Avon Lea Weymouth 2015 Limited

Avon Lea Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visits took place on 6, 9 and 13 February 2017. Avon Lea Nursing Home is a purpose built home, over three floors, registered to provide care for up to 40 people in a residential area of Weymouth. At the start of our inspection there were 23 people living in the home.

The service did not have a registered manager at the time of our inspection. The last registered manager had resigned in February 2016 after a period of absence which we were notified started in November 2015. The nominated individual had started managing the service in December 2016 and planned to apply to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Avon Lea Nursing Home had been through a sustained period of management change when we inspected in March 2016 and there were breaches of regulation related to how people were supported in a personalised way and how risks were managed. The provider sent us an action plan and told us they would be compliant with regulations by August 2016. At our recent inspection we found that the period of management change had continued and improvements achieved were not sufficient.

People were not always protected from harm because staff did not fully understand the risks they faced. People's care plans were not always followed and care records were not always accurate. This increased the risk that people could receive inappropriate or unsafe care. People did not always receive their medicines as prescribed.

Staff were committed to providing personalised care for people living in the home and supported each other to achieve this. However, systems to ensure the quality of care were not always embedded and there was a lack of consistent management oversight. This meant that monitoring was not adequate to review care practice effectively to ensure it was safe. Medicines and care delivery were not effectively monitored and as a result people were receiving inappropriate and unsafe care.

Staff had not consistently read people's care plans which put people at risk of receiving inappropriate care. Care plans had been updated but were not always accurate and had not always involved the people to whom the care plan related.

People did not always receive care that reflected their preferences and was based on information known about them. We have made a recommendation asking the provider to review communication approaches used by staff with people with dementia.

The home looked and smelled clean in most areas. However, we observed that some practice did not reflect

current guidance for good practice in infection control.

People told us the food was good. We observed that meal times were not promoted as an opportunity for choice and socialising.

There were enough staff to meet people's needs during our inspection however we were made aware that there had not been enough staff for people to get up at the weekend in between our visits. Staff and the owners told us this was an unusual occurrence.

Where people needed to live in the home to be cared for safely and they did not have the mental capacity to consent to this Deprivation of Liberty Safeguards (DoLS) had been applied for. Care plans reflected the principles of the Mental Capacity Act 2005 and promoted people's ability to make decisions about their care. However, staff sometimes missed opportunities to promote choice.

Health professionals told us that liaison with the staff in the service was improving. This meant people saw appropriate professionals in a timely and appropriate manner. People felt confident they saw health professionals when necessary.

Staff were safely recruited, felt supported and knew how to identify and respond to abuse. People were at a reduced risk because staff knew how to report potential abuse appropriately.

People were engaged with a wide range of activities that reflected individual preferences, including individual and group activities.

People and their relatives were positive about the care they received from the home and told us the staff were compassionate, kind and attentive. Staff treated people, relatives, other staff and visitors with respect and kindness throughout our inspection. Relatives told us they felt able to raise concerns.

There were breaches of regulation relating to the management of risk, person centred care and the oversight of the service. You can see the action we asked the provider to take at the back of the full report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were supported by staff who did not understand all the risks they faced.

People did not always receive their medicines as prescribed.

There were usually enough staff to meet people's needs.

The home was kept clean but staff did not always follow good infection control practice. This meant people were at risk of infection.

People were protected by staff who understood their role in keeping them safe.

Is the service effective?

Requires Improvement

The service was mostly effective. People enjoyed the food but were not supported to enjoy positive mealtime experiences.

People were cared for by staff who felt supported but induction training and formal supervision did not reflect good practice.

People had access to healthcare and health professionals identified improvements in partnership working.

Decisions about people's care were made within the framework of the Mental Capacity Act 2005.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

Is the service caring?

Requires Improvement

The service was not always caring. People were supported by staff who were caring in their approach but did not always offer choice.

People with dementia were not communicated with in a consistent manner.

People's dignity was not always supported. Information about people was left visible from a communal area.

Is the service responsive?

Requires Improvement

People received care that was sometimes responsive to their individual needs. Care plans were not all accurate and staff did not understand the information held in these records..

