Christchurch Housing Society

Avondene Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection commenced on the 14 August 2018 and was unannounced. It continued on the 15 August 2018 and was announced. The inspection was carried out by one inspector.

Avondene is a residential care home for older people. The home is registered to provide care for up to 11 people and was fully occupied. The service provides single occupancy accommodation over two floors with a communal lounge, dining room, conservatory and shared specialist bathrooms.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from avoidable harm as risks had not always been assessed such as for the use of bed rails to ensure they were a safe restriction. When risks had been identified actions had not always been put in place. One person had been assessed as high risk of skin damage but no care plan had been written to provide details of actions needed to minimise avoidable harm. When actions had been put in place their effectiveness had not been monitored. Two people had charts in place to record their daily fluid intake. Charts contained no daily minimum of fluid for each person to keep them hydrated or actions needed if this wasn't achieved. Records demonstrated that evening drinks had not been offered. The information being recorded had not been monitored which meant people were at risk of dehydration.

Statutory notifications had not always been submitted in a timely manner. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision.

Audits had not been effective in assessing, monitoring and reducing risks to people. Records of care were not always complete. Where risks had been identified records did not always detail the actions needed to protect people from avoidable harm.

Care plans did not provide enough detail to ensure people's care needs and choices were consistently met. The registered manager told us they would review plans in line with best practice guidance. When people had received end of life care they had their wishes respected and were supported in a dignified and kind manner.

People told us they felt safe. They were supported by staff who had completed safeguarding training and knew how to recognise and report any safeguarding concerns. People were supported by enough staff to meet their needs and staff had been recruited safely ensuring they were suitable to work with vulnerable adults. People received their medicines safely including topical creams. Limited guidance was available to staff for medicines administered occasionally. The registered manager told us they would review alongside best practice guidance. People were protected from avoidable infections as staff followed safe infection

control practices. When things had gone wrong lessons had been learnt and seen as a way to improve practice such as changes to the buildings security.

Mental capacity assessments had been completed and deprivation of liberty safeguards (DoLs) submitted to the local authority. When authorised DoLs had conditions attached these were being followed. When decisions had been made in a person's best interest they combined a number of aspects of a person's care. The Mental Capacity Act 2005 (MCA) requires that decisions need to be assessed for single decisions. The registered manager agreed to review in line with the MCA guidance.

Staff had completed a range of training which provided them with the skills and knowledge to carry out their roles. 50% of staff had not completed hydration and nutrition training and the registered manager told us they would organise for this to take place. Staff felt supported in their roles and had opportunities for professional development including diplomas in health and social care.

People described the food as good and were provided with choices of well-balanced nutritional meals reflecting people's likes and life style choices. When people had safe swallowing plans they were understood by staff and followed.

Avondene worked with other professionals such as community health teams and specialist nurses to ensure effective care. Staff were quick to respond to changes in people's health ensuring access to healthcare whenever needed.

Staff were described as kind, caring and patient. People talked about the friendly atmosphere and felt involved in their care. Staff were knowledgeable about people's life histories and family and friends important to them. We observed people having their privacy, dignity and independence respected.

People, their families and the staff team all spoke positively about the management of the home. They described the culture as open and transparent describing the registered manager as a good listener and somebody who got things done. Meetings were regularly held and used as an opportunity to share information about Avondene's plans for creating secure outdoor garden space, share feedback, staff achievements and reflect on practice when things went wrong. The registered manager had taken opportunities for professional development and was completing a management diploma in health and social care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from avoidable harm as risks were not always assessed, actioned or monitored.

People were supported by staff who had completed safeguarding training and understood how to recognise and report suspected abuse.

People were supported by enough staff to meet their needs who had been recruited safely to work with vulnerable adults.

People had their medicines administered safely.

People were protected from avoidable infections.

Lessons were learnt when things went wrong and led to improved outcomes for people.

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act 2005 framework for best interest decision making was not being followed meaning outcomes were not decision specific.

Pre admission assessments were completed and captured peoples care needs and choices.

Staff received training and support that enabled them to carry out their roles effectively.

People's eating and drinking likes, dislikes and lifestyle choices were known and met.

Relationships with other professionals ensured effective health and care outcomes for people.

People had access to healthcare for planned and emergency events.

People were independently able to access all areas inside the home as it had been adapted to meet people's needs. Safe outdoor space was not available but in the planning stages.

Is the service caring?

Good

The service was caring.

Staff were kind, patient and supported people's emotional needs.

People felt involved in decisions about their care.

People had their privacy, dignity and independence respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always provide enough detail to ensure peoples care needs and choices were consistently met.

A complaints process was in place and people and their families felt listened to when they raised concerns.

