HC-One Limited

Avalon Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 3, 4 and 6 of November 2015; our visit on the 3 November was unannounced.

Avalon Park Nursing Home provides accommodation for up to 60 people who require personal or nursing care. Accommodation is provided over two floors and consists of 58 single rooms with en-suite facilities. Access to the first floor is provided by a passenger lift. Avalon Park is a purpose built home situated in Salem, approximately one mile away from Oldham town centre. At the time of our inspection there were 54 people using the service.

We had previously inspected this service in January 2015 when we found that people were not always getting their medication as it was prescribed. We also had concerns that the improvements identified through the home's quality monitoring activities had not always been consistently maintained. The service was rated overall as "Requires Improvement."

Following that inspection, we produced a report and set the provider compliance actions to address the concerns raised. The provider sent us an action plan telling how they intended to address the concerns we had raised and to ensure compliance with regulation was achieved.

This inspection was a comprehensive inspection, we also checked to see if compliance had been achieved in those areas we had concerns about at the inspection carried out in January 2015.

There was a registered manager in place at Avalon Park. 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.

We identified eleven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Systems for the safe storage of medicine needed to be improved to ensure people were safe.

The Registered Manager was not using the quality assurance systems available to effectively monitor and improve the delivery of service.

We found that the cleanliness and hygiene standards of some areas of the service were poor.

People at Avalon Park did not feel they could raise concerns with the registered manager. The registered manager failed to fully explore and address complaints made by people and relatives.

Although people told us they generally felt safe in Avalon Park we found systems for identifying and

reporting safeguarding concerns needed to be improved in order to ensure people who used the service were protected from abuse.

People who used the service told us staffing levels needed to be improved. Our observations confirmed low staffing levels during busy times of the day.

We found that staff had not received the necessary induction, training, supervision or appraisal to help ensure they were supported to deliver effective care.

Our observations during the inspection showed that staff were mostly caring and reassuring in their interactions with people in Avalon Park. However we observed some staff showed a lack of respect towards people.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We found care records were not always fully completed or up to date with current needs. This meant there was a risk people might not receive the care they required.

People who used the service told us they had limited opportunities to comment on the care they received or the quality of care provided in Avalon Park.

There was no evidence that a regular programme of activities was in place, which reflected the individual preferences of people.

The overall rating for this provider is 'Inadequate'. This means it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The registered manager was unaware of concerns that people who use the service and their relatives had raised about staff behaviours and practice.

People were not adequately protected by the systems in place to manage the storage of medication.

Accidents and incidents were not always recorded or explored by the registered manager.

Care plans risk assessments were not always followed by staff.

There was no dependency tool being used to assess the correct staffing levels.

Is the service effective?

Inadequate

The service was not always effective.

Induction, training, supervision and appraisal systems needed to be improved in order to ensure staff had the necessary skills to be able to deliver effective care

Appropriate arrangements were in place to assess whether people were able to consent to their care and treatment. The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Nutritional and hydration monitoring charts were not updated regularly and people were not always supported to have the correct level of daily fluids.

Is the service caring?

Inadequate

The service was not always caring.

People who used the service had limited opportunities to make decisions about the care and support they received.

Some people who used the service spoke negatively about the staff and manager.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities which reflected the individual preferences of people.

People at Avalon Park did not feel they could raise concerns with the registered manager. The registered manager failed to fully explore and address complaints made by people and relatives.

Is the service well-led?

Inadequate

The service was not always well-led.

The service had a manager who was registered with the Care Quality Commission (CQC).

The registered manager failed to investigate complaints and safeguarding alerts.

The registered manager was not using the quality systems in place to effectively monitor services provided.

Staff told us they enjoyed working in Avalon Park and felt well supported by the Unit managers.

Avalon Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 3, 4 and 6 November 2015.The inspection team consisted of three inspectors and one Specialist Advisor (SPA), who specialised in dementia care with nursing.

