

ARTI Care Homes (Gloucester) Limited

Avalon Residential 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?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 27, 30 April and 1 May 2018. The inspection was unannounced and completed by one inspector.

Avalon Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 'Avalon', as it is referred to throughout this report, accommodates 20 people in one adapted building. It does not provide nursing care. At the time of the inspection 20 people were living there.

People were provided with single bedrooms across three floors, along with communal toilets and bathrooms. A passenger lift helped people access the upper floors. On the ground floor there were two lounges and a large dining room. There was wheelchair access to the front and back of the building. There was a garden and further outside space for people to enjoy. There was limited car parking on the property but this could be found in nearby surrounding roads

At our previous inspection on 14 and 16 February 2017 we identified three breaches of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. People's care and treatment was not always planned in a way which met their individual needs. Support was not always delivered in a way which helped to reduce risk to people. Care records were not always maintained accurately. The service's quality monitoring systems had not effectively ensured compliance with all necessary regulations and had failed to make all the improvements required to the service.

Following our previous inspection we met with the provider to asked them to complete an action plan to show us what they would do to meet the requirements of the regulations. At this inspection we found people's care had been planned and delivered to meet their individual needs. Risks to people had been identified and reduced and two of the three previously breached regulations had been met. However, management changes had delayed some improvements and we found people's medicine administration records had not always been accurately maintained. Some aspects of the provider's quality monitoring processes had improved, but a lack of robust governance had not led to improvements being embedded and sustained and further improvements were needed.

The improvements that had been made enabled the key questions, Is the service caring and responsive? to improve to Good. The key questions, Is the service safe, effective and well-led remain as Requires Improvement. This is the second inspection where the overall rating for the service has been Requires Improvement.

There should be a registered manager at Avalon. At the time of the inspection there was a new home manager who had been in post for six weeks. They were in the process of registering with the Care Quality Commission (CQC) to be the registered manager of Avalon. A registered manager is a person who has

registered with the CCQ 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.

We found the new manager had a good understanding of the improvements needed and had already started taking action to address shortfalls. Processes and systems, including those used for quality monitoring, were being reviewed and either strengthened or altered to ensure they resulted in sustained improvements. A stronger senior management team was being developed so that staff could be provided with the support and direction they required. These staff were to be provided with the skills to challenge poor care and promote best practice. More regular meetings with different staff groups and people's representatives were planned.

People were protected from abuse and discrimination because staff recognised what this looked like and knew how to report concerns they may have. Accidents and incidents were monitored and action taken to reduce the risks associated with these. The provider's recruitment procedures were followed which protected people from staff who may not be suitable. Although there had been a large turnover in staff, there were enough staff to meet people's diverse needs. Staff had received training but they required additional learning opportunities and support to improve their knowledge and skills. Guidance and support was being provided to promote best practice and additional training had been organised.

People were given help to make independent decisions and supported to have choice and control of their lives. They were supported in the least restrictive way possible. The policies and systems in the service supported this practice. Where people had been unable to consent to live at Avalon, their mental capacity, in respect of this, had been assessed. Where it had been found to be lacking applications for Deprivation of Liberty Safeguards (DoLS) had been submitted to the local county council by the provider. Care records about people's daily care and treatment needed to better reflect the fact that some people were not always able to retain and weigh up information about their daily care and treatment and that staff made daily best interest decisions to keep them safe.

People's nutritional wellbeing was monitored and those at risk of not maintaining this were provided with support. People had access to a GP and other health care professionals so their health needs could be met. Adaptions had been made to the environment to help people live safely and orientate themselves.

Staff were caring and responsive to people's needs and they supported people to feel included and valued. People's diverse needs were respected and they were supported to have a voice. People's individual life histories, interests, likes, dislikes and preferences were explored. Staff used information about this to help personalise people's care and to have better interactions with people. People's privacy and dignity was maintained and information about them kept confidential.

People's care needs were assessed and care plans devised for staff to follow. People were involved in planning and reviewing their care and their representatives, where appropriate, were able to contribute to this process. The content of care plans had improved and they contained accurate and relevant information about people's needs.

People were supported to take part in activities of their choice, which they enjoyed and which were meaningful to them. There were arrangements in place for people to make a complaint and to have this resolved where possible. Relevant information was available to people and visitors and this could be provided in different formats.

