HC-One Limited

Avandale Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

This inspection took place on 13 October 2013 and was unannounced. We arrived at the home at 9.30am and left at 7.30pm. The service met all of the regulations we inspected against at our last inspection on 9 December 2013.

Avandale Lodge is registered to provide personal and nursing care for up to 48 older people who have dementia. On the day of the inspection 45 people were living in the home.

Summary of findings

The home has single room en-suite accommodation over two floors. Each floor has two lounges, a dining area and bathing and toilet facilities. There is also a secure garden, which has seating and tables.

The home has a registered manager who has been in post since 2007. 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 experiences of people who lived at the home were positive. People told us they felt safe living at the home, staff were kind and compassionate and the care they received was good. Relatives told us they had no concerns about the way their family members were treated. Some of the comments from relatives included, "Mum is very safe here" and "We can rest easy knowing mum is safe and secure".

People were supported to have their nursing and personal care needs met. People spoke positively about the care and support they received. Comments included: "The staff are very caring"; "They're very good"; "They look after me". However, some people said they sometimes had to wait a while for assistance when staff were busy and staff confirmed this.

People received visitors throughout the day and we saw they were welcomed and included. People told us they could visit at any time and were always made to feel welcome. One relative said "Mum appears to be happy here and the staff always make us welcome".

The staff ensured people's privacy and dignity were respected. All rooms at the home were used for single occupancy, which meant that people were able to spend time in private if they wished to.

Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to help people feel at home. We saw that bedroom doors were always kept closed when people were being supported with personal care.

People remarked that the food was good. One person said, "The food's very nice. We get a choice and there's plenty of it".

People's needs were assessed and care plans were developed to identify what care and support people required, although some lacked detail. Information about any change in need was recorded in the monthly evaluation, but the care plan was not always updated to reflect the changes. The staff told us they had access to the care records and were informed when any changes had been made to ensure people were supported with their needs in the way they had chosen. However, staff also told us that they found the care files very repetitive, time consuming to complete and that it was difficult to find the information they needed quickly. This meant that people may be at risk of not receiving the appropriate care in the unlikely event there were staff on duty who did not know people's care needs.

There were regular reviews of people's health and the home responded to changes in need. People were referred to appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

People could choose how to spend their day and they took part in activities in the home and the community. The home employed one activity organiser who engaged people in activities in small groups during the day. However, we observed that several people were dozing in the lounges, particularly in the morning. Staff said they would like to be able to spend more time chatting to people and assisting them to pursue personal hobbies and interests.

Staff received specific training to meet the needs of people using the service and received support from the management team to develop their skills. Staff had also received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff spoken with were confident that any allegations made would be fully investigated to ensure people were protected.

People knew who to speak to if they wanted to raise a concern and there were processes in place for responding to complaints.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the systems

Summary of findings

in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

There were processes to monitor the quality of the service and we saw from recent audits that the service was meeting their internal quality standards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were safe because the provider had systems in place to make sure they were protected from abuse and avoidable harm. People said they felt safe and staff we spoke with were aware of how to recognise and report signs of abuse and were confident that action would be taken to make sure people were safe.

Recruitment records demonstrated there were systems in place to ensure staff employed at the Home were suitable to work with vulnerable people. There were enough staff to ensure people received appropriate support to meet their nursing and personal care needs.

Medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff received on-going support from senior staff to ensure they carried out their role effectively. Formal induction, training and supervision processes were in place to instruct staff and enable them to receive feedback on their performance and identify further training needs.

Arrangements were in place to request heath, social and medical support to help keep people well. People were provided with a choice of refreshments and were given support to eat and drink where this was needed. Where the home had concerns about a person's nutrition they involved appropriate professionals to make sure people received the correct diet.

The registered provider complied with the requirements of the Mental Capacity Act. The manager and staff had a good understanding of people's legal rights and the correct processes had been followed regarding Deprivation of Liberty Safeguards.

Good

Is the service caring?
The service was caring.

People were provided with care that was with kind and compassionate.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their families in order to provide person-centred care.

Good

Is the service responsive?
The service was not fully responsive.

Requires Improvement

Summary of findings

Systems were in place to assess and review people's needs. However, we found inconsistencies with the way information was recorded, which meant staff did not always have easy access to the most up-to-date information in regards to people's needs.

People said that sometimes they had to wait for assistance. Staff said they would like to have more time to spend with people to chat and help them pursue hobbies and interests. There was a range of activities available but this was not consistent across the home or throughout the day. People were able to access the community and see their families.

