Avonwood Manor Care Ltd

Avonwood Manor

Inspection report

31-33 Nelson Road
Poole
Dorset
BH12 1ES

Tel: 01202763183

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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?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

Avonwood Manor is a care home that provides residential and nursing care for up to 49 older people with mental health conditions or dementia. 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. At the time of this inspection there were 28 people living at the home.

There was a manager registered with CQC; however, before the inspection we were informed that the registered manager had ceased working at the home. An interim manager, who had been in senior role for the company, had taken over the management of the home a few weeks before the inspection. 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.

The inspection was unannounced and took place on 7 and 8 November 2017. At the last inspection in March 2017 we asked the provider to take action to make improvements in relation to dignity and respect of people, safe care and treatment of people, safeguarding, good governance and staffing levels. The service was rated 'inadequate overall' and was placed in 'special measures'.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are inspected again within six months of the publication of the last report.

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

During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures . However not enough time has elapsed to judge whether these will be sustained.

Improvements had been made so that people who had 'safe swallow plans' in place received safer care as staff were aware and following these care plans.

There was also better management of people's pain medicines so that people were kept free of pain. Other medicines were managed safely.

At the last inspection we judged that there were not enough staff deployed to meet people's needs. Since then, staffing levels have been increased and there was better deployment of staff across the building.

There was better monitoring of accidents and systems to make sure actions were followed up.

Staff were recruited in line with robust policies and all the necessary checks had been carried out.

People's needs had been assessed and risks identified in terms of delivery of care as well as safety of the premises. We identified a need to improve wound assessments and management and the manager arranged this for nursing staff before the end of the inspection process. We also identified a need for better compliance when monitoring forms were put in place to make sure aspects of care were followed through, such as fluid and food monitoring and repositioning of people to prevent pressure ulceration. Some improvements were required with regard to infection control.

At the last inspection we found the Mental Capacity Act 2005 MCA was not being complied with. Again, we found improvements, with conditions complied with where people were deprived of their liberty. People could make their own decisions or were supported by staff with the principles of the MCA complied with.

Staff were better supported though indirect and formal supervision than at the last inspection.

The home was working collaboratively with health services so that people's needs were met.

The premises had been adapted with signage to facilitate better care of people living with dementia. Some areas of the home were still in need of redecoration or refurbishment.

The home provided a good standard of food with people having choice of what they wanted to eat and their individual needs catered for.

Staff were kind, caring and compassionate in their interactions with people. At the last inspection we identified several issues where people were not treated in a dignified way and not treated compassionately. At this inspection there was one instance where staff failed to close a door compromising the person's dignity.

The home was in the process of moving to electronic record keeping. Despite this change care plans were up to date, reviewed and used by staff to inform on how to care and support people.

People were provided with individual and communal activities to keep them occupied.

Complaints were responded to and the procedure was well-publicised.

People were consulted, or their relatives, about wishes and preferences for end of life needs.

Since the last inspection, the registered manager had ceased working at the home and a new manager had taken over management responsibilities. The new manager had continued to implement the action plan and staff felt there was a more open, supportive culture that had improved the morale of staff to the benefit of people living at the home .

There were auditing and monitoring systems being followed seeking overall improvement.

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

Action had been taken to improve safety but some improvements were still needed.

Checks were undertaken before staff started employment to ensure they were competent and suitable.

Staffing levels had been increased and now met people's needs.

Overall medicines were managed safely.

Is the service effective?

Requires Improvement

People's needs were met effectively but some improvements were needed, particularly in assessment, identification and treatment of wounds.

The service was now complying with principles and requirements of the Mental Capacity Act 2005.

Staff were suitably trained and supervised.

People received a good standard of food.

Is the service caring?

Good

The service was caring.

Staff treated people with warmth and compassion.

Care staff knew people well and responded when they might need assistance.

Is the service responsive?

Good

The service was responsive.

Care plans were in place and were up to date and accurate.

Activities were provided communally and individually.

People's end of life needs were identified.

Is the service well-led?

Good

The service was better managed.

There was a more open and responsive management culture.