People's end of life wishes were explored with them, or an appropriate representative, so that staff could meet these at the right time. Staff provided care at the end of people's lives which supported a dignified and comfortable death.

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 not fully safe.

People's records in relation to their medicines were not accurately maintained. It was therefore not possible to fully ascertain, from these, if people had received their medicines as prescribed.

Risks to people's health and safety had been identified and action taken to remove these or to safely manage these. Improvements were being made to people's falls risk assessments.

People were protected against abuse and discrimination because staff knew how recognise this and report relevant concerns.

There were enough staff, safely recruited, to meet people's needs.

People lived in a clean home where measures were in place to prevent and control infection.

Requires Improvement ●

Is the service effective?

The service was not fully effective.

Staff had received training but they required additional learning opportunities and support to improve their knowledge and skills. Guidance and support was being provided to promote best practice and additional training had been organised.

People were supported to make independent decisions. However, care records about people's daily care and treatment needed to better reflect the fact that some people were not always able to retain and weigh up information about their daily care and treatment and that staff made daily best interest decisions to keep them safe

People had access to health and social care professionals. People were supported to attend health related appointments for assessments or on-going treatment or review.

Requires Improvement ●

People were supported to maintain their nutritional wellbeing. People had a choice of food and drink and work was being done to improve these choices.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness and their diverse needs respected and supported. They were encouraged to be included and to have a voice.

People's dignity was maintained and their privacy protected. Care records were kept confidential and arrangements were being made to improve the storage and archiving of all records.

People's loss of wellbeing and their distress and discomfort was recognised by staff quickly and addressed.

Is the service responsive?

Good ●

The service was responsive.

People's needs were identified and their care was planned in a personalised way. People and their representatives were able to discuss their care and were involved in reviewing it.

People were provided with support to take part in activities which they enjoyed and which gave them a sense of purpose and wellbeing.

Arrangements were in place for people to be able to raise a complaint and have this listened to and resolved where possible.

Staff provided care which supported people, at the end of their life, to have a dignified and comfortable death.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The home had experienced several management changes which had delayed the completion of the required improvements identified at our previous inspection.

Although improvements had been made to the quality monitoring systems these had still not always been effective in identifying shortfalls, making and sustaining the required improvements.

A new manager had been appointed. They had a good understanding of the improvements that still needed to be made and systems were being further strengthened so ensure action was taken to achieve longer term improvement to the service.

Avalon Residential 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 27 and 30 April 2018 and the 1 May 2018. The inspection was unannounced and was carried out by one adult social care inspector.

We gathered and reviewed the information we held about the service. As part of the Provider Information Collection the provider had submitted a Provider Information Return (PIR) on 5 April 2018. This was reviewed by us and helped to inform our inspection planning. We also reviewed all statutory notifications sent by the provider since the last inspection. The provider, by law, must send a notification to the CQC on all relevant significant events.

During the inspection we spoke with two people who lived at Avalon about the support and care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two visitors whose relatives lived in the home and we gathered their views of the services provided. We reviewed care plans and risk assessments relating to 10 people's care. We reviewed six medicine administration records, four weight records and paperwork pertaining to two continence assessments. We reviewed documents which related to the authorised Deprivation of Liberty Safeguards (DoLS) and saw records pertaining to further applications for DoLS. We followed up the details of two notifications sent to us in relation to falls and reviewed the accident and incident records.

We spoke with one provider director, the new home manager, deputy manager, the activities co-ordinator and three members of the care team, one being a dementia link worker. We reviewed the recruitment records of two members of staff. We reviewed a selection of audits and the complaints records. We reviewed staffs' maintenance records and contractors' service records. We requested to be forwarded to us and received, a copy of the staff training record, the service's Statement of Purpose, the provider's Equality and Human Rights Policy and procedures and a list of the training provided by health care professionals.

We requested and received feedback from two health care professionals who visited the home and commissioners of the service.

Is the service safe?

Our findings

At our previous inspection on 14 and 16 February 2017 the provider had not fully met Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not kept safe because ways of working had not always ensured that risks to them were either removed or reduced. For example, this included risks relating to how people were moved and those found in the environment. The provider's action plan told us they would meet this regulation by June 2017. During this inspection we found this regulation had been met. However, we found new concerns in relation to people's medicine records. An accurate record of when people's medicines had been administered had not always been maintained. There were several gaps found on people's medicines administration records (MARs). Accurately maintained MARs help prevent potential medicines errors as they provide a clear audit trail of what medicines have been administered to people and when.