People had an opportunity to discuss their end of life wishes which were respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes were not effective in assessing, monitoring and reducing risks to people.

Legal requirements to provide information to the Care Quality Commission were not always met in a timely way.

People, their families and staff spoke positively about the leadership of the home describing it as open and transparent.

Regular one to one and group meetings take place which provide opportunities for engagement with people, their families and the staff team.

Partnership with other agencies enabled improvements in service delivery and outcomes for people.

Avondene Care Home

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.

The inspection was carried out by one inspector and began on the 14 August 2018 and was unannounced. The inspection continued on the 15 August 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had not completed a Provider Information Return as we had not requested this prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with four people who used the service and three relatives. We spoke with the registered manager, administrator, three care staff and the cook. We reviewed six people's care files and discussed with them and care workers their accuracy. We checked four staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

After our inspection we requested additional information in relation to accident reporting and monitoring which we reviewed alongside information collected at inspection. The registered manager provided this.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm.

Risks to people had not always been assessed. One person had been assessed as requiring 24 hour supervision in order to maintain their safety. The registered manager told us they visited a friend in the community most weeks and travelled by taxi alone. No risk assessment had been completed to consider the person's safety and identify actions to ensure the person was safeguarded. Two people had bed rails in place but no risk assessments had been completed to ensure this was a safe restriction. Another person had not been included in Avondenes' emergency evacuation plan.

When risks had been identified actions had not always been put in place. One person had been assessed as high risk of skin damage. A care plan had not been written to provide care staff with details of the actions needed to minimise the risk of avoidable harm. Another person received most of their care in bed and required the use of a hoist for transferring out of bed. No care plan had been written to provide care staff with details of how to safely move and transfer the person.

When actions had been put in place to minimise identified risks they had not been monitored. Minutes of a staff meeting held on 25 January 2018 recorded that the registered manager had noted a staff members concerns that night time drinks for two people were being made but not given and left out of reach. These two people had been assessed as at risk of dehydration. We saw that charts had been put in place to monitor their daily fluid intake. Charts did not include details of the minimum amount of fluid each person required to remain hydrated. We looked at four days of recording for one person week commencing 10 August 2018. The last drink offered on one day was 1pm and on three days 4pm. Their recorded daily intake of fluids on three days was less than 600mls. The second person's charts over three days of the same week showed they had their last drinks offered at 3pm on two days and 4pm on one day. Their recorded daily intake of fluids on one day was 500mls. The information recorded by care staff on the daily fluid charts had not been monitored to ensure actions in place were keeping people safely hydrated.

One person had been assessed as a very high risk of skin damage. Care staff recorded on a chart how often they changed the position of the person to relieve pressure. No care plan was in place but the registered manager told us the person's position needed changing two to three hourly. The chart records from 9 – 14 August 2018 showed that over a one week period there were 15 occasions when their position had not been changed for over three hours. Of these 10 were over five hours and one was over 10 hours. The information recorded by care staff on the positioning charts had not been monitored to ensure actions in place to prevent avoidable harm were being carried out.

Risks for people had not been consistently assessed, actioned or managed in order to minimise the risks of avoidable harm. This is a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had swallowing difficulties and speech and language therapists had carried out assessments

and produced safe swallowing plans. These had been made available to both catering and care staff and we observed them being followed correctly. People had their weight monitored at least monthly and when needed had additional calories and supplement drinks to help them maintain weight.

Records showed us that equipment was serviced regularly including the lift, boiler, fire equipment, and hoists.

People and their families told us they felt safe. One person said "I feel 100% safe". A relative told us "We're sleeping again because we know (relative) is safe". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Staff had been recruited safely including checks with the disclosure and barring service to ensure they were suitable to work with vulnerable adults. People told us there were enough staff to meet their needs. One told us "If you use the call bell they come in a minute; there very good". Staffing levels were reviewed to meet the needs of people living at Avondene. The registered manager explained an additional staff member had worked when one person needed closer supervision to maintain their safety.

People had their medicines ordered, stored, administered and recorded safely. One relative told us "The GP visits every couple of weeks to check meds and (registered manager) always informs us of any meds changes or reviews". When topical creams had been prescribed for people's skin conditions a body map showed staff were it needed to be applied and detailed how often. Some people had medicines that only needed to be administered occasionally. Limited guidance was available to staff to ensure these medicines were given consistently. We discussed this with the registered manager who told us they would review alongside best practice guidance.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers were available at points throughout the building. All areas of the home were clean and odour free.

