Elderly Care Home Limited

Avalon Nursing Home

Inspection report

3-5 Nevill Avenue
Hampden Park
Eastbourne
East Sussex
BN22 9PR

Tel: 01323501256
Website: www.avalonnursingcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Avalon Nursing Home on the 17 and 18 December 2018. This was an unannounced inspection.

Avalon Nursing Home 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.

Avalon Nursing Home provides nursing and personal care for up to 38 older people, some of whom were living with a dementia type illness. There were 27 people living at the home at the time of the inspection. In addition to living with dementia people had a range of complex health care needs which included stroke and diabetes. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Avalon Nursing Home is owned by Elderly Care Home Limited and is situated in Hampden Park in Eastbourne, East Sussex. Accommodation for people is provided over two floors with communal areas and a garden.

There was a registered manager 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 and associated regulations about how the service is run. Avalon Nursing Home had two registered managers at this time who work together to manage the service. The senior registered manager visits three days a week and the junior registered manager is in day to day charge.

We inspected Avalon Nursing Home in August 2015 where the overall rating for this service was Inadequate. We looked to see if improvements had been made in May 2016 and found that improvements had been made and breaches in regulation had been met. However, the improvements had not been fully embedded in practice and the service was rated as Requires Improvement. Due to a high number of concerns raised we brought our scheduled inspection to November 2016. We found people's safety was being compromised in a number of areas and the home was rated as Inadequate and was once again placed into special measures. We inspected again in July 2017 we found that improvements had been made across all areas of the service. But the breaches of Regulations 9, 11, 12, 17 and 18 were not fully met. We took appropriate enforcement action at that time. The provider had continued to provide CQC with monthly audits of the service delivery.

This inspection found that improvements had continued and that the rating for Safe and Effective improved to Good, Caring had remained Good and Responsive and Well led had remained as Requires Improvement. The breaches of regulation whilst met were not fully embedded into everyday care delivery and further time is needed to ensure that improvements are pro-actively sustained. The overall rating of this inspection is Requires Improvement.

There was continued commitment from the management team and staff to consistently strive for improvement. Areas identified as needing to improve at this inspection were immediately acted on and details of the actions taken were sent to CQC. This demonstrated that the management were responsive and wanted to improve their service.

The quality assurance system, audits and checks had not identified the shortfalls we found. Care plans did not consistently contain the detailed information staff needed to support people to meet their individual needs and care documentation was not consistently and accurately recorded. However, management had a good oversight of what was required to ensure the service continued to improve and meet the regulations. Staff told us they felt supported by the registered managers, they could talk to either of them and raise issues at any time. They felt listened to and knew any concerns would be taken seriously and acted on.

People were relaxed and comfortable with staff. They said they felt safe and there were sufficient staff to support them. One person said, "I feel safe, the staff are kind and look after me." A relative said, "We visit everyday and we know she is safe." When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Medicines were managed safely and in accordance with current regulations and guidance. There were systems that ensured medicines had been stored, administered, audited and reviewed appropriately. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire or emergency situation. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff received training in order to undertake their role. Formal personal development plans, including two monthly supervisions and annual appraisals were in place. People were supported to make decisions in their best interests. The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had attended training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware of current guidance to ensure people were protected. DoLS applications had been made when required, to ensure people were safe and the registered manager was waiting for a response from local authority. People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people could give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People chose how to spend their day. Activities were mixed and people could choose either group activities or one to one. People were encouraged to stay in touch with their families and receive visitors. The provider had sent CQC notifications in a timely manner. Notifications are changes, events or incidents the service must inform us about.

Staff were asked for their opinions on the service and whether they were happy in their work. Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff could contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Avalon Nursing Home has improved to Good.

Measures were put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it.

Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

Avalon Nursing Home has improved to Good.

People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink to maintain their health and well-being.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

Avalon Nursing Home remained caring.