People were able to take part in varied activities.

People and their relatives were confident they were listened to and complaints were responded to effectively.

Is the service well-led?

Inadequate

The service was not always well led because systems in place to monitor and improve quality were not effective in ensuring positive change.

The organisation had the confidence of people and staff following a period of management change.

Avon Lea 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.

The inspection took place on the 6, 9 and 13 February 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We also looked at information we received in the provider information return. 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.

During our inspection we spoke with ten people who used the service and six relatives. Some of the people living in Avon Lea Nursing Home no longer used words to communicate, we spent time in communal areas and observed how staff supported and spoke with them. We spoke with nine members of staff, the owner/manager and the other owner. We reviewed records related to 14 people's care. We also looked at records related to the running of the home including: four staff files, management audits, accident and incident records, training records, staff and resident meeting records and records relating to compliments and complaints.

We spoke with two social care professionals and four health care professionals who had worked with the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection 23, 29 and 30 March 2016 we found a breach in regulation as the risks people faced were not adequately assessed, monitored or reviewed. At this inspection we found sufficient improvements had not been made and people continued to be at risk of harm as staff did not always have a consistent understanding of how to support people safely.

People were at risk of harm associated with eating and drinking. Eight people had safe swallow plans written by Speech and Language therapists, three of these plans were not being followed by staff putting the people at risk.

One person's safe swallow plan stated that they should not drink from spouts or straws. We observed that they had two drinks with straws in front of them. We spoke with a member of staff who told us the person used straws to drink. We also observed a staff member go into the room to give them a drink with a spout. We asked them if it was safe for the person to drink from a spout. The staff member told us it was ok and it was best as they sometimes dropped or threw their drink on the carpet. We suggested that they should not give the person the drink that way and that they should check the person's care plan and risk assessment.

A further person's plan stated that they should eat in a distraction free environment. We saw they were supported to eat in a noisy environment by a member of staff who was talking with another member of staff. These people were being put at risk of harm because guidance was not being followed.

Records relating to people's dietary needs contained conflicting information. For example, one person had a safe swallow plan stating they needed a soft diet. There was also an undated care plan in their records stating they had: "a normal diet". We saw that this person received a diet in line with their safe swallow plan, however, this lack of clarity put the person at risk of receiving foods that would not be safe for them to eat.

Another person had records that related to a safe swallow plan but there was not a copy of this in the kitchen or in their care plan. It was not possible to check if the diet they were following was appropriate. One person's safe swallow plan stated that they should have a soft diet, be fully awake to eat and should be monitored whilst eating. We saw that they had been left asleep with a sandwich with sliced cheese and tomato and bourbon biscuits on their bedside table. A record had been made by the member of staff that had left the sandwich stating: "Lunch given very sleepy." We spoke with five care staff, the owner/manager and the chef about this person; they did not have a consistent understanding of the diet this person should have. For example one member of staff said they should follow a soft diet and other staff said they followed a normal diet. The chef told us a nurse had told them they could now follow a normal diet but should be supervised. We saw that the risk information available about this been changed between our first and second visits. They told us the information saying they ate a normal diet had been in the wrong file when we looked at this information on our first visit. The risk assessment stated that they sometimes made decisions about food which was in conflict with professional advice. There was no information about how to respect the person's wishes and reduce the risks. We spoke with the manager about this and a risk assessment was completed after our inspection. This stated that they agreed to the crust removed from sandwiches but

wished to eat the foods they like. The risk assessment did not address the factors that mitigate this risk such as monitoring and food options however it did support the person's right to take risks.

We spoke with the manager about the people whose plans were not being followed. They told us they had recently made referrals to the speech and language therapy team to review some people's safe swallow plans. We saw that these people included a person who the manager had identified was starting to experience difficulties with eating and had highlighted this as an emerging risk. However, not all of the people we had concerns about had been referred.

