caused harm. Regulation 12 (1) (2) (a) (b) (e) (f) (g)

The enforcement action we took:

A Warning Notice has been served against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to ensure people's nutritional and hydration needs were met safely or effectively. Regulation 14 (1)

The enforcement action we took:

A Warning Notice has been served against the provider.