Lessons had been learnt when things went wrong. Incidents, accidents and safeguardings were seen as a way to improve practice and action had been taken in a timely way when improvements had been identified. An example had been a change to the building's security following an incident were two people had left the building unknown to staff placing themselves at risk.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 were not always followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. When people had been assessed as not having capacity decisions had been made in the persons best interest. Records were not specific to one decision but combined a number of aspects of a person's care needs. The MCA framework requires that capacity to consent needs to be assessed for specific decisions separately. We spoke to the registered manager who agreed to review any best interest decisions in line with the MCA guidance.

One person had conditions attached to their authorised DoLs. Records showed us these were being met. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a person's behalf. We observed care staff offering people choices and respecting decisions people made. Examples included offering people opportunities to go for a walk, join people at a dining table and where to spend their time. Staff told us how they helped some people make decisions with the use of a picture book.

People and their families had been involved in a pre-admission assessment which had been used to gather information about their care needs and lifestyle choices. The assessment gathered information about a person's medical history, a how they would like to be supported and reflected their level of independence. The information had been used to create an initial care plan.

Staff had completed an induction and on-going training that enabled them to carry out their roles effectively. Induction included for some staff the care certificate. The care certificate sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. The training matrix showed that only 50% of staff had completed hydration and nutrition training. The registered manager told us they would organise for this training to be revisited for all staff.

Some training provided had been specific to the needs of people living at Avondene. A care worker told us about their dementia training. "When you do dementia training you realise how people's heads work and you need to get into their heads". They gave an example of how they had found that playing a person's favourite music took away the anxiety they experienced when having a shower as the music focused the persons concentration.

Staff received regular supervision and told us they felt supported in their roles. Opportunities for professional development had included diplomas in health and social care.

People had their eating and drinking needs understood by both the care and catering staff. A menu was on display and included allergy advice. We observed people being offered a choice of meals which were well balanced and reflected peoples likes, dislikes and lifestyle choices. One person told us "They (staff) will offer something different if you fancy it. They will make me a sandwich at night. Never refused anything". When people needed the assistance of staff with eating and drinking this was carried out at the persons own pace ensuring their dignity.

The service worked with other organisation to ensure people had effective care. This included community district nurses when people needed support with wounds or health conditions and community mental health teams when people needed support with their dementia. When people moved between services, such as a hospital admission, key information went with them. This included a medicine record, communication needs and contact numbers of families.

People had been supported to access healthcare both in planned and emergency situations. Records showed us people had access to a range of health professionals including chiropodists, opticians and audiologists. One person told us "If they (staff) see something wrong with me they say we will get the district nurse in".

People were able to independantly access all areas inside the home which provided areas of both private space and areas to socialise. Secure outside space was not available but we were shown landscaping plans currently being considered. Adaptations around the home such as raised or coloured toilet seats, labelled bedroom drawers and signage enabled people living with dementia to retain independence around the building.

Good

Is the service caring?

Our findings

People and their families spoke positively about the caring nature of the staff team. One person said, "Can't fault the staff for kindness and they welcome my visitors. Always get a smile". A relative told us "The staff are fantastic; they are very caring towards (relative). They are a delight and are kind to me as well".

We observed a relaxed and friendly atmosphere between people, their families and staff. Staff spent time talking and listening to people demonstrating patience and kindness. One person became anxious and unsure what to do and a care worker immediately offered their time and reassurances. A care worker explained how another person can become upset but isn't able to verbalise the reasons. "We stroke their arm, talk to them nicely and slowly, slowly they relax".

Staff demonstrated a good understanding of people's individual communication needs. Picture cards were used to help people with limited speech or poor hearing to choose meals, indicate if they were in pain and offer personal care. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions. People had support to keep in touch with family and friends including telephones in their bedrooms and staff popping a letter in the post box when needed.

Staff were able to share with us stories about people's past interests, jobs, hobbies and interests. Conversations between staff and people reflected this knowledge. We observed conversations about people's families and others important to them. Conversations generated laughter and enabled positive, respectful interactions between people and the staff team.

People were involved in decisions about their care and how they spent their day. We observed people making decisions about where and how they spent their time and staff respecting people's choices. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. People's clothes and personal space reflected a person's individuality. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. People were addressed by their chosen name. We observed staff knocking on doors and waiting to be invited in to people's rooms. We observed people walking slowly with their walking aids and staff walking with them at the persons pace, demonstrating patience and encouragement enabling independence. The registered manager told us, "When we have agency staff and it's a gentleman we ask ladies if they would like another choice of staff".

Information about people and staff was stored securely to ensure their right to confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always provide the information care staff needed in order to provide consistent person centred care to people. One care plan included no details of equipment needed to help people move and transfer a person safely. Another person had no care plan detailing actions staff needed to take to help prevent skin damage. Care staff told us they were kept up to date with people's changing care needs at a daily handover. We saw that the handover sheet contained a snap shot of each person's care needs. This included medical conditions, medicine allergies, mobility, communication, skin care and eating and drinking requirements. The registered manager told us they would review care plans in line with best practice guidance.