People did not always receive their medicines as prescribed and administration systems were not robust. One person had not received a medicine prescribed to support their mental health for a month although it had been signed for as given once during that time. The person's medicines were also audited during this time and the omission was not identified. We spoke with the owner/manager and they told us they had only been made aware of this error the week prior to our inspection, although it had been raised with the GP on 17 January 2017. Whilst records did not suggest a return of the symptoms that the medicine had been prescribed for the person was put at risk of this and experiencing withdrawal symptoms that they may not have been able to communicate effectively due to the impact of their dementia.

We looked at records related to the administration of six people's medicines and found gaps in the recording of four of them. The records did not detail the medicines one person had taken for a month because the medicines administration sheet could not be found. Another of these people sometimes used an inhaler and one of the entries made by staff stated "inhaler missing" as a reason for them not using this medicine. Records of creams administered were also not consistent. We looked at four people's records related to their creams and found gaps in them all. We spoke to one of these people about the application of their creams. They told us: "You don't have the same staff and they don't do it, or don't do it as well."

Environmental risks were not always managed safely. There was a chair underneath a small unrestricted window on the top floor this made it possible for the window to be used as an exit. There were people living at Avon Lea Nursing Home who moved around the home independently and lived with dementia. This put them at unnecessary risk. The provider told us that they would remove this chair immediately. Air fresheners with automatic spray were used in the building. The risks associated with the use of air fresheners for people living with chronic obstructive pulmonary disease (COPD) had not been considered. NHS guidance on living with COPD suggests that air fresheners are avoided to reduce symptoms and the chance of a flare up. We spoke with the owners about the fact they were used in areas of the home used by a person with COPD. They sent us a risk assessment about the use of air fresheners after our inspection that stated they would identify if people, visitors or staff were sensitive to the sprays.

Infection control was not always managed effectively and this put people at risk of cross infection. People and relatives told us that the home was clean and we saw that the majority of the home was clean. We saw that cleaning in bedrooms and communal areas was undertaken by cleaning staff. An area around a person was not, however, tidied and cleaned regularly and we saw that there were tissues and food on the floor around them over the course of the second morning of our inspection. A person was spitting on one day of our inspection. On one occasion we saw staff used appropriate protective clothing and antibacterial wipes to clear this away. However, we also saw a member of staff who was helping someone with their lunch stop to clear up spit without putting on gloves. They then returned to helping the person with their food without washing their hands.

People were not always protected from the risks associated with being helped to move because staff did not pay sufficient attention to this support. We observed one person being hoisted from a wheelchair to a chair

in the lounge and one of the staff members supporting them was not talking to them. They were prompted to pay attention to the resident by a senior member of the team who stated: "Can you concentrate on the resident they are watching." On another occasion we saw a person who was identified as being tired by the staff being pushed in the wheel chair with the foot plates up with their feet close to the ground. We made the member of staff aware and they put the foot plates down to protect the person's feet.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were not always enough care staff to meet people's needs. Most staff, relatives and people told us that there were usually enough care staff and that they knew and liked the staff who helped them. Some people told us staff responded to call bells, found out what the issue was, turned the bell off and then came back later. They told us that this was usually in a timely manner. During our visits we saw that staff were available when people needed assistance. Staffing levels had been assessed based on the dependency needs of people living in the home. We saw that these levels were usual in the home. However, over the weekend between our inspection visits staffing levels were not sufficient to meet people's needs.

Two members of staff who worked over this weekend told us that due to staff absence there were two care staff and one nurse working for some of this period. We asked the manager to confirm the number of staff and they asked another member of staff who stated the minimum staff working had been three members of care staff and a nurse. Records were not conclusive regarding the number of staff in the home. Staff who had worked told us they had contacted the manager who had advised them to leave people in bed and do checks to ensure their skin was protected. We asked if they had been instructed to try to get agency staff and they told us they did not use agencies for care staff. One person told us that staffing levels had been "terrible" and there had not been staff available to help them with their personal care at the weekend. The manager/ provider acknowledged that they had told staff to leave people in bed and put in place regular checks. We asked if they had considered using agency staff to ensure they could meet people's needs and they told us that they had not but could do so in the future. They told us they had arranged for a staff member to work for some hours on Saturday and they had worked on Sunday afternoon. This still left staffing at levels where people who would usually get up needed to stay in bed for safety. This meant people had unmet needs because all avenues to ensure appropriate staffing levels had not been considered in this situation.