We reviewed four people's MARs and we found 16 gaps, across a period of three weeks. Staff had not recorded their signature as they should after administering a medicine or, recorded the reason for the medicine having not been administered. When we checked the stock balance of the tablets in question and the medicine packaging both indicated the medicines had likely been administered. When we spoke with staff about this they were fully aware of the correct procedures to follow and were of the view that people had received their medicines but staff had omitted to maintain the MARs correctly.

At the previous inspection, guidance on the use of individual medicines, prescribed to be used by staff 'as/when required', was not in place. The provider's action plan, dated June 2017, confirmed this action as completed. During this inspection we checked to see if this guidance, in the form of a separate protocol, was in place. This was not the case and we were informed that although these improvements had originally been started, they had not been maintained. When we spoke with staff, they were aware of when these medicines needed to be administered.

Accurate records in relation to the care and treatment provided to people had not always been maintained. This puts people at risk of receiving unsafe or inappropriate care and treatment because of this.

This is a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person was able to confirm they always received their tablets correctly. We observed medicines to be stored securely at all times. The new manager told us the above shortfalls would be addressed immediately. Following our visit they confirmed that all staff administering medicines were to have their medicine administration competencies re-checked. He added that additional training and mentoring in this task would be provided where necessary. They had also started to make arrangements to improve the community pharmacy support to the home.

Risks to people had been assessed and action taken to remove or reduce these. Since the last inspection ways of working had altered to ensure risks were comprehensively assessed. For example, one person had been assessed by health care professionals (since the last inspection) for the equipment staff were using at

the last inspection without appropriate assessment. Guidance on safe ways of moving this person were now added to their relevant care plan. Staff were fully up to date with training in safe ways of moving people. All mattresses had been checked to ensure, those in use, were now used for the correct person. People who required additional pressure reducing equipment had been assessed by health care professionals and provided with equipment to meet their needs.

People's mobility needs and their risk of falling, including falling from bed, had been monitored so staff were aware of who was at risk. Appropriate advice had been sought from health care professionals to reduce these risks. A bed which could be lowered almost to the floor, with a padded mat alongside it, was observed in use for one person. The use of this equipment mitigated the risks associated with the use of bed rails. Staff supported people's safety in a way which did not reduce their independence or ignore their particular preferences. For example, one person chose to use the stairs instead of the passenger lift, which increased their potential risk of falls. Staff told us they always tried to be aware of when this person used the stairs so they could provide a support and supervision.

At the last inspection a new electronic care record system had just been introduced. Since then this system had been used to develop and record people's care plans and risk assessments. Although the new system contained electronic falls risk assessments, which recorded people's level of risk, these did not enable staff to fully record information about how falls risks were to be managed. They could also not record the actions staff had already taken to reduce or mitigate relevant risks. We reviewed several care plans to see if the necessary information for staff had been added to these; it had not. This was addressed immediately by the new manager; who was still learning how to use the system. By the second day of the inspection, the system had been altered to accommodate falls care plans which could accommodate all necessary information and guidance. We reviewed three newly formed falls care plans, which identified the type of falls risk, the actions to be taken or the actions already in place to reduce the risk to people.

There were arrangements to ensure there were enough staff available to support people. The new manager had already requested additional domestic staff hours. This was so that laundry tasks could be completed with less input from the care staff. This had been agreed by the provider but had yet to be implemented. The new manager was also due to complete a review of staffs' working hours as they had identified that these were not always meeting the needs of the service.

Staff recruitment records showed that people had been protected against the employment of unsuitable staff. A robust recruitment and selection process included criminal record checks on staff before they started work at the service. These checks were carried out by the Disclosure and Barring Service (DBS) and helped employers to make safer recruitment decisions.

There were systems in place to check the safety of the environment. The Provider Information Return (PIR) stated that an external health and safety company supported the home to remain compliant with all aspects of health and safety. They had last visited the home in March 2018. Since our last inspection some areas of risk, in relation to the environment, had been reduced. For example, a step, had been made more obvious in order to reduce the risk of trips and falls. Items, which were previously in reach of people who lived with dementia and which during the last inspection had increased one person's risk of harm, had been moved out of reach. A keypad was now operational on the front door mitigating any risks associated with the use of a single manual key. The fire service had inspected the home since the last inspection and were satisfied with the fire prevention and evacuation arrangements. At the time of the inspection, one person was receiving continuous oxygen. As there are potential risks associated with the use of oxygen we asked if the necessary hazard safety notice could be placed on the person's bedroom door to make this risk clear. This was done immediately.