Complaints were dealt with effectively.

Is the service well-led?

Good

The service was well led.

The registered manager was well established and had managed the home for seven years. The staff were confident they could raise any concerns about poor practice and these would be addressed to ensure people were protected from harm. The provider had notified us of any incidents that occurred as required.

There were systems in place to make sure the staff had reflected and learnt from events such as accidents and incidents, whistleblowing and investigations. There was also a system in place for the service to learn from relevant best practice guidance. This helped to reduce the risks to the people who used the service and helped the service to continually improve and develop.

People were able to comment on the service in order to influence service delivery.

Avandale Lodge 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 13 October 2013 and was unannounced. We arrived at the home at 9.30am and left at 7.30pm.

The inspection was led by an adult social care inspector who was accompanied by another adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 looked at the PIR, reviewed all the information we already held on the service and contacted the local authority who funded the care for some of the people living there. No concerns were raised.

During our inspection we observed how the staff interacted with the people who used the service and looked at how people were supported during their lunch and throughout the day. We reviewed five care records, staff training records, and records relating to the management of the service such as audits and policies and procedures. We spoke with four people who used the service and relatives of eight other people who used the service. We also spoke with the registered manager and seven other members of staff. These included two nurses, one senior care assistant, three care assistants, the activity organiser and a housekeeper.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person, when asked, said "Safe? Yes, definitely!" Relatives told us they had no concerns about the way their family members were treated. Some of the comments from relatives included, "Mum is very safe here" and "We can rest easy knowing mum is safe and secure".

The provider had safeguarding policies and procedures in place to guide practice and staff training records showed that safeguarding training had been delivered to staff.

All staff, including agency staff, were given a copy of the whistleblowing procedure.

Staff that we spoke with told us what steps they would take if they suspected abuse and were able to identify the different types of abuse that could occur. They said they were confident about raising concerns with the manager and that appropriate action would be taken. One member of staff told us, "If I suspected something, I would report it to the manager. I did once and the person I reported didn't work here again". A more senior member of staff said "If I witnessed someone abusing a resident I would make the resident safe and reassure them, ask the abuser to leave the premises, inform the registered manager and refer the matter to the local safeguarding authority and possibly the police". The information held by the Care Quality Commission (CQC) and the local authority demonstrated that the registered manager followed the correct procedures when any alleged abuse was reported.

Individual risk assessments were completed for people who used the service. Staff were provided with information as to how to manage these risks and ensure harm to people was minimised. Each risk assessment had an identified hazard and management plan to reduce the risk. Staff were familiar with the risks and knew what steps needed to be taken to manage them. Where people had behaviours that challenged the service, management plans were drawn up to inform staff about what may trigger this behaviour and the best way to manage that person's behaviour to defuse the situation. We observed this in practice. One person became very angry when a member of staff suggested a bath and the staff member tried to calm them by talking quietly and gently. As this did not seem to be effective the staff member left the room but continually monitored the situation by watching from outside the room until the person became calmer. Later that day, when the person was more accepting of care, the staff member suggested a bath and the person agreed.

The provider consulted with external healthcare professionals when completing risk assessments for people. For example, where people had been identified at risk of choking because of swallowing difficulties, we saw that they had been referred to the appropriate health professional and the professional's guidance was followed by staff. Charts were on display in the dining rooms to guide staff on the different consistencies of food, such as soft, thick puree and thin puree. When the meals were delivered to the dining room a chart was provided for the staff stating what each person had ordered and what type of diet they required.

Staff took appropriate action following accidents or incidents. These were reviewed by the home's health and safety committee to make sure that steps had had been taken to minimise risk.

The manager told us that staff rotas were planned in advance according to people's support needs. They told us that although they used staffing ratios to work out the number of staff on each shift, people who used the service could be provided with additional support during the day to meet their needs should this be required. Staff said there were enough staff to keep people safe and provide for their basic personal care needs.

The home did not have a full complement of permanent staff, but the registered manager told us that the provider was actively recruiting. Agency staff were used to cover vacancies and the registered manager had arranged with the agencies for the same staff to work in the home on a regular basis in order to provide continuity of care for the people who used the service.

Records showed that all the necessary checks were carried out on staff before they were employed.