Prior to this inspection we checked information that we held about the service and the service provider. The provider completed a Provider Information Return (PIR) before the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR and also reviewed other information we held about the service such as statutory notifications, local authority minutes from a recent quality monitoring audit, and feedback from members of the public.

We contacted the Local Authority to ask them about their views of the service provided to people. We were told by the local authority that they were working with the registered manager and provider to improve on quality standards. Since we completed our last inspection in January 2015 CQC had received a number of concerns about the service from relatives of people using the service. We shared these concerns with the local authority (LA) adult safeguarding team and the local NHS Community Commissioning Group (CCG) that were monitoring the home.

During the inspection we spoke with seven people who used the service, seven relatives, one chef, one kitchen assistant, one senior care worker, one unit manager, seven care workers, two laundry assistants, the receptionist, one registered nurse, the registered manager, four visiting health professionals, and the area operations director

Some of the people living at the home were unable to give their verbal opinion about the care and support they received therefore we used a short observational framework inspection (SOFI). This is a tool used by the CQC inspectors to capture the experience of people who use the services who may not be able to

express this for themselves. During the inspection we saw how the staff interacted with people using the service. We also observed care and support being provided in the communal areas.

We walked around the home and looked in all of the bedrooms on both floors. We looked in all the communal areas, the kitchen, shared toilets, and bathrooms. We reviewed a range of records about people's care which included the care plans for six people, the medicine records for 21 people and observed a medication round.

In addition we looked at a range of records relating to how the service was managed; these included twelve staff personnel files, training records, quality assurance systems and policies and procedures relating to the management of the home.

Inadequate

Is the service safe?

Our findings

On arrival on day one of the inspection we were escorted to a small lounge on the first floor by the registered manager to use for the inspection. As we entered the lounge, three residents were found asleep in their day clothes. We queried if these residents had been up for long as they were fast asleep. We were told by night care staff that all three residents had not been to bed and had spent the night restless and walking around. We found a chest of draws in the middle of the room restricting movement for one person. The registered manager explained that one of the people has severe aggression and that they may have moved the chest of draws to the middle of the lounge to release their aggression. This posed a risk to the two other people in the room. We noticed the door to this lounge had no door handles and could not be opened from the inside restricting all three residents movement. There was no evidence to show that any of the three residents had been offered any drinks during the night. We raised immediate concerns with the registered manager and asked to see each person's care records. Following this occurrence, the CQC alerted the local authority adult safeguarding team of our concerns.

We spoke to one person who uses the service whi disclosed serious concerns to us about about two night staff workers. This person told us that they often felt they were unable to raise concerns they said "Don't tell I've said because I'm telling you they take it out on you". When asked if they felt safe, thier response was "I feel mostly safe with the people but those two night carers moved the call bell out of reach so I'm not able to call anyone on a night ." We shared these concerns with the registered manager who acknowledged them but we needed to prompt the registred manager to deal with these concerns immediately.

The above examples demonstrate a breach of Regulation 13 (1) (2) (3) (4) (b) (c) (d) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safeguarding service users from abuse and improper treatment.

Most people told us they felt safe with the service. However three people we spoke with told us they had concerns with some staff and one person told us "I'm telling you [staff] take it out on you". One person spoken with told us "I feel safe but I dread who's coming on shifts, there are some staff who work me up" and another person told us "Some staff are kind but others don't care"

Risk assessments were in place which covered a wide range of risks including moving and handling, nutrition, medicine and medicine management. We reviewed one person's mobilisation risk assessment and noted it stated 'requires support from two members of staff using the stand aid.' Clear guidelines from the moving and handling team at Pennine Care had recommended mobile stand hoist with medium chest strap to be used for all transfers and for carers to give clear verbal instructions throughout the transfer. We observed this person being transferred by two care staff, at no time was the person reassured. Staff used the underarm lifting technique, this technique is no longer suitable or safe to use as recommended by the Health and Safety at work Act 1974. We witnessed this person being lifted into the air by both staff and quickly placed into her lounge chair. At no time was this person reassured. We immediately asked the care staff if this is how they normally lifted the person; the care worker told us "Yes, as it is the way [person] likes to be lifted."