People lived in a clean home. The person responsible for the cleaning kept a record of the cleaning they had completed. There were arrangements in place to reduce the risk of infection. These included colour coded cleaning equipment and the segregation of soiled laundry. We also observed staff wearing protective gloves and aprons when delivering personal care or when serving people's food. This reduced the risks associated with cross contamination. Since the last inspection some staff had received further training in infection control and their practices had been monitored. In particular practices in relation to waste management and the segregation of laundry to ensure this was done correctly. Staff who required infection control training had been identified and this was to be provided. The Food Standards Agency had assessed the standard of food hygiene and food safety in March 2017 and this had been rated as "very good". The service had sustained the maximum rating of "5".

We inspected the arrangements in place to maintain the building and to ensure all equipment, safety systems and services remained safe. Records showed that contractors visited on a regular basis to either maintain or service the systems. General maintenance and safety checks were carried out by one of the provider's directors and members of the maintenance team. These staff completed weekly and monthly safety checks which included for example, monitoring water temperatures, flushing through unused water outlets and window restrictor checks. The latter had identified that some window restrictors on the ground floor were needed so this had been organised. There was an emergency business continuity plan in place and arrangements to accommodate people in the event that a total evacuation of the home was necessary.

Is the service effective?

Our findings

At our previous inspection we found the effectiveness of staff training required improvement and we made a recommendation to support the provider to make this improvement. At this inspection we found some action had been taken and some training had been provided to staff since our last visit. The new manager planned to review all staffs' competencies and organise training where it was needed. Health care professionals had delivered training to some staff in person centred care planning, planning for and managing people's behaviours, dignity in care and infection control. The training record provided during this inspection, showed training had also been given to some staff, in fire safety, first aid, health and safety, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), moving and handling, nutrition, dementia care and end of life care.

Training was being organised for those staff who had still not completed the provider's required training. Due to the change in management following our last inspection training had been delayed and time was needed for the planned training to still be completed to ensure all staff had the knowledge and skill required to support people effectively. In the interim, for example, safety data sheets for chemicals potentially hazardous to health had been reviewed and staff made aware of these. The dementia link worker was supporting some staff with their communication skills with people who live with dementia.

One health care professional told us that some staff would benefit from an update in dementia care. This training need had been identified by the new manager and they were taking action to develop staff's understanding of dementia care. The home's dementia link worker had already supported staff with 'bite size' training sessions in dementia care and helped staff to review how they provided people's support. In one person's case this had helped to transform how one person received and accepted their personal care.

The new manager had re-registered with the Skills for Care learning service in respect of Avalon. They had already emailed staff and asked them to complete various basic modules of training as a 'back to basics' exercise. A specialist health care practitioner was soon to provide further learning and support on the MCA/DoLS and end of life care pathway.

We checked to see if staff had adhered to the principles of the MCA 2005. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. In practice we observed staff supporting people, including those living with dementia, to make independent decisions and to have choice and control of their daily lives. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do this for themselves. When people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At Avalon, on a practical level, people could agree to receive the support provided by the staff once this had been explained to them. However, many were not able to fully retain and weigh up the information given to them, about what care and support was planned for them on a daily basis. Care records did not always reflect the required framework for when staff were effectively making decisions about people's care, on their

behalf. When speaking with staff about the absence of capacity assessments and the recording of best interests decisions in relation to people's daily care needs, we found this was an example of where more knowledge was needed. The new manager explained this would be addressed by ensuring capacity assessments were in place for areas of daily care and that the care plans would reflect that the planned care was delivered in people's best interests. They also explained that the training on the MCA and DoLS they had organised would help staff to understand what was needed.

Where people had been unable to consent to live at Avalon their mental capacity had been assessed on relation to their accommodation. 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 (DoLS). Where required staff had submitted DoLS applications to the local county council (the supervisory body). Three people had authorised DoLS in place; there were no conditions attached to these. When we spoke with staff they were aware of who had DoLS in place. The supervisory body had yet to process other submitted applications from the home.