People were supported by staff who were kind and caring. They supported people to maintain their dignity and respected people's privacy.

We observed positive interactions taking place and people were supported to make their own choices.

Is the service responsive?

Requires Improvement

Avalon Nursing Home remains Requires Improvement.

Not everybody had a care plan that reflected their current individual needs.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Requires Improvement

Avalon Nursing Home Requires Improvement.

Quality assurance systems needed to be further developed and embedded into everyday practice.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

The registered manager promoted an open culture in the service. The provider's values were embedded in staff working practices.

The service worked in partnership with other relevant organisations.

Avalon Nursing 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 17 and 18 December 2018 and was unannounced. The inspection team consisted of four inspectors' and two experts 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 home.

Before our inspection we reviewed the information, we held about the service including previous inspection reports. We used information the provider sent us in the Provider Information Return. 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 considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We used a range of different methods to help us understand people's experiences. Some people who lived at the home had limited verbal communication. Therefore, as well as speaking with eighteen people, we also observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit.

We spoke with two registered nurses, eight members of staff, two activity coordinators, the maintenance coordinator, and a chef.

During our inspection process we spoke to two visiting professionals who provided specialist support to people who lived in the home. We also contacted the dietician from East Sussex County Council's community team, for their feedback on the quality of care being delivered in regard to people's nutritional and dietary needs.

To help us assess how people's care needs were being met, we reviewed eight people's care plans and associated records. We also case tracked a further three people who received specialist diets and with other more complex needs, such as Parkinson's disease and diabetes. Case tracking involves talking to the person (if they are able), observation of their care, talking to staff directly supporting the person and examination of care records. We looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures. We displayed posters in the communal area of the service inviting feedback from people and relatives.

During the inspection, we spoke with three relatives for their views about the safety and quality of the services provided for people. Following the inspection, we were contacted by a visitor who wished to share their views. We also sought feedback from Health Watch and staff from the local authority on their experience of the service. Health Watch are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. The feedback we received is included in this report.

Good

Is the service safe?

Our findings

At our inspection in July 2017 this key question was rated Requires Improvement because improvements were needed to ensure people's health needs were appropriately risk assessed and managed safely and that staff were appropriately deployed. This inspection found that steps had been taken by staff to ensure peoples' health needs were managed safely and staff deployment had ensured people's safety. The rating in this key question had improved to Good.

People told us they felt safe living in the home and we observed people were relaxed and comfortable. People told us, "I feel very safe, they are kind and attentive," and "I have never had to grumble about anything."

Risk assessments identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. Risk assessments for health-related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, people with mobility problems had an assessment that was used to give clear guidance for staff to follow. This included specific equipment to be used, such as hoist, type of sling and sling size.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

The home was clean, and there were regular audits to make sure cleanliness levels were maintained. People told us, "Always very clean, never any odours." Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or aprons when needed.

Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

The provider had ensured the proper and safe use of medicines within the service. Medicines were given by

registered nurses (RN) who had received appropriate training and competencies. Medicine records showed that each person had an individualised medicine administration record sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts are a document to record when people received their medicines. MAR charts indicated that medicines were administered appropriately and we saw trained staff giving people their medicines safely. Records confirmed medicines were received, disposed of, and administered correctly. There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. All medicines were securely stored in two separate clinical rooms which were kept locked when not in use. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

Staff had received training in safeguarding adults and records confirmed this. Staff understood their roles and responsibilities in supporting people to keep safe from potential harm or abuse. Staff were knowledgeable about the different forms of abuse and how to recognise the signs of abuse taking place. Staff told us, they would not hesitate to report abuse to the registered manager and were confident they would take appropriate action. The registered manager understood their responsibilities in reporting any concerns about people's safety which included reporting incidents of potential harm or abuse. A staff member said, "There are various kinds of abuse; physical, financial, emotional, sexual. If I come on shift and I am alerted to something I'd check the person to make sure they're ok and then do an incident report and tell the manager." Procedures were in place for whistleblowing and safeguarding, as well as policies in relation to emergencies, fire safety, medicines, bullying and harassment. People were protected as far as possible from abuse.