There were systems in place to monitor and bring about improvement.

Avonwood Manor

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The aim was to also look at the overall quality of the service, review the improvements as had been agreed following the last inspection and to provide a rating for the service under the Care Act 2014.

At the last comprehensive inspection of the home, carried out in March 2017, the home was rated as 'Inadequate' with six breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. A Warning Notice was issued in respect of Regulation 9 (Person Centred Care). A subsequent Focused inspection was carried out in July 2017 to follow up on the Warning Notice, when requirements of the Notice were found to be met.

Before the inspection we reviewed the information we held about the service. This included a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also liaised with local authority and health commissioners to obtain their views.

On the first day the inspection team comprised two inspectors and a specialist nurse advisor. The second day of the inspection was carried out by two inspectors. The interim manager assisted us on both days of the inspection as well as the registered nurses on duty and the residential manager. We also spoke with three health care assistants, the two activities coordinators, the chef, seven people who lived at the home and three visiting relatives. We also used the Short Observational Framework for Inspection (SOFI) as many of the people living at the home were not able to relate their experience of the home to us. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition, we made general observations, including watching the delivery of care in communal areas. We viewed three people's care records in depth as well as sections of a further eight personal files. We reviewed everyone's medicine administration records, three staff files, staff rotas for the past month and other records relating to training, supervision of staff and management of the service.

Requires Improvement

Is the service safe?

Our findings

Relatives and people we spoke with had no concerns about safety issues . A relative told us, "Overall. I am very happy and have no complaints. A person told us, "The nurses are brilliant".

People were protected against the risks of abuse because staff had all received training in this area. The provider ensured that they received regular refresher training. The staff had a good understanding of what constituted abuse and how to make referrals should they have any concerns. The importance of safeguarding was reinforced by information, including how to report concerns to the local authority or police, being clearly displayed around the home.

At the last comprehensive inspection the failure to ensure 'safe swallow' plans were followed compromised the safety of people who were at risk of choking because of swallowing difficulties. At this inspection care plans, as well as notices within people's rooms and the handover sheet consistently informed staff of people at risk and the actions needed to make sure their fluid and food was appropriate for them. Staff had adhered to the care plans and people received the correct diet and consistency of prescribed thickened fluids. The fluid thickener was stored away from people appropriately as this product has been known to cause serious harm if ingested. A denture cleaning product, which has also been known to be harmful to people when ingested was removed from a person's room when we brought this to the attention of the manager. (This product was most likely to have been brought in for the person by their relative, unbeknown to the staff because staff were aware of the dangers associated with such products).

At the last comprehensive inspection we identified other hazards to people's safety such as trip hazards from trailing leads, pressure mattresses not being set to correspond to people's weight, and some dirty equipment. At this inspection we found management had addressed these concerns and there was a system in place to assess health and safety risks through a monthly audit of each person's room. Following a walk around the home, we brought to the attention of the manager an electric wall socket that had become loose at the wall. The manager took steps to make this safe.

Where there were particular personal risks for people, such as the use of bedrails or a risk of choking because of swallowing difficulties, specific risk assessments had been developed. We saw that where bedrails were in use, a risk assessment was in place. The records of one person noted they had been observed trying to get their legs over the top of the bedrails. This presented a further risk of significant injury should the person climb over the top and fall from height when the carers were not present. It is recommended that alternative strategies be considered in these circumstances other than 'staff to monitor the situation'.

With respect to other safety considerations, the management had made the home as safe for people as possible to comply with legislation and guidance. The premises had been risk assessed to identify hazards and to minimise the risks to people. Freestanding wardrobes had been attached to the wall to prevent the risks of being pulled over, window restrictors were fitted to windows above the first floor and radiators were covered to prevent scalds and burns. Portable electrical wiring had been tested and the fire safety system

inspected and tested to the required intervals. The home had contracted with an external company and met water regulations. Emergency plans had been developed for the event of situations such as loss of power or heating. Certificates seen showed that the home's boilers, wheelchairs and hoists, the lift, electrical wiring were tested and maintained for safety.

