Avonpark Village (Care Homes) Limited

Alexander Heights Care Home

Inspection report

Avonpark
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alexander Heights is a Care Home providing personal care for up to 28 people. At the time of this inspection there were 16 people living at the service. The home is situated in the grounds of Avon Park Retirement Village, where there are other care homes and independent living apartments and houses.

This inspection took place on 31 May 2017 and was unannounced.

At the last comprehensive inspection we found breaches of Regulations 11, 18 and 17. We took enforcement action for Regulation 17 and imposed conditions on the registration of this service. Following the inspection the provider developed a comprehensive action plan to meet the imposed condition of registration and to address requirements orders on Regulation 11 and 18.

A registered manager was in post. '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.'

Some identified risks to people were assessed. Staff said risk assessments were developed on how to minimise potential risks to people. However, risk assessments were not in place for risks including choking A member of staff on duty acknowledged that two risk assessments were in need of reviewing. We asked to see copies of the risk assessments and were told they were not available.

Accidents and incidents were documented and an investigation was conducted following the event. The actions following the accident included observations for signs of head injury, arranging for GP visits and to review care plans and risk assessments were reviewed. However we found no documented evidence of this occurring after an incident or accident had taken place.

Staff signed the MAR charts when medicines were administered. A record of medicines that were no longer required had been maintained. Protocols for medicines prescribed to be administered when required (PRN) were missing, although the procedure in place stated one must be kept within the Medicine Administration Records (MAR) file. The staff on duty were not aware of the protocols or about their location. Directions on the use of thickeners were not provided to staff and the only information stated to administer "as directed".

While the staff knew about enabling people to make day to day decisions we found gaps in their understanding of assessing people's capacity to make decisions. The assessment records that related to people's capacity t were inconsistent, which showed a lack of staff's understanding regarding assessing people's capacity to make decisions. Mental Capacity Assessments were not in place for specific decision such as restricting people access to their lighter and cigarettes. Where people lacked capacity to make decisions best interest decisions were not taken to show the decision was in the person's best interest and the least restrictive.

Care plans were inconsistent and some were not always person centred. Care plans were not updated with people's current needs. Staff said whilst they read the care plans, handovers were the main source of information about people's changing needs". They said care planning training was attended. Whilst they read the care plans, handovers were the main source of information about people's changing needs. We were told that new care plan formats were to be introduced.

While people acknowledged attempts to improve the meals served had been made, some negative comments about the food were received. We were present during the lunchtime meals and we saw people eating the meals. Feedback about the quality of meals was variable but people said the quality had improved and the menus had changed. People told us the catering manager made regular visits to the home and their feedback was sought. Staff told us the catering manager visited daily to gain people's feedback about the food. They also stated a complaints book was available in the dining room for people to give their feedback about the food,

The people we spoke with said they felt safe at the home and they received adequate levels of support from the staff. The rota showed there were three staff on duty. One senior or the unit manager and two carers were on duty. During the week the unit manager had a supernumerary day for administration tasks. One relative and people told us the consistency was better and they recognised the staff when they visited as staff faces were more familiar now.

The staff we spoke with said they had attended training in the safeguarding of people from abuse. They were aware of the different types of abuse and the action that must be taken where there were concerns of abuse.

A member of staff recently employed said their induction was excellent and prepared them for their role. The activities staff told us they had access to all mandatory training set by the provider. They said there were opportunities for personal development through one to one meetings with their line manager.

The training matrix showed staff attended mandatory training set by the provider and training which depended on the role of the staff. For example medicine training for senior carers. The staff we spoke with said the training provided was good.

Staff said their one to one meetings were regular and occurred every eight weeks. The supervision matrix in place showed all staff had regular one to one meetings with their line manager. We noted that all staff had a one to one session with their line manager in February 2017 and the meetings for June 2017 had been scheduled.

People told us they were able to join in group activities and one to one activities were available for people who preferred to spend most of their time in their bedrooms. An activities programme was on display and coordinators had documented the group and one to one activities undertaken. Activities coordinators knew people well and their likes in relation to one to one and group activities.

People told us they had made complaints in the past and their concerns were taken seriously and had been acted upon. The Complaints procedure on display needed reviewing as the name of the previous quality assurance manager was included for people to approach with their complaints.

Quality assurance systems were in place to monitor the quality of care provided. Visits on behalf of the provider were monthly and action plans developed where shortfalls were identified. Staff said the team worked well and stated the registered manager was approachable. People told us their views were gathered

using surveys and during meetings. An agency worker told us they worked at the service regularly to provide continuity of care to people.