People's needs were assessed prior to them moving into Avalon. This ensured staff were able to make an informed decision about whether they could meet an individual's needs. One relative told us their relative had been visited and assessed by a representative of Avalon prior to their admission. The relative confirmed they had been fully involved in the assessment process and able to support their relative with this. In people's care records there was evidence of their health and care needs being regularly reviewed and re-assessed.

People had access to health and social care professionals as needed. People had seen a GP when they had needed to and the registered manager was looking into arranging routine GP surgeries at the home. Professionals who also had contact with the service included community nurses, physiotherapist, occupational therapists, mental health and specialist dementia care practitioners. When required people also had access to speech and language therapists (SLT) and NHS dental and optical care. A chiropodist visited on a regular basis to provide foot care. At Avalon many people had support from their relatives or friends to attend health appointments, however where needed, staff also supported people to attend these.

People were given help to eat and drink. Those at risk of not maintaining their nutritional wellbeing were monitored and provided with additional support. For example, some people needed to be reminded it was time to eat and others required more hands on support to eat their food and to drink. We observed one person being supported by a member of staff to eat their food and this support was provided in a quiet and dignified way.

Records showed that people's weight was reviewed on a regular basis and monitored. Daily care records showed that people were provided with regular meals and snacks and drinks in between. Any concerns relating to people's appetites or their ability to swallow properly were referred to their GP. If required a referral was then made to the SLT for a swallowing assessment. Some people had been through this process and their food was provided in a texture (pureed or fork mashable for example) to meet their needs and reduce the risk of choking. One relative told us their relative required food which was softer to eat. We saw this provided to this person. Another person said, "The food is generally good."

Although there were meal options, the menu was under review so that people's choices could be improved. The options for lunch were written on a blackboard in the dining room, before each meal, to remind people of the choice. Information on food allergens was available and personal food allergies had been identified and recorded in people's care records. In order for the kitchen staff to be able to meet people's nutritional

needs they were kept up to date with information about people's allergies, dietary needs and their weight. The new manager told us they would be looking at how the nutritional value of the meals provided could be determined to ensure people being well nourished.

Advice had been sought from appropriate health care professionals, following our last inspection, on how to make the premises easier for people to use and to engage with. In particular to help people who lived with dementia find their way around the building. Signage had therefore been improved, we saw both written and pictorial signs, in use to help people locate their individual bedrooms, the lounge and the dining room. It had been suggested that a recognisable focal point be added to the lounge so a fire surround had been installed on one wall. We observed one person sitting in a poorly lit area of one lounge. This had an impact on this person because due to poor eyesight they required far more light to see. This person's relatives talked to one company director and the activities co-ordinator about this and they said this would be arranged. Both lounges were due to be decorated following this inspection and the lighting was due to be improved. The new manager had also requested a better choice of seating for these rooms.

Is the service caring?

Our findings

One person told us staff were kind to them and helped them when they needed support. Both relatives told us staff were caring and helpful towards their relative. One relative told us staff had a good "talking relationship" with their relative. They said they had noticed an "amazing improvement" in their relative since they had been living at Avalon. They said, "It has changed [name of person] life; given it quality." Another relative told us the staff who had been looking after their relative in a previous home and who now worked at Avalon knew their relative well. They had so far found the staff that were new to their relative's care needs, to be attentive and kind. Both relatives were able to visit when they chose and felt welcomed. They both felt able to contribute to their relatives' support when they visited and able to speak on behalf of their relative when needed.

Care records were kept on electronic devices which were password protected. Information relating to people was also kept in a cupboard, easily accessible to staff, which was kept locked. An office where sensitive information was kept required a lock and this was being installed. The new manager had already started to go through records in this room to ensure risks of confidentiality breaches were reduced and that records were properly stored and archived.

A new activities co-ordinator had been employed since the last inspection. They had been adding to the information already gathered by staff about people's particular life histories, backgrounds and wishes. This information was being used to further personalise people's new electronic care plans. This gave staff meaningful information about people which they could use to support people's physical, emotional and social needs. We observed that staff knew the people they looked after well. Staff treated them as individual people with different and diverse needs. The home's dementia link worker used this information to help staff to "think out of the box" when it came to supporting people's needs.