Staff recruitment practices remained robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation PIN for all qualified nursing staff. The PIN is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Rotas demonstrated that staffing levels were consistently set at eight care staff and two registered nurses (RN's) in the mornings and seven care staff and two RN's in the afternoon. At night there were four care staff and one RN. There was also a 24 hour one to one for one person at this time. During our inspection there were two new staff members who were extra to the normal levels. Sufficient staff were deployed during our inspection to ensure people's needs were being met in a timely manner. Not everyone could verbally tell us of their experiences, but those that could told us, "Always come when I ring, never left waiting," and "Very good, they look after me very well."

Good

Is the service effective?

Our findings

At our last inspection in July 2017, this key question was rated Requires Improvement as improvements were needed. This was because whilst staff understood the principles of the Mental Capacity Act 2005 (MCA), there was no information about how people who lacked capacity were able to make decisions. Staff competencies had not all been assessed and safe care delivery was not consistent and improvements were needed to the meal service. This inspection found improvements had been made. The rating for this key question had improved to Good.

People and relatives had confidence in the skills and abilities of the staff employed at Avalon. People told us, "You can't fault the staff. They (staff) do know what I need and want", "They know when I'm feeling unwell and get the doctor to see me" and "The staff are lovely and I think they are well trained." Visitors said, "We visit every day" and "They keep us informed and I think things have really improved."

The provider had ensured that staff had the skills, knowledge and experience to deliver effective care and support. We viewed both the training programme and individual certificates that confirmed that staff received training and refresher training. Essential training included safeguarding, infection control, moving and handling, health and safety and fire safety. Specific training which reflected the needs of the people who lived at Avalon, for example, syringe drivers, dementia and wound care.

Staff told us that the training programme was good and that they also received support with training whilst working with people. One staff member said, "I was shown how to change a stoma bag and then I was observed doing it to ensure I was doing it properly." This enabled senior staff to monitor how effective the training programme was and had resulted in bespoke training. During the day we observed staff supporting people with moving and re-positioning. Staff followed good practice guidelines, ensuring that people who needed hoisting had their personal sling, explaining what was happening and offering reassurance throughout. These 'on the floor' sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff told us they were supported through supervisions and the records in the service confirmed this. Records showed staff had received supervisions as well as appraisals. A member of staff said, "I feel supported and receive supervisions regularly."

All new staff completed an eight-week programme which included a week shadowing with training, then a second week fully shadowing and supporting a senior member of staff with care delivery. All new staff have an induction pack to work through and signed off as competent when completed. If staff need further time to compete then their induction period would be extended. Staff were doing a quality standards framework with the care certificate mapped in to it, which included the principles of care; organisation and employee role; risk management and maintaining safety; effective communication; recognising and responding to abuse and developing as an employee.

People had access to care, support and treatment in a timely way with referrals made to appropriate social and health services when people's needs changed. We saw records of visits and letters from healthcare

professionals in people's care files, such as speech and language therapists (SALT), diabetic team, chiropodists, opticians and dentists. We saw SALT had assessed people with swallowing problems and guidance was in place regarding food texture and thickening levels for fluids. Staff were knowledgeable about people's nutritional needs. All this information was on the person's care plans and in the kitchen. People had access to their GP if needed. People told us, "The doctor can be called," "I can see the doctor if I needed to" and "I do get my toenails cut," "When you need it, they will get the doctor in" and "I have a daily check on my diabetes." Visiting healthcare professionals told us people were referred to them appropriately. One health professional said, "They respond quickly when a health problem is noted and work well with us." Another health professional said, "They know their residents well."