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 consistently safe

Risks were assessed and action plans developed to minimise risk. Risk assessments were not always reviewed following an accident or incident. Assessments were not in place to support people to take risk safely.

Medicine management systems needed to improve. Procedures on administering medicines prescribed when required were not available to staff.
Members of staff were able to tell us the safeguarding procedures including the types of abuse people may be vulnerable too.

Staffing levels were maintained with the use of agency staff. Recruitment of permanent staff had taken place. Agency staff told us they worked regularly at the service.

Is the service effective?

Good

The service was effective.

Documentation about people's capacity was inconsistent and where people lacked capacity, staff' had little insight on the impact this had on some decisions. Mental Capacity Assessments were not always in place to show decisions had been made in people's best interests and in the least restrictive way.

People were able to make day to day decisions and told us who helped them with more complex decisions if they needed this support.

Staff attended essential training that the provider deemed as necessary for their role. One to one meetings with the line manager took place regularly so staff had the opportunity to discuss their performance, areas of concern and future development.

People had access to health care professionals for their ongoing healthcare needs.

Is the service caring?

Good

The service was caring.

People received care and treatment from familiar staff that knew their needs and respected their human rights.

Members of staff were respectful and consulted people before they offered support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's needs were assessed and care plans had variable guidance for staff on people's preferences. Care plans were not always updated following a review of needs.

There was an activities programme in place and people were encouraged to pursue their hobbies and interests.

People said they felt able to approach staff with concerns.

Is the service well-led?

Good

The service was well led

The provider had developed systems to assess, monitor and improve the quality of care. The provider had developed effective systems to assess, monitor and improve the quality of care where breaches of regulations were identified

The views of people were gained by forums such as meetings and surveys. Relatives views had been gathered on the quality of the service..

Staff said the team although small worked well together and were well supported by the unit manager.

Alexander Heights 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 31 May2017 and was unannounced.

Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector and during the inspection we spoke with five people and two relatives about their views on the quality of the care. We spoke with the two staff and two activities coordinators, the registered manager and area regional manager.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included three care records, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection in May 2016 we found breaches of Regulation 18. We found the staffing arrangements were not always adequate to meet people's needs during peak periods. The number of staff employed were not adequate to cover all shifts and agency staff had been used to cover any shortfalls. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to staffing levels. We found some improvements had taken place.

At this inspection people made positive comments about the staff and the consistency provided by having a stable staff team. One person told us their personal care was delivered by staff that were familiar to them. A relative told us they observed consistent care when visits to the home took place. They were aware of previous issues within the organisation and stated that stability of staffing levels was being achieved.

A member of staff said the staffing levels had improved. They said two new staff were employed and there was less reliance on agency staff to cover vacant hours. Another member of staff said the staffing levels were adequate and stated there were two staff and a senior on duty during the day. An agency worker said they had regular shifts at the home and were kept informed about people's current needs.

The rota in place showed a senior and two care staff were on duty during the day and at night one senior and one care staff was on duty. The unit manager in post had one supernumerary day per week for administration tasks.

Medicine systems were in place and we found aspect of medicine management were safe. Medicine administration records (MAR) charts were signed by staff to indicate the medicines administered. A record of medicines no longer required by the person and for disposal had been maintained.

Protocols for when required (PRN) medicines were not available for all PRN medicines. For one person the instructions for thickeners [prescribed to help make fluids safer to drink] were as directed. The use of incorrect amount of thickener may increase people's risk of choking. Medicine procedures were missing for PRN medicines which included glycerine trinitrate (GTN) and for eye drops. This meant staff were not provided with clear and concise information on how to administer PRN medicines consistently. Subsequent to the inspection we were provided with copies of PRN protocols. However on the day of the inspection the member of staff we spoke with was not aware of PRN procedures or about their location.

One person said medicines were administered by the staff and they had "no issue with that. "Another person told us they were able to self-administer their medicines. This person said a lockable cabinet was supplied for them to store their medicines.

A member of staff said risks were assessed for trip hazards, for people at risk of choking and for people at risk of malnutrition. They said soft diets were served for people at risk of choking and for people at risk of malnutrition their weight was monitored and enriched diets were served. Another member of staff said risk assessments were devised by the unit and registered manager. This member of staff said some people at the

home were at risk of choking, weight loss and with a history of falls.