We observed staff communicating with people in a caring way by listening to them and engaging them in conversation. One person required hearing aids to be able to hear enough to engage in conversation and to feel included. Their relative confirmed these were usually put in their relative's ear by the staff. We observed one member of staff 'pick up' on one person's non-verbal communication and respond to them in an appropriate and helpful manner. When staff interacted with people they often referred to things they knew people preferred, had knowledge of or could associate with. This showed the staff used their knowledge of people to help them build positive relationships with them.

We observed the activities co-ordinator also speaking with people in a caring and compassionate way. They clearly were able to connect with people who had varying communication needs and levels of understanding and comprehension. We observed them giving people encouragement and praise and putting their arms around people's shoulders when they knew this was wanted. They were interested in what people had to say and valued their contribution. We spoke with one person about the painting they were doing. They told us about how the activity co-ordinator had encouraged them to do it and they showed it to us with great pride. They spoke about how other people were going to be later involved in this project. On the second inspection day we saw how others were involved in this. This activity had started off

by people exploring, together, in a poetry group, their life time contributions. These had later been incorporated into the painting the person had completed for others to see and appreciate.

We observed staff responding to people's discomfort or distress quickly and effectively. One person had become uncomfortable in what they were wearing and had asked staff to help them alter their clothing, which staff did. Another person had become less settled and staff spent time with them until their wellbeing improved again. People were treated with dignity and all personal care was delivered in private. One improvement from the last inspection, had improved how people's privacy and dignity was maintained when they had their hair cut. Space in the home was limited but haircutting and styling was now done at one end of the large dining room instead of in the middle of the lounge in front of others sitting there. The new manager told us this was done away from dining tables and not at mealtimes. They were going to purchase a screen to further separate this activity when it was taking place.

Is the service responsive?

Our findings

At our previous inspection on 14 and 16 February 2017 the provider had not fully met Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care plans were not accurately maintained. They did not always contain relevant information about how people's needs were being met. The support being provided was not always personalised and meeting those needs. The provider's action plan told us this would be met by June 2017. During this inspection we found the required improvements had been made. Care records were accurate and relevant and improvements had been made to the personalisation of people's care and support.

People's care records, which included their care plans, had been fully transferred into the new electronic system used by the home. Since creating the electronic care plans staff had taken the opportunity to further personalise these. This process had been supported by the work done by the activities co-ordinator and other staff, in gathering more meaningful information about people. The personalisation of care plans was still work in progress and was improving as staff became more confident in writing these. Staff had benefitted from the training provided by health care professionals on writing person centred care plans.

We found the information in people's care plans to be far more current and reflective of their needs and preferences. They gave staff accurate guidance on how to meet people's needs and there was evidence of regular and meaningful review.

People we spoke with were not able to speak about their care plans however, two relatives confirmed they had been involved in discussions with staff about the planning of their relatives' care. They told us they had not physically seen their relatives' care plans, in order to read them, but they had felt able to speak on behalf of their relative when their care had been reviewed. The newly appointed manager planned for people and appropriate representatives, to be able to read these in a way which was easiest for them. More opportunities for formal care reviews were to be introduced. One relative told us they would welcome this as they lived some distance from the home.

People were supported to take part in activities which they personally enjoyed and in social activities of their choice. Since the last inspection a new activities co-ordinator had been employed. Their working hours were predominantly 9am until 1pm (Monday to Friday) although, they did support special events which were outside of these hours. This member of staff was experienced in supporting older people and people who lived with dementia with activities. They belonged to a local wellbeing and activities forum (organised jointly by commissioners of adult social care services) which supported staff who took a lead in doing this. The activities co-ordinator was able to network with other activity co-ordinators with regard to ideas, joint ventures and best practice.

We also observed people being supported to fulfil daily tasks which they enjoyed and which gave them a sense of purpose and belonging. For example, the folding of napkins ready for a meal. Throughout the inspection we observed people being supported to take part in single activities and group activities. An example of a group activity was a poetry group one morning and a quiz, organised by the care staff one

afternoon. People were clearly engaged in these and were competitive during the quiz.

We observed one person sitting in front of and looking at family photographs and other objects which were personal to them. The activities co-ordinator explained this person's wellbeing was greatly improved by having these items placed quietly in front of them. They had also been able to hold a brief conversation with the person by using the objects as a talking point. During lunchtime conversation we observed the activities co-ordinator and people discussing their plans for future activities. People were clearly involved in making decisions about these.