People's needs were assessed before they came to the home. Information was sought from the discharging service, people's relatives and other professionals involved in their care. Care, treatment and support was delivered in line with legislation and evidence-based guidance. For example, staff had a copy of newly published guidance by the International Dysphagia Diet Standardisation Initiative (IDDSI) which described new definitions for texture modified foods and thickened liquids for people with dysphagia (difficulty swallowing).

Staff were working within the principles of the Mental Capacity Act 2005 (MCA). 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 are called the Deprivation of Liberty Safeguards (DoLS).

Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for bed rails, and life changing choices about medical treatment and intervention or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. The provider had up to date policies and procedures in relation to the MCA and staff were provided with information on how to apply the principles when providing care to people who lived at Avalon Nursing Home. We were also made aware of people subject to DoLS authorisations.

People that could, commented they felt able to make their own decisions and those decisions were respected by staff. People told us, "The carers first tell me what they want to do and ask if that's okay with me" and "Very respectful and polite, always tell me what's about to happen." We saw staff constantly talking, explaining to people and waiting for responses before assisting them or moving them in their wheelchairs. A relative told us, "I am involved with all aspects of care and decisions. I feel my views are valued." Another relative told us, "We are always consulted on any decisions and attend most appointments."

Care records included people's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status. This meant that if a person's heart or breathing stops unexpectedly due to their medical condition, staff were aware that no attempt should be made to perform cardiopulmonary resuscitation (CPR). The DNACPR

records were up to date, included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals who were involved in the decision.

People were supported to eat and drink enough. People said that they liked the food, they were given choices and food that they enjoyed eating which was cooked well. We saw that alternatives were available if people wanted something different. Throughout the day we saw that people had access to drinks with staff offering hot and cold drinks. People had drinks in their rooms and communal areas were well supplied with drinks. People told us, "Yes, I like the meals" and "I eat in here (bedroom)" "The food's average, they try their best" and "I like the fish but I'm not keen on the meat dishes." "The food's okay", "The food was awful but it is getting better", "The food is absolutely super, couldn't be better" and "Anytime you want a drink, you can have it."

People's weight was regularly monitored and documented in their care plan. Senior staff told us, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT) and GP." The staff we spoke with understood people's dietary requirements and how to support them to stay healthy. Staff kept the kitchen informed of any changes to peoples' dietary needs and who needed their food fortified. Guidance was readily available in people's care plans about any special dietary requirements such as a soft or pureed diet. One person's care plan had a report identified they required a specific textured diet and we saw that this was provided correctly. Staff said, "We monitor people carefully" and "We weigh people monthly as the norm but if weight loss is noticed we weigh weekly." This was supported by the weight records available.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. There were both baths and showers available so people had a choice. People were supported to move around the home and were assisted to remain mobile by staff. Communal areas and most corridors were suitable for people who used wheelchairs. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using electrical hoists. The lift enabled people to access all parts of the home. The garden areas were safe and accessible to people who lived at Avalon. People had personalised their rooms with pieces of furniture and photos of relatives and pets.

Good

Is the service caring?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People, relatives and visitors gave positive feedback about the care provided at Avalon Nursing Home. Comments included: "Staff are kind", "Staff are kind and respectful" and "If I asked, they would take me to the dayroom." "The staff are very good, kind", "We are all well looked after" and "No problem having a bed-bath when I want it."

People were observed to be comfortable around the staff. Staff spoke to people in a friendly and respectful way and people responded to staff in a positive way.

Staff promoted people's independence and involved people in their care and lifestyle decisions as much as possible. There was evidence of commitment to working in partnership with people, which meant that people felt consulted, listened to and valued.