Care plans described people's religious and cultural needs and these were understood and respected by the staff team. Links had been made with local churches that were able to provide religious support when needed. The registered manager told us one church visited regularly to provide holy communion.

People and their families felt involved in planning of care. One person explained how they had wanted a change from their pressure relieving mattress. They had discussed their options with the staff and agreed an alternative. We spoke with a district nurse who told us "They (staff) communicate really well with us. They are good at recognising change. Staff have been here a while and know the customer (people)".

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People had their communication requirements assessed. We saw that menus, reminiscence boards and posters used large print and words and pictures to aid people's understanding.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. We observed one person enjoying a relaxing pamper session. Another person enjoyed classical music and a quiet area had been created for them to sit and enjoy their favourite albums. A relative told us, "Staff will put (relative) in a wheelchair and take them around the park which is great". Links had been made with a befriending service and one person had a weekly outing for a shop and a spot of lunch. Staff had a good knowledge of people's past interests and were able to offer activities that reflected them. This included drawing, baking and listening to favourite music artists. People told us they enjoyed the quizzes and visiting musicians. A care worker told us, "We have exercises and I love doing it with them. It helps with their balance."

When people chose not to participate in activities this was respected. One person told us "I like to sit in my room with my table (newspaper, books, and word games). I like the radio and have that on". One person spent their time in bed and had colourful ceiling mobiles and a bird table outside their window to encourage bird life.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if

needed. A relative told us "If we have any concerns we have approached (registered manager) and they get sorted". The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. No formal complaints had been received since our last inspection but there was a record of comments and issues raised by people and their families. The record demonstrated that people had been listened to and appropriate actions taken. One person had been unhappy with supper choices and had requested alternatives. We spoke with the person who told us they had requested alternatives and this was happening. A suggestion box was in reception for people, their families, visiting professionals and staff to use to share feedback and ideas.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. A district nurse spoke positively about end of life care. They said, "They do have people who become palliative and will keep them here with our support. One person, staff sat with the person; very particular with their care".

Requires Improvement

Is the service well-led?

Our findings

Systems and processes were not effective in assessing, monitoring and reducing risks to people. The registered manager told us as part of their management of risks to people they reviewed each person's care plan monthly. This process had not been effective in highlighting areas found at our inspection that required improvement. This meant that people had not consistently had risks assessed, monitored and reviewed in order to minimise the risks of avoidable harm.

Records of the care people needed were not complete. Where risks had been identified records did not consistently provide details of how to reduce risks of avoidable harm.

The registered manager told us they felt their time supporting with care had impacted on completing management tasks. They agreed more effective auditing processes were needed.

Systems and processes were not effectively assessing, monitoring and reducing risks to people related to their health, safety and welfare. This is a breach of Regulation 17 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications had not been made to CQC appropriately or in a timely manner following two safeguarding concerns. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had not received information to support their monitoring of the service. Actions were taken by the registered manager following this incident which included additional training for senior staff in reporting responsibilities and changes in building security to prevent a further incident.

People, their families and the staff team all spoke positively about the open and inclusive culture at Avondene. One person told us, "(Registered manager) comes in (bedroom) and has a little chat". Another told us "(Registered manager) and second in charge are brilliant. If I want anything doing they just do it. No humming and arrghing". A care worker said, "(Registered manager) is a good boss. Always listens, always helpful". A district nurse told us, "Well run home; good management and happy carers".

The registered manager provided visible leadership and had also taken opportunities for professional development. They were completing a level five diploma in management and leadership in health and social care. They had also started plans to work towards a nationally recognised accreditation in end of life care.

Staff understood their roles and responsibilities and spoke positively about team work. They had been kept up to date with new legislation such as changes in data protection law. Engagement with people, their families and staff was achieved through a range of methods. These included both group and individual meetings and a quarterly newsletter. We read staff minutes which included sharing feedback from families, recognising staff achievements and plans to enhance the outside environment. Meetings also provided an opportunity for reflective practice when things had gone wrong.

A bi annual quality assurance survey had been completed by people and comments had led to changes. An example had been a review of supper and dessert choices on the menu.

The staff team worked with other organisations and professionals to ensure people received seamless care. One example was the home had worked with the local NHS and implemented the 'Red Bag Scheme'. The scheme involves using a red bag containing information about the person that stays with them and ensures an effective transition between services.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from avoidable harm as risks were not always assessed, actioned or monitored.

The enforcement action we took:

NoP Imposed conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective in assessing, monitoring and reducing risks to people.

The enforcement action we took:

NoP imposed conditions