The home had systems in place to maintain infection control standards with a senior member of staff delegated as lead for the prevention and control of infection. This member of staff had an advanced infection control certificate, as well as one of the activities coordinators. They told us they worked to the Department of Health Code of Practice on the prevention and control of infections as well as NICE guidance. These documents had been used to develop the home's policies and procedures. We spoke to one of the domestic staff who told us, "We all work so well as a team now. I like to help as much as I can and I'm part of the health and safety and Fire Marshall team". The infection control lead told us that regular infection control audits were carried out as part of their role. We did however identify some areas for further improvement. For example, in some areas of the building there were urine odours. When first arriving into the home and in some bathrooms it was particularly strong and one person's room had an odour throughout the inspection. We observed that no gloves were used to apply a plaster to a person's bleeding finger and hand gel was used to decontaminate when hand washing was advisable. A suction machine kept in a person's room was not clean. A shower chair on the first floor had a few rust patches on the base and one mattress was noted to have a damaged cover exposing the mattress. The manager agreed to take action to address these issues and confirmed in writing after the inspection that the shower chair had been removed and another purchased .

At the last comprehensive inspection actions were not followed through to minimise the incidence of accidents and incidents. At this inspection records showed that there was more robust scrutiny and monitoring of accidents and incidents to reduce likelihood of their recurring. For example, a new infra-red alarm had been put in place for a person who had experience a fall in their room. The use of this alarm had been reviewed to make sure it was the most suitable to support this person .

The home was in the process of transitioning to an electronic record keeping system. Overall, we found that people's records were up to date and accurate and the transition was reported to be going well. There was still room for improvement of monitoring records despite regular auditing of these by management. Staff were recording food and fluid intake of everyone in the home. Although there was no evidence that people were not having enough to eat and drink, some of the records were inconsistently completed with gaps and sparse information. Some people, because of poor health or wounds needed closer monitoring than others in more robust health. There seemed to be no distinction and understanding of when to monitor people more closely. Following the inspection, the manager informed us of tighter monitoring system that they had put in place. Care team leaders and registered nurses would check the monitoring charts at set times of the day to make sure they were completed accurately.

At the last comprehensive inspection we found the levels of staffing provided were insufficient to meet people's needs. We also found that when there was short notice absence of staff, their shifts were not always covered so that staff were under even more pressure in supporting and caring for people. We found significant improvement over both days of this latest inspection. Staff made comments, when asked about staffing levels, such as; "I used to hear all the time that we were short staffed, but that hasn't been the case for a while now…we have enough staff on shifts although we are in the process of recruiting permanent staff" and, "The staffing levels are fine; everything is good here now and things run much smoother". We were also told that short notice absences were now covered by the home's staff or agency staff if this was at all possible.

'Dependency' tools were used to assist in determining staffing levels, taking into account the geography of the building. At the last inspection staffing was divided into two sections of the building. The manager told us that the building was now separated into three staffing areas that mapped the geography of the building. (The home is comprised of two older properties adjoined by a newer middle section). If one particular area was busy, staff from another area helped their colleagues. This system was reported to be working well. Another change to staffing was the introduction of 'activities companions'. Their role is to support the two activities co-ordinators to make sure people had individual time to engage in conversation, to check on their mental well-being, as well as freeing the care workers to focus on meeting people's care and support needs.

Management had followed robust recruitment procedures to make sure that suitable staff were employed at the home and all the required checks had been carried out with records in place. These included, a photograph of the staff member concerned, proof of their identity, references, a health declaration, a full employment history with gaps explained and reasons given for ceasing employment when working in a care setting. A check had also been made with the Disclosure and Barring Service to make sure people were suitable to work with people. There was also a system to make sure new members of staff did not start work until all the procedures and record collection had been concluded.

We required improvements at the last comprehensive inspection as we had found significant gaps in people's medicines records and people were not always getting pain relief medicines they required. At this inspection, overall, peoples' medicines were managed and administered safely. The home had suitable storage facilities and these were noted to be locked at all times maintaining safety of medicines. Staff who administered medicines were appropriately trained and had their competency assessed. On the day of inspection a new trained member of staff was observed to be practising under supervision pending a competency assessment and told us they had completed 'half a dozen' supervised drug rounds as part of her induction. Staff responsible for medication management wore red tabards to try and reduce the number of disruptions during the round.