People's individual equality, diversity and human rights were respected because staff had completed training and put their learning into practice. People did not experience harassment or discrimination, their rights to family life were respected and they were supported to maintain their personal relationships. This was based on their choices and staff understanding of who was important to the person, their life history and where appropriate their spiritual and cultural background. Visitors were welcome at the home. One person told us, "My visitors can come at any time. My relatives live close by and visit frequently, they also take me out." A visitor said, "I know that there aren't really any restrictions I know I can come at any time. I'm always made to feel very welcome, not just by the staff, but by other residents, who are getting to know me." Staff understood the importance of involving family and friends in people's care. One staff member told us they extended the care provided to people to their relatives. For example, discussing their welfare and ensuring they had the appropriate support at home. One visitor said, "I can come in whenever I want. I can have a meal here if I wanted. Everyone knows me and they make me feel very welcome. I'm always offered a drink or I can go and make one for myself." People were supported to meet their spiritual needs. People who were able, were supported to attend church each week. For those who were unable, or chose not to, staff held a church service at the home.

People were treated with dignity and respect. People were supported to maintain their own personal hygiene and maintain their independence. People were well presented and dressed in clothes of their choice and in their own style. Staff complimented people on their appearances and the clothing they were wearing. Where appropriate people were supported to wear jewellery and make-up if they wished to. People's bedrooms were personalised with their possessions such as personal photographs and mementos. This meant, as far as possible, people's bedrooms were individual and homely. Staff knocked at people's bedroom doors before entering. One person told us how staff supported them with their continence. They said, "It's very personal and it's done so discreetly. They always knock before they come in and they'll always ask for consent before they do anything. They wouldn't do anything without asking if it's okay to do it."

People could express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

People had detailed care records in place to ensure staff knew how they wanted to be supported. These were recorded on a computerised system and were accessed by staff on hand held electronic devices and computers. Each staff member had their own log in details, which ensured only staff with appropriate authority were able to access people's details. Printed information about people was stored securely to ensure their privacy and confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2017, this key question was rated as Requires Improvement because people did not always receive care that was person centred or that reflected their individual needs and preferences.

This inspection found that whilst improvements had been made there was still further work to be done to ensure that everyone received person centred care that was responsive to their individual needs.

At the last inspection we identified that improvements were needed to ensure care plans were personalised and contain the information necessary to support people. Improvements had been made but there were still areas that needed to be improved. For example, there were no personalised care plans for some people with epilepsy and what staff should do if a person had a seizure. There was also a lack of information in specific care plans in respect of guidance for bowel monitoring and constipation, visual and hearing impairment and choking. For example, Staff contacted the G.P for one person as bowels not opened since admission nine days previously. There was no further check for constipation until staff contacted the G.P.

One persons nutritional care plan identified that they prefer finger food as this had been successful in encouraging the person to eat. However, not all staff were following this instruction and the cook told us they were not aware finger foods were needed. Over the two days of inspection the person ate little and staff had not responded as directed in the care plan until prompted through discussion. The delay on the second day in responding to the persons individual need meant that they had to wait a further hour for their meal and then lost interest very quickly and little was eaten, placing them at risk from weight loss.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Whilst staff told us that they understood the importance of communicating with people in a way that met their individual needs, we found inconsistencies within people's documentation. For example, one person who was registered blind had a social care plan that stated 'to offer (name) daily 1:1 sessions as a minimum. Avalon to offer reading materials newspapers/magazines daily to prevent isolation and boredom.' It was not clear how this would be achieved given their disability. Another person also registered blind did not have any reference to the disability or a care plan that guided staff in assisting the person with their disability.

Within the social care plans there was a record of people's likes and dislikes but some important information had not been communicated to the kitchen or care staff. For example, one person who lived with dementia had a documented dislike of pasta; this was offered and given to the person during the inspection. Staff said the person had indicated that the pasta dish was what they wanted. However, the person was not able to make that choice. The person did not eat the meal. The staff and cook said they were not aware the person did not like pasta.