Risks for people with mobility needs had been assessed. Risks were not assessed for people at risk for people with swallowing difficulties. The current risk assessment for one person identified at risk of choking was not available. Staff had recorded the risk assessment was to be reviewed on 1 June 2017 with the GP. We asked for a copy of the risk assessment but it was not available to view as the member of staff said it was "locked in the office drawer".

Maintaining Safe Environment review minutes dated 12 May 2017 stated the "care plan was updated" following a fall. However the care plan was dated 30 November 2016 which meant it had not been updated on the increased risk of falls. The member of staff confirmed the care plan and risk assessment was not updated.

The moving and handling risk assessment for another person included the medical conditions that increased the risk of this person falling. A falls assessment had identified the person at medium risk of falls and stated visual impairments was the reason for the score.

Accidents and incidents were documented and an investigation was conducted following the event. The actions following the accidents included observations for signs of head injury, to arrange for GP visits and to review care plans and risk assessments were reviewed. However we found no evidence that the care plan was reviewed. For example, for one person the Maintaining Safe Environment care plan was dated 30 November 2016 which said there was reduced mobility because of poor vision. The accident form was dated 16 May 2017 which meant the care plan was not updated.

Individual evacuation plans in the event of an emergency, included the person's medical condition that had an impact on people's mobility for example, visual and mobility impairments. The equipment and number of staff needed for a safe evacuation from the property was also part of the plans.

People we spoke with said they felt safe living at the home and staff made them feel secure. The staff we spoke with were able to describe the procedure for safeguarding people from abuse. Staff knew the signs of abuse and were clear on the procedure for raising concerns. A member of staff said external agencies such as local authority leads in safeguarding would be approached if their concerns were not taken seriously by their line manager or registered manager. Another member of staff said they had attended safeguarding of vulnerable adults training

Good

Is the service effective?

Our findings

At the comprehensive inspection in May 2016 we found breaches of Regulation 11. People's consent to care and treatment was not consistently sought in line with the Mental Capacity Act (MCA) 2005. Where people had the capacity to consent to their care and treatment, this consent was not recorded. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to gaining consent from people.

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 signed consent forms for photographs. One person said they had given lasting power of attorney for finance and health and welfare to their family member. The relative agreed with the comment and we found copies of this in the care record. This person also said that the staff "asked [gained consent before undertaking tasks] and nothing is imposed"

A member of staff said people living at the service had capacity to make day to day and complex decisions. Another member of staff said they didn't understand MCA but was able to say that people made "all sorts of decisions. Times to rise and retire, what people eat and activities".

Do not attempt resuscitation (DNAR) orders where signed by the GP to allow natural death where appropriate for some people. Where people had capacity the GP had discussed the wishes with the person before a decision was reached. Where people lacked capacity the decision was reached following consultation with relatives where appropriate

The comments from people about the meals was variable. One person said the meals were very good. Another person said their dietary requirements were met. They said pureed diets with no lumps were served and that the presentation of pureed meals had improved.

Other people gave negative feedback about the meals. One person said "do I dare to say it's dreadful. Taste buds change as [people] become older. The soup was ok." Another person said the food had deteriorated. They said the catering manager consulted with people to gain their feedback about the food. A third person said "it's ok, there were efforts to improve" and new menus were to be introduced.

A member of staff told us a complaints book was available in the dining room for people to give their feedback about the meals. They said the information was then passed onto the chef. They also stated the catering manager visits the home during mealtimes to gain people's feedback about the food. Another member of staff said the menus had recently changed and "people are happier with meals."

Members of staff told us people made decisions about menu choices the day before. We observed the lunchtime meals and one person said to another "it's better than yesterday". Another person said to the person sitting next to them "try the chicken it's very tender." People were left to eat their meals and during the meals staff entered the dining room and offered assistance. We saw member of staff encourage people to eat their meal and when they refused people were offered alternatives.

A new member of staff said the induction programme prepared them for the role they were to perform and were registered on the Care Certificate. This member of staff said they shadowed more experienced staff for the first month of their induction and there were opportunities to discuss their progress with a line manager during one to one meetings. The other member of staff said there were opportunities for vocational qualifications and they were registered onto the Care Certificate [a set of standards that assist staff to develop their knowledge and skills needed to provide safe, compassionate care].

The training matrix provided showed the training staff had attended included Health and Safety, MCA and DoLS, Equalities and Diversity. Where staff administered medicines they attended competency based training.