There were polices in place to make sure medicines were safely administered. Medicines were stored safely, securely and administered in accordance with prescriber's directions. We saw medication administration records and noted that medicines entering the home from the dispensing pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the home to know what medicines were on

Good

Is the service safe?

the premises. We checked some of the medicines in stock against the home's records and found them to be correct. Appropriate arrangements were in place for disposal of any unused medicines.

Some people were being administered medicines covertly. Covert administration of medicines is the term used when medicines are administered in a disguised form without the knowledge or consent of the resident receiving them (for example, medicines added to food or drinks). The covert administration of medicines may be necessary or appropriate in the case of people who actively refuse medication but who do not have the capacity to understand the consequences of their refusal. The manager had followed current best practice recommendations and a best interests decision had been made with the person's representative and relevant professionals to determine whether it was in the person's best interests for the medication to be administered covertly and there were instructions in place as to how this should be done.

The home was spacious and had appropriate equipment, such as hoists, to keep people safe. Equipment was checked and serviced at the required intervals and staff were trained in its use.

Good

Is the service effective?

Our findings

Relatives we spoke with said they were happy with the care provided. One visitor described the family's current experience compared to that prior to their relative coming to Avandale Lodge. They described how the manager and staff had focussed on their relative's needs and worked with the family to put plans in place to reduce incidents of behaviour that challenged the service. The visitor said there were still incidents, but these were managed much better and their relative was well cared for.

People received care from staff who were aware of their responsibilities and had the knowledge and skills to carry out their roles effectively. Induction training was provided to all new staff. This covered all the Skills for Care Common Induction Standards. Staff also shadowed more experienced staff until they were assessed as competent to work on their own.

Staff we spoke with were aware of their roles and responsibilities and had the skills, knowledge and experience to support people using the service.

The provider had a comprehensive training programme, which staff were required to undertake. This included a training package on dementia care called 'Open Hearts and Minds'. We viewed the staff training records and saw that 87% of the staff were up to date with required training. Staff were supported to continue with their professional development and we saw that care staff had completed national vocational qualifications in health and social care are. Nurses attended training organised by the Care Home Learning and Development Manager of East Cheshire NHS Trust in order to maintain their continuing professional development.

Records showed that staff received regular supervision and staff said the manager and deputy manager were very approachable and supportive, listened to their suggestions for improvement and acted upon them.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Staff were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had received training in these topics and had read the policies available. They were aware of recent changes in DoLS practice and were in liaison with the local authority to ensure the appropriate assessments were undertaken to ensure people who used the service were not unlawfully restricted in any aspect of their care and accommodation. People were not restricted to staying indoors. The entrances and exits to the home were locked and secure. The internal stairs had coded key pads. People's movements were restricted to keep them safe where it was assessed to be in their best interests in accordance with the Mental Capacity Act 2005. Staff did, however, assist people to access other areas of the home and grounds. People were able to go out with the appropriate supervision.

The people we spoke with said they enjoyed the food provided. One person said "It's not bad at all" and the others said "It's very good". We observed lunch being served. Staff offered assistance in a sensitive manner and people seemed to enjoy their meals. If people didn't want what they had ordered alternatives were offered. It was noted that there were no menus available in alternative formats to assist those with verbal or memory difficulties to make choices.

The care records showed that people had an initial nutritional assessment completed on admission to the home and people's dietary needs and preferences were recorded. Some people required special diets and the staff we spoke with understood people's dietary requirements and how to support them to stay healthy. Staff were also able to tell us what people's food likes and dislikes were.

People were weighed at least monthly to make sure they were maintaining a healthy weight. If anyone lost weight we saw that their care plan was reviewed and additional measures were put in place, such as weekly weights, offering food more frequently and offering a fortified diets. There was evidence that appropriate referrals were made to a dietician or GP for further guidance and advice.

Drinks were available throughout the day and we saw staff regularly asking people if they wanted a drink. Cold drinks dispensers were filled with squash so those that were able could help themselves. We saw that fluid intake charts were in place for those at risk of dehydration.

The care records showed that, when necessary, referrals had been made to appropriate health professionals. For example, one person had not been well and we saw that their doctor had been called and treatment had been given. Another person had mobility problems and they had been referred to a physiotherapist who had provided advice and equipment to aid mobility. Other health

Good

Is the service effective?

professionals consulted included opticians, dentists, dieticians, speech and language therapists and mental health professionals. A podiatrist and a GP visited on the day of the inspection.

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received. Comments included: “The staff are very caring”; “They’re very good”; “They look after me”. Relatives also expressed satisfaction with the care provided. One relative said “Mum appears to be happy here and the staff always make us welcome”. Another relative said “I visit every day and the care is superb!”