The above issues are areas that require improvement. Following the inspection visits we received information that the above shortfalls had been immediately addressed. This included arranging training for

staff in AIS.
Before moving into the home, a pre-admission assessment was completed to ensure people's needs and preferences could be met at Avalon. These were completed, as far as possible, with each person, and where appropriate, their representative. Information from the pre-assessment was then used to develop care plans and risk assessments. These were regularly reviewed and updated as people's needs changed. Staff were updated about changes to people's care and support needs at each shift handover. A handover sheet was in place which provided staff with an overview of people's support needs, for example mobility and dietary support.

There was an electronic care planning system for all care plans, risk assessments and daily notes. They were accessible to staff via computers and a hand-held device. Care staff recorded the care and support people received on this system. People's care plans, assessments and risk assessments had been reviewed and updated regularly.

Care plans included information about people's needs in relation to personal care, mobility, pressure area risks, nutrition, health and personal preferences. People received care that was person-centred and reflected their individual choices. Staff knew people well; they had a good understanding of them as individuals and were able to tell us about people's daily routines, care and support needs, choices and interests. Staff responded to people's needs appropriately. This included support with mobility and at mealtimes. Regular position changes for people who were at risk of pressure damage and support to maintain appropriate continence. Where pressure relieving mattresses were in place there was information about the setting and these were seen to be correct.

Registered managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. We looked at the care plan for one person who was approaching end of life care. The documentation had reflected care had been adjusted for this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring food and fluids should be offered regularly in small amounts. On discussion the RN stated, "We know we need to improve aspects of our care documentation and are continually doing so and end of life is one area we will be focusing on."

There were specific staff employed to organise and facilitate therapeutic activities for people. There was a program of activities which people could take part in if they wished. This was displayed around the home to inform people what was happening each day. In addition, the activity team were working with people to develop individual activities and further improve the current activity program. There was mixed feedback about the provision of activities, we were told, "Not much entertainment, it was good, but not now" and "I do get out sometimes and someone pushes me around," "I don't mix much with the others," "No visits from anyone to entertain me in here (their bedroom)", "There is always something going on" and "My brother visits and we go out and he takes me to my hospital appointments" and "We do get out, like for coffee or the air show." Staff said, "We try to do a variety of things, including trips out." Staff said, "We try to accommodate all residents' interests and "We hold themed events from time to time and celebrate birthdays and special occasions such as Christmas and Easter."

During the inspection we saw a range of group and individual activities taking place. Staff told us that some activities may happen spontaneously. For example, decorating Christmas trees and puzzles.

There was a commitment to developing activities outside of Avalon. There was a mini bus and people told us of trips out which included going to the airshow and going out for coffee. These were sociable occasions which people told us they enjoyed. We were told more individual activities were constantly being developed but this was taking time as some of the staff were new in post. The staff member explained they had spoken with one person a number of times, asking if there was anything they would like to do or whether they would prefer to spend time. Over time the person informed staff they liked quizzes and staff were able to engage in one to one quizzes with the person which they enjoyed.

Staff knew people well and we saw people enjoying one to one interaction with staff. Staff demonstrated an awareness of people's individual personalities and responded to specific facial expressions and body language. Signs of discomfort or agitation were picked up quickly by staff and responded to with patience and distraction techniques. Throughout the communal areas there were photographs on the walls showing group activities that had taken place at the service throughout the year. For example, visiting pets, birthday celebrations, Halloween and other occasions such as parties and BBQs.

Regular staff and resident/family meetings were being held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the kitchen team. The minutes of meetings were shared with people and families and were available in the home.

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log is kept and monitored by the registered manager. There was evidence that complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and displayed in the home which showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I have been asked to complete forms - I give feedback all the time."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2017, this key question was rated as Requires Improvement because there was a failure to consistently assess, monitor and mitigate the risks relating to the health, safety and welfare of all service users. This inspection found it remained Requires Improvement.