Staff on duty told us one to one meetings with their line manager every eight weeks. The supervision matrix showed staff had regular planned one to one meetings with their line manager. This meant staff had opportunities for personal development.

One person told us they were supported with their ongoing healthcare. They said they were supported to access community facilities which included regular dental and optician check-ups. Records of people's ongoing healthcare were maintained. We saw the staff recorded the outcome of visits from GP, specialists and community healthcare services. For example, chiropody, optician and dentists. A member of staff told us there were twice weekly visits from the GP.

Good

Is the service caring?

Our findings

People gave us positive feedback about the caring nature of the staff. Two people said the staff were "exceptionally good. I've been well looked after. Always supervised by staff when walking as I am unsteady." Another person said there had been improvements and staffing was more stable which meant people were more able to "get to know the staff".

A relative told us the staff managed the care of their family member well and the staff were "helpful". They said staff welcome visitors and offered them refreshments when they visited the home. Another relative said on each visit they know were able to recognise staff which meant there was consistent staff including agency staff were delivering personal care.

Lifestyle profiles in place gave staff information on people's likes, dislikes and preferred routines and activities. During our observations we saw staff interact well with people. We observed the activities coordinator offer refreshments to people. The activities coordinator said to people in the lounge "just making a coffee for myself, can I make you one?"

We observed staff during the lunchtime meal encourage people to eat their meal. When one person refused and asked for ice cream the member of staff served the alternative requested.

A member of staff said people accepted support once staff had gained peoples trust which staff achieved by talking and giving reassurance where there were concerns. They said "knowing people's background histories helped them discuss people's interests." Another member of staff said spending time and getting to know people's likes and dislikes helped developed relationships with people which made them feel they mattered. They said spending time with people and getting to know their likes and disliked helped to develop relationships.

Orientation boards were used to keep people informed about the staff on duty, activities for the day and the weather.

Residents meetings were also used to gain feedback from people. The minutes of the residents meeting held on 23 May 2017 included the names of the people and staff who attended. We saw areas identified by people using surveys were discussed and included menus and food served, the improvements with staffing and activities.

A couple living at the service told us the accommodated was organised for them to have an en-suite, sitting area and bedroom. They said the gardens were a "delight" and that they were able to walk around the garden safely.

Staff said people were treated with respect. The staff we spoke with gave us examples on how they respected people's privacy and dignity. People told us their rights were respected.

Advanced care plans included people's wishes regarding their future care for their end of life. People advanced decisions were kept with their End of Life plans and people's wishes for pain free natural death was part of their care plan. Where people had signed DNAR this was documented in the care plan.

Requires Improvement

Is the service responsive?

Our findings

There was a personal profile page in place which had a photo of the person displayed and summarised important information about the person such as their health and personal care needs. The regional operations manager told us new care plan formats were to be introduced. When we drew to the attention of a member of staff that care plans were not in place for all needs identified This member of staff said the care planning system had recently changed from online recording to paper copies. They said not all care plans had been downloaded to paper copies.

One person we asked was not aware of having a care plan or had a discussion with staff on the manner in which their needs were to be met. Another person said "they [staff] have just started to ask people how they want their care. A residents meeting was held the previous week." A couple preparing to leave the home told us weekly meetings were taking place to discuss their intention to leave the home.

Staff said whilst they read the care plans, handovers were the main source of information about people's changing needs. Handover sheets were used to maintain staff starting their shift informed about people's current needs. We saw recorded for the 30 May "all residents fine no concerns on all shifts." Another member of staff said care plans were devised by the staff and seniors checked them for accuracy. They said care planning training was attended.

The care plans were variable on detailed guidance about people's preferences and their ability to manage aspects of their care. The Eating and Drinking care plan dated 16 October 2016 for one persons stated the person had "no swallowing problems and needed assistance with cutting food". However, the care plan had not been updated with changes of dietary needs. The review notes dated 23 February 2017 stated the care plan was updated and "continues to be offered soft diet and thickeners". The same care plan was reviewed again on 23 April 2017 and stated "pureed diets and thickened drinks which aid her ability to swallow." This meant the care plan was not updated and lacked detail on the pureed diet and how to thickened fluids. We asked a member of staff who was unaware of the care plan and whether it was updated.