There were systems to monitor the temperature of the room where medicines were stored. There was some inconsistency of monitoring the storage temperature, however; recorded temperatures were within recommended guidelines.

Staff consistently and correctly completed medication administration records (MAR) with any omissions noted as to why on the MAR chart. For people receiving medicine patches there was separate documentation to aid staff with location of patches and when these were applied.

Protocols were in place to advise staff of how and when to consider offering people medication that was prescribed on an as and when basis.

With the registered nurse, we audited some medicines held at the home. Storage and management of these met all legal requirements and guidance.

Some people, under a 'best interest decision' of the Mental Capacity act 2005 (MCA) needed to have medication administered covertly (disguised in food/fluids). Authorisations from the pharmacist and GP had been obtained to make sure this was safe for people.

We identified a few areas for improvement. There was inconsistency with documenting carried over stock, in particular the use of thickener and supplements. Without a robust audit trail and reconciliation there was a risk of medication running out or overstocking. There was one missing GP authorisation for a person who

had covert medicines. Following the inspection the manager wrote to update us that she had reviewed all seven people who required covert medication and contacted the GP about two people. She also confirmed that mental capacity assessments and Best Interest documents were in place. A system was to be introduced to check stock of thickener and supplements half way through the prescription cycle as part of medicines auditing.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection we required improvements in the delivery of people's care. We had found one person in bed with dried faeces on their hands, a person whose catheter was full and some people not re-positioned who needed this intervention. At this inspection we found the manager had put more robust systems in place, coupled with more staff, to make sure that people's care and support was delivered more effectively but the need for further improvements was identified in some areas.

Before an admission was agreed, a senior member of the staff carried out a preadmission assessment of a person's needs to make sure their needs could be met. This was evidenced within people's care records.

Once agreed and someone moved into the home, staff completed a range of more in-depth assessments with that person or their representative. The assessments covered a spectrum of conditions and risks commonly associated with old age; such as, personal care needs, continence, risk of falls, communication, skin care, medical and social care needs, nutrition and hydration as well as people's needs in relation to them living with dementia.

People's weight was monitored and there was evidence that action was taken in the majority of cases if there were issues. However, there was one person who had wounds and was diabetic about whom we had some concerns. They had lost 10kg over a three month period and although the GP had been informed the previous day, there was no evidence available to confirm that they had been commenced on a fortified diet or receiving a high protein to aid wound healing. The food chart could have been completed more robustly to monitor dietary intake and their care plan should have been updated to reflect they were nutritionally at high risk. This was an area for improvement. We fed this back to the manager who agreed to take action to address this.

At the beginning of the inspection the manager, when reviewing progress and planned improvements, told us that a nurse trainer had started to work alongside the nursing team to raise the skill set of the registered nurses. Our findings in relation to wound care supported this action.

There was an effective system in place for reviewing wounds at set times, however; we recommend improvement in the initial recording and assessment when wounds are identified. This was because skin tears 'found' on people did not have the cause identified within documentation and if the cause was unknown, there should have been some investigation to rule out any unsafe practices.

Wound assessment could also be more robust to monitor whether the wound was healing and if current treatments were effective. Wound dimensions were not recorded and there was inconsistency with recording assessments at each dressing change. Wound management care plans could have provided more detail to reference to infection control practice or the action staff should have taken in the event of a wound deteriorating. Reposition records indicated that one person was being repositioned onto the site of the wound which could have caused further deterioration of the wound. When discussed with the nurse they were unable to advise of alternative ways to manage this. We discussed our findings with the manager who

agreed to provide further training to the nursing team. Following the inspection the manager wrote to us to inform that specialist would care training had been put in place from an external provider. They also confirmed that this person had been referred to the GP and closer monitoring of the person's skin integrity and nutritional intake was taking place.