People enjoyed the wider community with staff and relatives. One person was taken out for a drive in the car by their relative. On their return they had clearly enjoyed this. One other person's daily care records showed they were supported to take walks locally with a relative and sometimes with staff. Through the process of gathering information about people's past hobbies and interests the activities co-ordinator had been able to support one person to take part in an activity they had enjoyed before living at Avalon. They told us this had been an addition to this person's quality of life as they had been otherwise disengaged from other activities offered. This activity enabled the person to get out into the local community and meet people who enjoyed the same activity.

There were arrangements in place for people, their representatives and others to raise a complaint or an area of dissatisfaction. The new manager had not received any complaints or been made aware of any areas of dissatisfaction since starting in post. We reviewed the complaints records and saw that two complaints had been received in 2017. According to these records these had been acknowledged and addressed to the satisfaction of the complainant and their representative/s. The new manager told us that any complaint received, was always an opportunity to reflect and learn from.

Meetings were held with people who lived at Avalon. The activities co-ordinator organised these and supported people to be included. These were another opportunity for any concerns or areas of dissatisfaction to be identified and explored further. People had recently been asked if they felt able to speak out and if they knew how to make a complaint. Those able to respond to this question had said they did. The new manager told us they operated an open door policy and they were keen for anyone, who had a concern or something they were not satisfied about, to talk to them about it. One relative, who had known the new manager prior to their appointment at Avalon, told us they had always found them to be "approachable and helpful." They said that whenever they had previously had a concern or query the manager had dealt with it. A member of staff, who had worked with the new manager before told us the manager had always been "very approachable" and was "proactive in sorting things out."

We observed information to be available to visitors on safeguarding, the Mental Capacity Act and Deprivation of liberty Safeguards, living with a terminal illness and the complaints procedure. The new manager informed us they planned to also include information on and for the LGBT (Lesbian, Gay, Bisexual and Transgender) community. We were told information for people could be provided in different formats according to people's needs.

People who moved into Avalon were able to remain there and receive care until the end of their life. People were supported to have a dignified and comfortable death. People's end of life wishes and preferences were discussed with them. These were recorded in people's care records so staff were fully aware of them. People were, sometimes, specifically admitted to the home to receive palliative and end of life care. At the time of our visit no-one was receiving end of life care, however, notifications previously sent to us by the provider, told us this care was supported by the community nursing teams.

When required end of life medicines were prescribed by the person's GP and administered by community nurses. Staff who worked at the home were experienced in this type of care and were able to support both the person and their relative/s. Some staff had completed training in end of life care and the new manager had already planned for further training so staff were fully up to date with the current end of life pathway of care.

Is the service well-led?

Our findings

At our previous inspection on 14 and 16 February 2017 the provider had not fully met Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems to monitor the service's performance and compliance had not always been effective in identifying areas that required improvement and maintain compliance with necessary regulations. The provider's action plan told us this regulation would be met by June 2017.

During this inspection, although we found some improvements, these had not been sufficient to fully ensure compliance with the necessary regulations, ensure best practice and sustain overall improvement. Some actions had initially been taken following our last inspection to improve the governance of the service. Processes and systems put into place to do this however, had not always been maintained and we evidenced how this had impacted on the service during this inspection. For example, monitoring processes were put into place to reduce gaps on people's medicine administration records when these were identified first in August 2017. These however, in practice, had not continued and gaps had occurred again. We also found action had initially been taken to ensure appropriate protocols were in place for medicines prescribed to be used 'as/when required' but changes in staff practice had not been embedded and the improvements not sustained.

Meetings with senior care staff as well as training, in these meetings, had taken place to help address some of the shortfalls found in the last inspection in the staff knowledge and senior staff performance. However, these initiatives had not continued and further improvement and support was still required to ensure all staff had received the required training and skills development. The overall governance of the service had not remained sufficiently robust as the management of the service changed.

The content of the provider's audit, which they completed monthly, had improved. However, improvements were needed to ensure the provider's auditor was up to date with current best practice to ensure they would be able to identify shortfalls when completing their audits. For example, although people's records had been audited the auditor had not identified the shortfalls we found in relation to the assessment of people's mental capacity in relation daily care needs and the lack of comprehensive falls care plans.

This was a repeated breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During this inspection one of the provider's directors applied to complete an advanced level of training in the MCA/DoLS with the local county council to further support improvements.