Care staff were recruited in a way that protected people from the risks of being cared for by staff who were not suitable to work with vulnerable people. Care staff files included references from previous employers, applications forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role. The manager/provider told us that they had a plan to recruit more care staff however, they identified the recruitment of suitable nurses was one of the biggest challenges facing the home.

Some of the people living in the home were living with dementia and did not use words effectively to communicate their emotions and could not tell us whether they felt safe. We saw that they were relaxed with staff; smiling and engaged when staff were with them. People who could speak told us they felt safe. One person said: "I do feel safe here." Relatives we spoke with shared a confidence that their relative was safe. One relative told us, "I am sure (person's name) is safe. The staff are very kind." Staff were able to describe how they protected people from the risks of abuse by describing the signs they needed to be aware of and knowing where they would need to report any concerns they had.

Requires Improvement

Is the service effective?

Our findings

Mealtimes taken in the communal area were not promoted as an enjoyable social experience. Tables were not set with cloths or condiments and people sitting in armchairs were not offered the opportunity to move to tables. There was not space for all the people in the lounge to eat at dining tables should they have chosen to.

People enjoyed the food and had enough to eat and drink. People, relatives and staff all told us that the food was good. It smelled and looked appetising during each day we visited and we were told that there was always a choice of meals available. One person told us," The food is nice." Another person told us: "The food is very good." A relative told us that their relation had started to eat more. Where people were at a risk of not eating or drinking enough staff kept monitoring records. Records of how much people had drunk were much improved since our last inspection and this information was used to plan care.

A nurse working in the home had not had their safeguarding or moving and positioning training refreshed since joining the service. Staff supervision had not been kept up to date during the management changes in the home. For example, one member of staff told us they had not received any formal supervision although they had worked in the home for more than six months. It is good practice to ensure that staff are provided with formal supervision time that is not their responsibility to initiate during periods of organisational change.

Care staff told us they felt largely supported to do their jobs and that they were able to ask questions should they need to. They described access to training and gave examples of how they were able to use this training to support people. For example one member of staff described how online dementia training had enabled them to speak more easily with people living with dementia. There was a system in place monitoring staff training identified by the organisation as necessary for their role and this was used to ensure training was current and met national standards. This was not always effective for example; the Care Certificate had recently been introduced by the provider. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. It became mandatory in April 2016 however two staff who met this criteria and started working at Avon Lea Nursing Home in May 2016 had not been registered until January 2017.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

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

The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately.
We saw looked at three people's care plans related to the principles of the MCA and they were clear about how decisions about care should be made. Staff described how they checked for consent when people could no longer use words to do so. One member of staff told us: "They tell us with their eyes. We can see if they are in pain of uncomfortable." Staff were also able to describe how they would approach situations when people refused care in ways that were least restrictive and ensured their best interests.

People and relatives told us that they were supported to maintain their health. One person told us: "The doctor comes regularly." Another person told us a nurse visited them. Feedback from health professionals identified that liaison and partnership working was improving with the home since the current manager had been working as a nurse in the home.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives described the service as caring. One person told us: "The staff have all been kind, friendly and gentle." Another person told us: "You can't fault the care staff. They are very caring, all of them." We also heard from relatives, people and a professional who felt that some practices were not respectful. This included people's files being in communal areas, and the failure to look after clothing appropriately.

Staff liked and cared about the people living in Avon Lea Nursing home and this was evident in many interactions and the way they spoke about people with us. For example we saw a member of staff taking time to sit with a person who was distressed talking quietly and stroking their skin to comfort them. The person told us later how much they valued this support and kindness. This was in evidence in all the interactions we saw during our inspection and reflected in the comments made by people and relatives. One person told us they treat me as I would like to be treated."