At the last comprehensive inspection we identified staff supervision could be improved. Staff felt much more supported at this inspection. Not only had the frequency of formal one to one supervisions increased in line with the home's policy, staff felt improvement was down to the change in management and management approach. They made comments such as: "I feel listened to and the supervisions are very supportive, they help me"; "We all work well now; everyone seems much happier and better at working as a team. I feel well supported. They are flexible when I need shifts off"; and, "We are well supported with daily meetings and regular supervision meetings. The handovers are really good, we are all involved; it's been good".

As we found at the last comprehensive inspection the management had a system in place to make sure people received training they needed in order to meet people's needs effectively. Training records showed that staff had received training in essential areas such as; health and safety, infection control, manual handling, safeguarding, first aid, food hygiene safe administration of medicines, dementia and fire safety. Staff confirmed that they received appropriate induction. A care worker, new to care and therefore inexperienced in working with older people and people living with dementia, told us they had attended mandatory training. They had then had two weeks supervised practice before being allowed 'on the floor' independently. They felt they had received good induction. Staff new to care undertook the Care Certificate, the industry standard for inducting new staff.

We asked people and relatives about the standard of food and no one had any complaints or negative comments. People's comments regarding the food were recorded daily in a book, which were all positive.

Records showed people's dietary needs were assessed and catered to. The chef was knowledgeable about people's dietary needs including what foods they particularly liked. The chef told us, "I'm now very involved with people's meals. We plan the menus in a four week cycle, roughly sticking to the different seasons. I'm well supported in my role and I love it. I'm shown the surveys that get completed for people regarding what foods and meals they like and we go from there. There is always choice for everyone and I make snacks daily such as cake and biscuits as well as fruit and ice cream being available if people want something different." All meals were prepared in the kitchen and were cooked using local fresh produce.

The dining area was attractively laid out with fresh flowers, tablecloths, place settings and condiments. Pictorial menu cards were displayed on each table to assist people with the menu choices. People were able to choose different meals if they did not like what was on the menu, choices included, eggs on toast, curry, chilli, jacket potato or a variety of salads.

We observed a lunchtime period. Soft background music was played and staff discreetly supported people who needed assistance with eating and drinking. Staff took the time to make sure they had eye contact from people and waited until they indicated they were ready for the next mouthful of food before giving it to them. A few people asked for second helpings, which were given and staff ensured the food was still hot. We asked one person if they had enjoyed their meal, they replied, "Oh yes, it's all very good." Another person changed their mind about what they wanted to eat three times. On each occasion staff checked what the person preferred to eat and went and got it for them straight away.

The provider has acknowledged that some areas of the home were in need of decoration and refurbishment

and there is a plan for these improvements. Some bedrooms have been redecorated since the last inspection and the manager told us how people had been involved in choosing colours for their rooms. Throughout the home specific dementia signage was displayed. This ensured people living with dementia could orientate themselves around the home safely. There were handrails and rest areas where people could stop and have a sit down if they needed. People's bed room doors were painted in different colours and had their names and their bedroom number clearly displayed. Each person had a memory box outside their bedroom door, where items that were meaningful to them were displayed. All these measures helped people living with dementia to recognise their own bedroom and maintain a level of independency in moving around the home. Light switches and toilet seats were in contrasting colours which enabled people to see them clearly and distinguish them from the surroundings.

At the last comprehensive inspection the home was non-compliant with The Mental Capacity Act 2005 (MCA). This 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. We had found that some people's capacity to make specific decisions had not been assessed and the 'best interests' checklist was not followed. We made a recommendation that staff receive further training. At this inspection we found improvements had been made the provider has properly trained and prepared their staff in understanding the requirements of the MCA. Mental capacity assessments had been recorded for specific decisions, such as not being able to consent to personal care or for medicines that people required. The assessments showed that the principles of the MCA had been followed and that any decisions made on behalf of people were the least restrictive. The manager had consulted with relatives to ascertain if there were any Lasting Powers of Attorney in place for people affecting decision making.