The service currently did not have a registered manager. The previous registered manager of Avalon had stepped down from this role on 31 January 2018. For a brief period of time another, new manager, had managed the service. The second new manager was now in post. They were an experienced adult social care manager who had previously been registered with the Care Quality Commission. They had already started to apply to the CQC to be the registered manager of Avalon.

The newly appointed manager had already carried out an initial review of the service's needs. They were aware of the past non-compliance with necessary regulations and were actively identifying where improvement was required. The new manager had already reviewed the actions taken by the service so far to see if they were sufficiently robust to be sustained. Areas of immediate focus included reviewing all actions previously identified on completed audits and ensuring staff were provided with appropriate and effective training.

We reviewed an infection control audit, completed in March 2018. This had been introduced since the last inspection as part of the quality monitoring improvements. It was compliant with the necessary criteria laid out in the Health and Social Care Act 2008 Code of Practice on the prevention of infections. It had resulted in 10 actions of which two had been addressed so far. The new manager was aware of the other eight and planned to ensure these were addressed.

An audit completed in March 2018 on the kitchen, had also resulted in 10 actions of which seven had been completed. A need for some key staff to be trained in, infection control and the Control of Substances Hazardous to Health (COSHH) had contributed to these necessary actions. This was being addressed under the staff training review. We also inspected the monthly medicine audits which had identified past gaps in medicine records but where the actions had not been sustained. The current gaps identified by us were on records which had not yet been audited by the provider. The lack of action in relation to these showed that effective staff auditing, before and after medicine administration, was either not being completed or was not overall effective. An environment audit had led to paperwork being archived and other actions taking place to ensure the requirements of the Data Protection Act were met. The new manager was currently auditing the staff personal files to ensure all necessary information was present. Where they were finding missing information this was being requested.

The new manager had already altered some of the systems and processes which supported the governance of the service. Some had been reinstated and others altered or discontinued. Those relating to the monitoring of medicine administration records were reviewed immediately following this inspection. Ideas for improving the community pharmacy and GP service to the home had already been considered and discussed with the provider. Meeting with these services were due to be organised. Following the introduction of several new staff, consideration was being given to developing lead roles. For example, such as that of the dementia link worker and the planned infection control and end of life leads.

A meeting with staff had already taken place to introduce the new manager to those who did not already know them. The new manager had communicated their vision and expectations for the service and listened to feedback. They told us their vision for the service was to be "far more dementia focused" in order to better meet the needs of this group of people. They told us they were still in the process of introducing themselves to people, their representatives and relatives and others who had contact with the home. Relative meetings were to be held more regularly in the future. The Friends of Avalon were still active and had planned events for 2018 which would help raise money, for the benefit of people living in the home.

We observed the new manager to be at ease as they moved around the home communicating effectively with people and staff. They had recognised the need to develop a strong senior team, who would support their visions and expectations. They told us they were keen to get the new team working as 'one team' so team building was being focused on. The new manager spoke positively about the progress already made considering staff and people had gone through some significant changes.

There were future plans to gather the views of people, their representatives and the staff on services provided by Avalon. In the future this would include more targeted questionnaires on areas where

improvement needed to be made. A new box for complaints, compliments and feedback was planned for the reception area.

The new manager was soon to receive training on the new electronic system. They told us they wanted to learn how to be able to gather information from the system, on for example, weights, pressure ulcers and risk levels to help with the auditing of these areas. The electronic system also held information related to the running of the business, which meant managers could monitor staffs' care records and other information remotely.

The new manager kept themselves updated with current practice and relevant professional news by attending and being a member of local professional forums. This included workshops and forums run by the local county council and registered manager meetings through the local care providers' forum.

The new manager complied with all necessary requirements under the Health and Social Care Act and associated regulations. This included making sure that the rating awarded to the service was displayed both in the service and on any website. They ensured CQC received all necessary notifications.

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 17 HSCA RA Regulations 2014 Good governance Care records were not sufficiently completed and were not always accurate in respect of service users' treatment [this was in respect of people's medicines only]. Regulation 17 (2) (c). Systems in place to monitor and assess the quality of services provided had not always operated in a way which ensured compliance with the necessary regulation. These arrangements had not always led to necessary improvements being made or being sustained. Regulation 17 (2) (a).