We saw some staff taking time to talk with people to develop positive relationships by making a connection. For example two staff spent time with a person who was distressed in discussion about places in a town that they knew. This person centred approach had a visibly calming and mood enhancing effect on people. A relative reflected this in their observation that: "staff have time to talk to people". However, we also saw that sometimes staff engaged with people in ways that did not respect their experiences. For example, a person with dementia received inconsistent communication from staff when they were experiencing distress based on their experience. Some staff acknowledged what the person said and then aimed to distract them, whilst another member of staff disagreed with the person and told them what they said was wrong. This lack of a consistent approach was acknowledged by a member of staff who told us they did not think all staff shared an understanding of how best to respond to people with dementia in these situations.

We recommend you seek appropriate guidance with regard to appropriate consistent communication between staff and people living with dementia.

People were able to make some choices that promoted their independence throughout our inspection. One person told us that staff only ever helped with things that they could not do and always encouraged them to retain skills. Where people were no longer able to make complex decisions due to their dementia they were encouraged to make choices such as what they wore, and whether they joined in activities. One person told us: "I do things the way I want." Where people did not use words to communicate due to their dementia staff reflected on their demeanour and behaviour and respected these as expressive communication when possible. For example, people were checked regularly before being supported to get up and this was done when they were awake and responsive to staff. Other opportunities to encourage people to make choices were missed by staff. For example, we observed people being helped to move by staff but not offered a choice of where they sat. Once people were sitting in a communal chair they were not offered an opportunity to move unless they were returning to their bedroom or needed personal care. This meant people did not have a choice of who they talked with at other times.

People were supported to dress as they chose and a member of staff had taken on a new welfare role which

included undertaking pampering activities such as nail painting with people. One person told us they were not happy with the way their clothing had been cared for and they alleged that this had resulted in clothes they had made becoming damaged. They did not have confidence that this would not happen again and as a result they were wearing clothes that had become misshapen. We were told that the home had acknowledged their concern and consistently apologised although they had been unable to determine if the clothes had been damaged at Avon Lea Nursing Home. We observed that most people were wearing clean clothes that fitted them well.

There had been a new partition erected in the lounge creating an area closed off by a glass wall. There were cupboards in this room for records storage. The room and cupboards were not always secure during our inspection and there were usually files with people's names on them out on the table. The use of this room had not been discussed with people living in the home and its current use did not respect the dignity of people sitting in the lounge who could potentially see their own or other people's care records. We spoke with the owners about this and they told us that files would be put away and this space would also be made available to people living in the home.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 23,29 and 30 March 2016 we found that people's care was not always planned for and delivered in a way that reflected their preferences and ensured their social needs were met. At this inspection we found that people had improved access to social activities but that they remained at risk of not receiving person centred care because their preferences and experiences were not always known or taken into account in the delivery of care.

People's care needs were assessed and recorded alongside plans to meet these needs in their records. The manager told us that most care plans had been updated and reviewed to reflect a more person centred approach. Care plans included detail about how people liked to receive support and included information about people's histories and preferences and most of the care plans we reviewed had been updated and reflected people's current needs. However, we found examples of important information being incorrect or not being used to inform care delivery.

One person's care plan stated that they had a urinary catheter, however the person did not have a catheter. This could put them at risk of not receiving appropriate support. We spoke with them at a time when they were waiting for support to get changed as their clothes were soaked and they wanted to get clean.

Another person who did not communicate effectively with words had information on their care plan stating that they liked to go to bed at 9pm. They were offered to go to bed before we left the service at approximately 5pm. We asked staff and the owner/manager about this and they said this person usually got very tired and needed to go to bed early. Another person's records included information gathered from a relative detailing that they did not choose to listen to the radio but preferred the television. The radio was on in their room playing a commercial channel with modern music. We discussed the radio stations that people were listening to in their rooms with the manager as two further people were listening to modern commercial radio. They acknowledged that this was not likely to be all these people's choice and they could not use words to let staff know if this was not their preference. If not already known, this detail should be sought where possible from those who know the person and well and used to ensure that people's experience reflects their preferences.

Another person often called out when distressed in a way that may have reflected a negative experience from their earlier life. Staff were not aware of this experience although it had been available in their file and highlighted our last inspection. It had also recently been identified as significant by other professionals working with the person. The person had continued to be cared for by staff who had not been supported to understand and assimilate important details about people's lives in order to ensure that care was provided appropriately and sensitively. We saw that they received varied approaches from staff in response to this.