Staff understood the need to support and assist people in exercising choice and making their own decisions as far as possible. We saw a more experienced carer worker supporting another carer worker who suggested moving a person from one location to another. The more experienced care worker responded, "Ask the resident what she would like to do". A staff member also checked a that a person was happy with what was showing on the television. People were asked if they wanted to stay in wheelchairs or choose where they wanted to sit in the main lounge .

At the last comprehensive inspection the home was also non-compliant with respect to the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We had found there was no system for monitoring authorisations that had been granted by the local authority. Three people who had authorisations granted with conditions which legally must be complied with. The registered manager and staff were unaware of these conditions and therefore in breach of the MCA. At this inspection there was a robust system in place and the manager was able to tell us of authorisations that had been applied for, those granted with their expiry dates and whether any condition to people's restrictions had been made. Records showed that the conditions attached to four of the 15 people with DoLS in place were being complied with.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People had access to a GP, dentist and an optician and could attend appointments when required, with support from the registered manager if necessary.

Good

Is the service caring?

Our findings

At the last comprehensive inspection we required improvements as people were not always treated with respect and dignity including not always being treated in a caring and compassionate way. One of the reasons identified for staff not showing compassion was because they did not have time due to there not being enough staff.

Staff were very positive about improvements they felt had been made since the last inspection. One care worker told us, "I love coming to work, I am very happy with the standards of care we provide here".

At this inspection staff interacted with people in a positive way with kindness and compassion. A member of staff told us, "I feel the staff that are working here now are here because they care. We lead by example and guide and support people with subtlety it's very important to maintain people's dignity." Management had increased staffing levels to give staff more time but had also introduced the role of the activities companion whose role was to focus on well-being of people. In addition staff had been given guidance on how to effectively communicate with people. Staff were encouraged to engage with people before any task or interaction by using some prompts of open questions to open up communication. Each person had a communication component to their care plan that was personalised to their individual needs. Another tool staff used pictorial flash cards to see when people may need to use the toilet to ensure they were treated sensitively in communal areas.

We noted that when we spoke with staff they all knew people's needs, personalities and circumstances. Within people's care records was information about people's life histories that assisted staff in getting to know people.

At this inspection, staff and management had made improvements to promoting people's dignity. This was apart from one instance where a door was left ajar when a second member of staff went to assist another member of staff and the person's dignity was compromised. Following the inspection the manager informed that the room door, which did not close properly, had been repaired by their fire safety contractor ensuring the door closed correctly. They also informed that staff had again been reminded at handover of the importance of dignity issues.

Three dignity champions had been appointed and trained, who worked across the home as a team to raise and promote standards in how staff treat people with respect and dignity. The champions completed a dignity audit each quarter to ensure staff training was at an appropriate level. We spoke with one dignity champion who gave us examples of how they would challenge tactfully any incidences where a better approach could be taken to promote respect and dignity. The champions had set up 'Dignity Tea's', which provided people with an opportunity to put their views across about the running of the home whilst enjoying tea and cake. A recent adopted suggestion was for cream cakes and éclairs to be made available. One of the champions told us they were looking at compiling 'end of life boxes', which would incorporate people's good memories for them to use at that stage of their life. They also ran, 'Cake, coffee and a giggle', meetings for all.

Staff respected people's privacy. One example was where a care worker said to a colleague that they needed to close the office door as they wanted to make a phone call about a person in privacy. We also saw that privacy screens were used for moving and handling in the main lounges and a clinical procedure completed by nurses.

Relatives told us that they were free to visit at any time and were kept informed of changes in circumstances.

Good

Is the service responsive?

Our findings

Care plans had been developed from assessment tools and risk assessments as well from involvement of people and their relatives, where this was appropriate. As part of the assessment process the manager established whether any relatives held Lasting Powers of Attorney that would have a bearing on decision making should a person not have capacity with regards to specific decisions.

Overall, people's plans gave clear instruction to the staff and were person centred in their approach. For example, one person's care plan instructed, 'staff to ensure that a peaceful atmosphere is created by ensuring lights are dimmed and quiet is maintained, curtains to be drawn'; whilst another person's plan informed, '… likes two pillows under her head and either a blanket or a duvet'.