Staff we spoke with showed a caring attitude towards those in their care. One member of staff said they were taught to treat people who used the service like one of their own relatives.

We saw that people were supported with kindness, patience and compassion. We observed a member of staff comforting one person who was upset and observed another staff member assisting someone to the dining room. The person was at first reluctant to walk but the staff member knew the person liked music and put the radio on. The person then started dancing to the music on the radio and the member of staff danced and sang with them along the corridor to the dining room.

We also saw staff treating people with dignity and respect. When they provided personal care, people were discreetly asked if they wanted to use the toilet or to have a bath or shower. Staff always knocked on bedroom doors before entering and ensured doors were shut when carrying out personal care. Staff chatted to people who used the service while they moved around the home, and when approaching people, staff would say ‘hello’ and inform people of their intentions. For example, when helping one person prepare for lunch a member of staff approached them and said “Lunch will be here in a minute, can I put this apron on you?”

People’s life history was recorded in their care records, together with their interests and preferences in relation to daily living. Staff we spoke with were familiar with the information recorded in people’s files.

People’s wishes for end of life were also recorded and relatives confirmed they had been consulted about this. The registered manager and deputy were working with the local hospice to draw up a staff training package for end of life care for people with dementia.

Requires Improvement

Is the service responsive?

Our findings

We asked whether call bells were responded to promptly and people who used the service and visitors told us that they usually were. One person said, "They usually respond fairly quickly nine out of ten times unless they're too busy, which happens now and again." A relative said that people sometimes had to wait a while for staff to respond. Staff said they couldn't always respond to people's calls for assistance as quickly as they would like. They said they thought there were enough staff to meet people's nursing and personal care needs, but would like to be able to spend more time supporting people's social care needs and engaging them in activities they had a particular interest in.

On the day of the inspection we observed that one person waited over an hour until two members of staff were available to assist them to get washed and dressed. We raised this with the registered manager who told us that the provider had recently agreed to increase staffing by ten percent and showed us evidence that she was actively recruiting.

We observed that one person was sitting in a chair that had no cushion and she was observed to be slipping out. There was a risk that the person could develop pressure ulcers from the shearing action of frequently slipping down. Staff informed us that they were aware that she was at risk of slipping so they had removed the cushion some time ago following the failure of a non-slip pad to make a difference. This was brought to the attention of the registered manager who assured us that her care plan would be reviewed as a matter of priority and appropriate action taken to ensure her comfort and safety.

The service employed an activity organiser to support activities and entertainment for people who used the service. This person was very enthusiastic and also wanted to extend the opportunities for people to become involved in activities they enjoyed. We observed her interacting with six people in the activity room. Whilst people were waiting for lunch she played a CD of Frank Sinatra and encouraged people to sing. One person who had been slumped in their chair not interacting with anyone suddenly sat up straight and sang all the words of "My Way" and "New York New York". All the other people also appeared to enjoy the music except for one person who was becoming agitated. The activity organiser then suggested painting her nails which calmed her. The activity programme was displayed on the noticeboard and included board games, bulb planting, arts and crafts, cake decoration, armchair exercises and IPad games. The home had access to a minibus and there had been recent trips to a garden centre and a local animal sanctuary. However, there was little social activity and interaction in the morning on the upstairs unit. People in the lounge area were not able to occupy themselves and one person spent most of the morning asleep with his head on the table.

All of the care records we looked at showed that people's needs were assessed before they had moved in. They were reviewed again on admission and appropriate care plans were drawn up, although some lacked detail. For example, one person was noted to be at risk of self-neglect and would refuse staff intervention on a daily basis. The care plan and risk assessment did not detail what staff should do should this continue for a prolonged period and when staff would need to consider more proactive intervention. Discussion with staff indicated that the person lacked capacity around this aspect of their care but staff were able to tell us what actions they took, which were appropriate. However, the care plans lacked this depth of detail to direct any person who had no prior knowledge of how to care for this person.

Care plans were reviewed at monthly intervals or when needs changed. Information about any change in need was recorded in the monthly evaluation, but the care plan was not always updated to reflect the changes. For example, one person had become immobile since admission, and although the monthly evaluation reflected this, the care plan still said the person walked with a walking aid.