We also heard from a family member that their family had highlighted with staff on a number of occasions preferences they knew to be important to their relative. They told us that this had included information about how they were dressed and how they were cared for and explained that these things were central to their relative's view of themselves. They explained that they did not feel sharing this information had led to

a change in the care and support their relative received and gave examples of this. We looked at their care plan and found that the information they had shared about their relatives preferences was not reflected in their care plan or information shared at staff handover. We discussed one aspect of this with the owner/manager who told us they would update the person's care plan. They sent us a risk assessment after our inspection covering this preference.

These examples related to staff not understanding and utilising people's care plans as the basis for ensuring person centred care. People's preferences were not always reflected in their care plans. This is particularly important when supporting people with dementia and or difficulties with communication who cannot direct their own care.

People who were able to direct their own care were not sufficiently involved in their care planning. We spoke with two people who were able to contribute to their care plans. Their plans had both recently been updated but both people told us they had not been asked to contribute to this process. One person said: "I am happy with my routine but no one has checked that with me." The other person told us that a member of staff who had now left did their care plan with them but they didn't know who did it now. This person had significantly changed the way they lived in the home and told staff what they wanted; this was not, however, reflected in their care plan. Care plans should underpin the care people receive in order that the care people receive can reviewed and to promote consistency. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw examples of sensitive and responsive care experienced by people when they had a new need presenting. For example one person was anxious and equipment was sourced for them that alleviated their anxiety. Another person was offered a doll to care for and this reduced their agitation. The owners described the importance of ensuring person centred care and explained that they had been focussed on trying to achieve a more person centred approach. Whilst staff felt able to be responsive and try to meet people's needs they had not been supported to understand important information about people as individuals.

Activities were developing in the home. During our inspection people took part in balloon exercises, a quiz, a birthday celebration and had one to one time with staff. The activities coordinator was committed to improving people's experience and showed us photos of events, parties and visiting entertainers. People told us they enjoyed the activities and were happy to see this developing. The owner/manager told us they were increasing the hours available to support meaningful activities.

Complaints were addressed by senior management and we saw records that indicated that they were taken seriously. One complaint had resulted in an apology being sent, another complaint had led to meetings with a family and the owner/manager explained this had led to improved understanding and communication. People and relatives told us they were and would be comfortable to raise any concerns they had with the managers or staff. One person told us: "They always listen".

Inadequate

Is the service well-led?

Our findings

Avon Lea Nursing Home had been through a sustained period of unstable management since our last inspection and we found evidence of a lack of effective leadership and oversight during this time. There was not a registered manager in post and we had been notified of the absence of the last registered manager in November 2015. Two potential registered managers had left the service and this had been concurrent with a period of high staff turnover. Relatives and staff referred to this during discussions but identified that they felt confident in the current owner/manager who was now working full time in the home. One member of staff told us: "They (owner/manager) listens." The current owner/manager was in the process of applying to become the registered manager.

There were systems and structures in place but these were not effective in ensuring that the quality of service people received was improved.

An audit had been undertaken of people's eating and drinking and some people had been referred to speech and language therapy for review. This audit had not identified the concerns we identified about people's safety when eating and therefore action had not been taken to mitigate the risks we identified.

We saw that a 28 day audit process had been implemented but the member of staff responsible for some areas of this audit had not received training to enable them to do it effectively. They had responsibility for the monitoring of mattresses and bedrails. We found that people's mattresses were set correctly but they were not aware of safety issues around entrapment and did not check gaps around mattresses. We observed that one person had a gap that may have posed a risk at the foot of their bed. We asked if this may pose a risk and the member of staff told us they didn't know but had recognised it was different to other beds. We advised them to update themselves on guidance from the Health and Safety Executive relating to the safety of mattresses and bedrails. This member if staff also had responsibility for auditing infection control. This involved a check on antibiotics in use in the home but did not involve any checks on hygiene and safe infection control practice by staff. We highlighted unsafe infection control practice during our inspection. We spoke to the owner/manager about this and they told us they would instigate a review of this practice.