Care plans reflected the needs of people who we case tracked through the inspection and covered all aspects of a person's needs. We observed that people received care in line with their care plans whilst they were in communal areas, such as support to mobilise. People were clean and neatly presented, indicating that they had received any support they needed with personal care, including attending to their hair and make-up. Where people had specific or long term conditions there was a care plan detailing action staff should take. For example, there was a clear diabetic care plan in place which gave staff detailed guidance on what triggers to look for, how people presented when 'hyper' or 'hypo' and what normal blood glucose levels people had.

The home employed two activities co-ordinators and had introduced the role of activities companions to provide additional support. One member of staff told us, "The companion care roles have been brilliant." The companions start the day by checking people's room, making sure people were comfortable, have access to their reading glasses or hearing aids if necessary and have access to their call bell, as well as engaging with people through the day. This meant that people who did not engage in some of the group activities were not forgotten. The activities coordinators provided a range of communal activities as well as spending time with people individually.

By gaining life histories about people and by welcoming visitors at any time, the home supported people to maintain relationships meaningful to them. One of the activities coordinators told us that the provider had purchased a tablet computer for use in activities and so that people could make on line calls to relatives overseas.

The home had a well-publicised complaints procedure as this was displayed prominently in the home. A relative told us, "I have no complaints, my [relative] is looked after well here." The complaints log listed a small number that had been made since the last inspection. They had been responded to within the home's timescale for responding and had been resolved with the complainants.

People or their relatives, where this was appropriate, had been consulted about wishes for end of life care and what arrangements were necessary to meet any religious or other needs. The service was planning to develop end of life care by enrolling with the Gold Standards program for end of life care.

They used the butterfly system for highlighting to staff when a person was nearing the end of their life. This system ensures they are treated with dignity and peacefulness (if this was their wish), by placing a butterfly on their bedroom door staff are aware of the stage the person is at and can act with sensitivity around the area, such as, making sure they are not talking in loud voices.

Good

Is the service well-led?

Our findings

At the last inspection in March 2017 we identified a breach of Regulation 17. The quality assurance systems at that time failed to identify the issues and breaches of regulations we found at that inspection. Since that inspection the registered manager had ceased working at the home and an operations manager had taken over the running of the home.

Staff told us that this change had made a big difference to them and felt that the culture of the home had changed significantly. The staff we spoke with felt more supported in their role as well as there being clearer lines of accountability. Examples of comments included, "It has been so nice to feel valued, the manager checks we are all ok especially if we have had a tough day, there is always someone to go to for help." "Management is much better. Things run so much smoother. Residents are happier and it works really well". A member of staff told us that some staff who had left the home because the morale was low, were now seeking to return to Avonwood Manor.

The provider produced an employee's newsletter, in which the vision and values of the organisation were clearly communicated. Regular staff meetings were also held so that issues affecting the whole team could be communicated and staff had a forum to raise issues and suggestions with the management.

The manager also felt supported by the provider. They told us about weekly meetings with the owner of the company and heads of departments in the home where each set goals for the week ahead that followed up to make sure agreed actions were followed through.

Staff told us that the manager met with staff each morning so that issues could be communicated and resolved quickly. They also told us that the manager had an open door policy and could raise issues of concern or suggestions at any time. The manager also made sure they went around the home regularly so that they could talk and meet people living there. Throughout the inspection all of the staff, including the manager, were very acquainted with people and their histories and needs.

On the first day of the inspection, the manager was interviewing to fill vacant posts. More than one member of staff told us that they thought recent appointments were of people more suited and competent than had sometimes been recruited in the past.

There were systems in place to monitor the quality of service and to drive improvements. Since the last inspection, the manager was being supported by an outside consultant who visited the home once a month and carried out to audit processes and effectiveness of the service, as well as spending time supporting the manager.

The registered manager had notified CQC about significant events such as deaths and serious injuries. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

Although we found a more positive morale throughout the home and amongst the staff team, it was only a

few weeks since the new manager had taken over from the registered manager. There was therefore an insufficient period to judge whether improvements had been sustained.