The Tissue Viability care plan dated 30 November 2016 for another person detailed the condition of the person's skin, the waterlow score and checks staff must undertake for a medical condition. The review of the care plan dated 16 May 2017 stated a skin tear was noted but there was no evidence of further action taken. For example, the extent of the skin tear and how the skin tear was to be monitored as the person had a medical condition that could impact on the healing process of the tear. For another person the Tissue Viability care plan dated 30 September 2016 stated the person had "swollen feet and gave guidance for staff to ensure the person elevated their feet. This care plan was reviewed on 26 April 2017 and it was reported the person had a cut on there right elbow. However, there was no evidence of the action taken or if the cut had healed.

The care plans for one person with visual impairments gave staff specific guidance on how to deliver care in their preferred manner. The safe environment care plan stated the person was able to move around their bedroom and gave staff guidance not to remove or move items of furniture due to visual impairment. The

Eating and Drinking care plan listed the equipment needed for the person to eat their meals independently. The preferred diet was also included and stated the person had refused to be weighed and had declined input from the dietician. The personal care plan for this person included their preference on how staff were to deliver their care and the times when staff were to assist them with personal care.

One person told us it was their decision not to participate in group activities. This person told us they participated in one to one activities. Another person told us activities were organised. This person said they arranged with the "home's driver" outings. They said there was a home's vehicle and when the driver was going to places of interest they organised support and went on the outings.

The activities coordinators we spoke with told us they worked across the three registered locations within the Avonpark Retirement Village and delivered a variety of group and one to one activities. They said that while most people preferred to be in their bedrooms during the day people were invited to join group activities. One to one activities were undertaken to avoid isolation for people who prefer to remain in their bedrooms. The activities coordinator said eight hours per week was allocated for one to one activates and the priority was for people who do not join activities.

A weekly activities programme was devised and people were provided with copies. We saw activities programmes in bedrooms and on display in public areas. The activities coordinators told us people's suggestions on activities were gathered. The responses showed people preference on group activities were quizzes, games, pampering sessions and watching movies.

One person told us they had complained in the past. They said the complaint was taken seriously and resolved to their satisfaction.

The complaints procedure was on display within the home. We noted the procedure needed reviewing as the name of staff to approach were no longer working at the service. A relative said they knew who to approach with concerns but "there was no reason for complaints only high praise".

Good

Is the service well-led?

Our findings

At the comprehensive inspection on May 2016 we found a breach of Regulation 17. There was a lack of quality auditing and governance processes which we judged as Inadequate. We found the lack of clear quality auditing process had not informed the senior management team of concerns we identified during the inspection. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous Care Quality Commission inspection reports and to prevent the reoccurrence of issues. We took enforcement action and imposed conditions on the registration. The provider was told to undertake monthly audits and provide the Care Quality Commission with a report which confirmed the dates on which these audits had taken place and the action taken or to be taken as a result of these audits.

Monthly visits to assess the standards of care were undertaken on behalf of the providers. A copy of the May 2017 visits showed all areas assessed and an action plan was developed from the shortfalls identified. For example, staff appraisals to commence in June 2017 and staff were to sign care plan documentation and to indicate care plan has been read.

Documentation and Records audits were undertaken in May 2017. The Documentation and Records audits showed a sample of four care records was assessed and an action plan was devised on how shortfalls were to be met. For example, including the likes and dislikes in a personal care plan and for staff to refrain from documenting no change in review notes.

People told us their views about the service were gathered using surveys. The analysis of the 13 surveys received showed most people found the quality of the service to be excellent to good. Some people assessed the home to be average and from the 11 responses received about the food three people said it was poor. Additional comments about the "positives" of about the service included the staff, the friendliness of the staff and feeling safe. Issues identified as negative included communication and the "cooking". While we some areas identified in the survey were discussed at the residents meeting an action plan was not provided on how the feedback received from people was to be used to drive improvements. For example, communication. One person told us there had been improvements with staff turnover. They said it was possible to "get to know staff" as the staff team was stable.

A registered manager was in post. The registered manager told us the vision of the home was "to have open warm and friendly home that enables residents to get the best from their lives. Follow hobbies and interests." They said "it's an open door policy and staff feel confident to raise concerns". People feel able to approach the [registered] manager. Residents meetings were held to gain feedback on what is important to people and about the improvements.

The registered manager was aware of the key challenges which included "recruitment, getting and retaining the right staff". This was to be achieved by "improving their [staff] working conditions" and progression. It was also stated "the right staff for the number of people".

A member of staff said the staff team were friendly and "nothing is too much trouble." Another member of staff said the team worked well together including regular agency, the unit manager was supportive and the registered manager was "ok". One person said the registered manager was "lovely".