Relevant information about medication was recorded in the person's care file and not always with the medicine administration records. For example, when medication was prescribed as 'when required' the situations when it may be needed were not recorded on the medicines record. We spoke with the senior staff on duty who knew when these medicines should be administered but a new member of staff or agency nurse may not know under what circumstances to give the medication.

All the staff we spoke with were familiar with people's needs. The staff told us they had access to the care records and were informed when any changes had been made to ensure people were supported with their needs in the way they had chosen. However, staff told us that they found the

Requires Improvement

Is the service responsive?

care files very repetitive, time consuming to complete and that it was difficult to find the information they needed quickly. Handover between shifts was detailed in a diary but this only reflected the significant changes. There was no care summary as an easy reference for new or agency staff, but one of the staff we spoke with was an agency nurse who worked in the home every week and was also very familiar with people's needs.

We saw that visitors were welcomed throughout the day and staff greeted them by name. Visitors and relatives we spoke with told us they could visit at any time and they were always made to feel welcome. They said they were consulted about their relatives' care and the staff were responsive to requests. For example, one visitor told us that their relative did not like taking tablets so staff had contacted his GP and he was now prescribed patches and liquid medication, which had helped reduce his distress. This visitor also said "The staff listened to everything we said and then tried to provide everything to suit dad." Whilst we were there another visitor expressed concern that her mother's hair was not styled the way it used to be and a care assistant offered to see if the hairdresser could fit the lady in that afternoon.

We observed the manager in various parts of the home throughout the day speaking to people who used the service, staff and relatives. She knew them all and was welcoming to all the visitors. One relative commented, "The manager and supervisors are all very professional. Most of the staff are good". Another visitor said "It's a well-managed home". The visiting hairdresser was full of praise for the staff, the manager and the atmosphere in the home and said, "I've been coming in here a long while and I'd let my mum come here if she needed care".

Visitors told us they felt they were consulted about the service and relatives' meetings were held about every three months.

People told us they were aware of how to make a complaint and were confident they could express any concerns. One relative said she had raised a concern about the cleanliness of her mother's room and it had been dealt with straight away. We looked at the complaints file and saw there had been three complaints made about Avandale Lodge. Responses contained information on how they had been investigated and any action the home had taken to resolve the issue and improve the service.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post for seven years. She was supported by a deputy manager. People and their relatives knew the management team well, saw them often and told us they felt comfortable speaking with them. Staff told us their managers were approachable, valued their opinions and treated them as part of the team. They said they felt well supported and could easily raise any concerns and were confident they would be addressed appropriately. One staff member said "Best job I've ever had".

Staff meetings were held on regular basis and issues of concern noted and addressed. Four staff we spoke with told us they were informed of any changes occurring within the home through staff meetings, which meant they received up to date information and were kept well informed.

The provider had a good quality assurance system and evidence was provided that recent checks had been carried out. We saw evidence that the manager undertook audits of the service. These included health and safety audits and care audits as well as a 'walk around' of the building each day making observations of care practice and the environment.

The provider had its own quality inspection team that had inspected Avandale Lodge unannounced in February 2014 and given it a green (good) quality rating. One of the provider's quality assurance managers also visited the home monthly to carry out an audit.

We were provided with evidence of a computer based system that allowed all accident and incidents within the service to be reported electronically for immediate analysis. This enabled the provider to identify if there were any patterns to accidents and to review how risks to people who used the service could be reduced. Incidents and accidents were also reviewed at health and safety committee meetings. The provider had key performance indicators for safeguarding, pressure ulcers, weight loss, falls, bedrail usage, infections and hospital admissions. These were also audited monthly.

We had been notified of reportable incidents as required under the Health and Social Care Act 2008.

The provider sought feedback from the staff and people who used the service through questionnaires. Visitors we spoke with confirmed they had been consulted about the quality of service provision and could provide this information anonymously if they wished to. The manager said that, where any concerns were identified, this was discussed with people who used the service and their relatives and improvements made. One relative described an occasion when the family had contacted the chief executive of the company providing the service and said they had been very pleased with the response they received.

The registered manager attended a dementia steering group, which had been set up by the provider to look at best practice in dementia care and implement improvements in dementia care within the organisation. The registered manager told us that, as a result of this, the provider had funded some improvements to the environment at Avandale Lodge to enable people to more easily find their way around the home, and further improvements were planned.

The registered manager also told us about a support group she attended away from the home for relatives of current and past residents of the home. She said that the group was also attended by members of the local Alzheimer's Society and that she had recently engaged the group in looking at how the admissions process could be improved.