The 28 day audit schedule also included a call bell audit. We asked about this audit and were told that the call bells records were not reviewed but were filed. We reviewed a sample of readouts from the call bell system and asked about the record stating 'lost'. The owner manager said they had never seen that and did not know what it meant. The member of staff who filed the readouts did not know what the readouts meant or how to review them. They did not know what 'lost' meant. We noted that where a person's bell gave the reading lost they sometimes did not call again for a time. The owner/manager told us they thought this might mean that no signal was coming from the person's bell. They told us they would check this and let us know after our inspection. We did not receive this information. There was a risk that people did not have access to their call bells during these times and this had not been investigated because the information the system provided had not been reviewed.

Medicines were audited and reviewed regularly but this was not effective. We saw that a person's medicines were audited during the time that they did not receive one of their medicines and this was not identified by the audit. This meant the system of audit was not effective in identifying errors and this meant a person stayed at risk of harm.

Records were not kept securely at all times during our inspection. They were on three separate occasions left in an unlocked room in unlocked cupboards or out on the table in the room. People's records were disorganised; a number of people's records such as medicine administration records, daily care delivery records and an assessment could not be located when requested or took periods of up to four hours to find. This meant that the information they contained could not be used to review or plan their care effectively.

We spoke to staff about their understanding of the purpose of the care records they used and kept. Two staff told us they had not read people's care plans and had learned how to support people from other staff. Staff were not clear about why they were keeping these records and referred to the records primarily purpose being to "cover" them. This lack of understanding of the purpose of records was reflected in how they were managed and raised the chance of information being lost. For example staff were monitoring the food and fluid intake of a person and important information about this had been recorded in care delivery records rather than on the designated monitoring chart in place. This meant that information about a food that the person had eaten well was not in the place where their food was monitored. This may have meant that this food was not offered to the person again.

At our inspection of 23, 29 and 30 March 2016 we identified breaches of regulation related to risk management and person centred care. We also highlighted that Avon Lea Nursing Home required improvement in all five areas we look at. The provider had submitted an action plan stating that they would be compliant with the regulations by August 2016. The oversight of the home since that inspection had not been effective and as a result the quality and safety of care people received had not been assessed, monitored or improved sufficiently.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were also elements of proactive learning evident such as a learning log which detailed the important learning identified following a meeting to address why a person living in the home had not been able to access a chair that met their needs. This identified the importance of communication in ensuring people's needs were met.

The owners did not show that they sufficiently understood their legal responsibilities. Examples of this were that the care certificate was not introduced as required in April 2106. Safety certificates were not in date in relation to gas and electrical safety checks and the fire safety risk assessment was not adequate.

We discussed strengths and challenges facing the service with owners. They told us that the biggest challenges related to the inconsistency of management experienced within the home and difficulties associated with recruiting and retaining skilled nurses. The owners spoke highly of the care staff team. They told us the staff team were very supportive, hardworking and responsive. This respect was reflected in how the staff viewed the management team and how they understood their purpose. One member of staff told us "We work together. We are like a family."

Meeting minutes reflected the open approach the management team were aiming to promote with agendas to facilitate discussion about staffing concerns and focussed practice based discussion around care issues.

We observed this approach being taken in the daily handover meeting with staff views about recording being taken on board.

People recognised the owner and owner/manager who was working as the nurse in charge during our inspection. People were comfortable with them and we observed residents, staff and relatives talking with them throughout our inspection. One person said: "Nothing is too much trouble. They will all ways answer you." Another person told us about how the owner /manager had sorted out something very important to them personally.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not appropriately involved in planning their care. Staff did not understand important information about people in order to support them in a way that met their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess and improve the quality of the service. Systems and processes were not operated effectively to mitigate risks to the health and safety of staff and people living in the home. Records were not kept securely. Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm because plans to mitigate identified risks were not always followed. People did not receive their medicines safely. People were not protected from environmental risks. The provider was not doing all that was practicable to reduce the risks people faced. Regulation 12 (1) (2) (a) (b) (d) (g) (h) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The enforcement action we took:

We served a warning notice and told the provider to comply with this regulation by 24 April 2017.