Following our last inspection the provider submitted monthly audits to CQC as a way of driving and monitoring improvement. The audits provided for CQC were based on areas that had been identified as needing improvement on July 2017. For example, the settings of pressure relieving mattresses. The audits had identified on three occasions mattress settings were incorrect and successfully reset to ensure they were working effectively. The audits however had not evaluated the reason why they were inaccurate and what other action had been considered. This was an area that required development to continually learn and drive improvement.

Quality monitoring systems had been developed since the last inspection supported by the computerised care system. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Some areas of concern had been identified and changes made so quality of care was not compromised. We saw that learning objectives were taken forward by the management team. However, some areas of care delivery were not accurately documented. For example, fluid records were printed off twice a day however at random times. It was not clear of the purpose of this. Senior Management said it was printed twice so that night staff could be updated and day staff could also be updated if someone was not drinking. However, as these were at random there was no clear plan of what was being audited. Some were highlighted, some stated 'improved' whilst others had low intake of fluids but were not highlighted as a risk. The recording on handsets was inconsistent with some people getting 3000mls by 1 pm in the afternoon or having 2250 on one day but only 500 in total the next day. Following the inspection process we were informed the systems for monitoring fluids had changed and would be trialled for effectiveness.

Daily comfort round sheets where staff were to have hourly contact with the person being looked after, were not completed consistently. These sheets also evidenced if a drink had been offered and these did not reflect the data put in the handheld computer. This had been identified by the provider in December 2018 and the provider will be implementing changes to the recording system in January 2019. These will be reviewed at the next inspection.

These shortfalls identified that whilst the quality assurance systems had been improved there was a need to further improve and develop systems to ensure people received safe person-centred care at all times.
The registered manager told us that areas for improvement were on-going such as ensuring person centred activities were offered to people and care planning. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned, such as laundry service, activities and menu choices.

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-

occurrence. Call bell responses were monitored informally to ensure staffing levels were sufficient. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

Effective management and leadership was demonstrated in the home. The registered managers were knowledgeable, keen and passionate about the home and the people who lived there. The management team were open and transparent about the challenges they had faced, but were very proud of what the staff team had achieved in the past twelve months. They were committed to embrace the changes and continue to grow and develop the service.

The registered managers took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly by people and staff. The registered managers said their door was always open if staff, people and visitors wanted to have a chat with them. One member of staff said, "You're not going to get any better bosses." Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

The philosophy and ethos statement was 'Avalon Nursing & dementia Home is committed to meeting the needs of our residents by providing them with the highest level of person centred care in a home from home environment'. Staff of all denominations had contributed to developing values for the home. The values of the service included, 'Staff will treat you with respect and dignity, respect your rights, privacy and confidentiality, include you in any decision making and care planning, tailor care to meet your specific social, spiritual, cultural and health needs and offer range of services that encourage participation and inclusion'. One staff member said, "Our residents are all special and very different personalities." The registered managers and staff had a strong emphasis on recognising each person and their identity. The culture of the home had improved and staff were proud of their achievements and were committed to driving improvement.

Systems for communication for management purposes were established and included a daily meeting with the staff. These were used to update staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The senior staff are open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are involved in developing the service here", "I think the management is really approachable" and, "We feel listened to."

The management team had been working consistently to develop the support and care provided at the home. The registered manager said, "We are continually looking at ways to improve people's lives." All the staff spoken with were enthusiastic about their role in the service. One staff member said, "It's a good place to work, supportive and approachable." Another staff member said, "We get lots of training and are encouraged to develop our skills."

The service worked in partnership with key organisations to support the care provided and to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Really

good communication and they are pro-active when something needs changing, they ask for advice and listen." We were also told, "Very good communication with us, the staff are dedicated and committed."

Relatives felt they were able to talk to either of the registered managers and staff at any time and the relative's meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "I can talk to the staff and the manager is very kind, knowledgeable, so I have always felt listened to."

The provider was aware of the statutory Duty of Candour which aims to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The service had notified us of all significant events which had occurred in line with their legal obligations and displayed their CQC rating on their website.