We noted in one care record a number of unwitnessed falls which had not been appropriately recorded or reported to the local safeguarding team or CQC. In one care record one person had been assessed as needing a frame to walk, but we noted the risk assessment for Manual Handling as ticked as "independent – walks alone". We reviewed this person's care records and noted 4 falls during September and October (2 requiring hospitalisation) and only one entry was made in the accident/incident recording system for this person. This meant that there was a lack of information available to effectively analyse potential risks and triggers to enable appropriate action be taken to prevent them from happening again.

The above examples demonstrate a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the systems for managing medicines in the service. We looked at the medication administration record (MAR) charts for all the people who used the service. The recording of medicines was done in line with current guidance. The registered manager, unit managers and senior staff were trained to give medication and we observed two medication rounds during our inspection. Medicines were given in a calm and unhurried manner; the staff explained what they were doing and asked each person if they were ready to have their medication. There was a controlled dose system in place for medicines to minimise the risk of harm, and medicines were recorded on each person's medication administration record (MAR) which also displayed a current photograph of the individual, which further reduced the risk of giving medicine to the wrong person.

We checked the stock of medicines held for four people who used the service against the MAR charts and noted the register was complete for the past 6 months without any omissions or discrepancies. When we checked the stock of the controlled drugs held in the service we found these corresponded accurately with the records.

One resident had been assessed as requiring covert medication. Medication given covertly is the administration of any medical treatment to a person in a disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication. Information contained within the care plan about covert medication was clear and we observed good practice, in that the registered nurse encouraged the person to take his medication openly by explaining its benefits and the risks of not doing so.

Although people we spoke with were happy with the way the service managed their medicines, we found the provider did not always manage people's medicines safely. There were no medication care plans in place for one person who used the service, detailing how their medication needs to be taken, if there are any risks associated with not taking medication and what support staff should provide. The lack of medication care plans meant there was a risk that staff would not be aware of how they should respond to the person's needs.

During the inspection we saw the treatment room on the first floor was accessible to all staff, people using the service and their relatives as the code lock number was written on the door frame. We gained entry to the treatment room using the code on the door frame and observed the room to be dirty and untidy, with new medications left on the floor awaiting sorting and putting away. The floor was dirty and dusty with three capsules/tablets discarded. The waste medicines container was over-flowing with a number of prescribed medications sitting on top, including antibiotics and beta blockers. The sharps container was over-following with dangerous sharps visible and exposed.

The examples above demonstrate a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at 12 staff personnel files and saw a safe system of recruitment was in place. The recruitment system was robust enough to help protect people from being cared for by unsuitable staff. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, a job description and two references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Systems were in place to check that nurses were registered with the Nursing and Midwifery Council (NMC).

Care workers received training on how to safeguard people as part of their induction. Staff we spoke with had a good understanding of safeguarding and whistleblowing and what to do if they suspected abuse. Staff we spoke to told us that they were aware of how to inform the manager of safeguarding issues. However, we saw that when concerns had been raised about staff behaviours and practice by people who use the service and their relatives, the registered manager was unaware of this. We raised these concerns with the registered manager, who told us she was unaware of any recent complaints but will investigate further.

Relatives of people living at the home told us that they believed there were insufficient staff to meet the needs of the people who use the service. We reviewed four weeks rotas and saw that the staffing levels had not been reviewed in over six months. The Registered Manager confirmed that staffing levels had not been reviewed even though the number of people using the service had increased over the previous 6 months. We asked the Area Operations Director if a dependency tool was used to assess the correct staffing levels, but was informed at present no dependency tool was being used. Our observations confirmed low staffing levels during busy times of the day.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that the cleanliness and hygiene standards of some areas of the service were poor. We noted on the first floor an unpleasant odour on all 3 days of our inspection and that the unit would benefit from a deep clean. We queried the odour on the first floor and what action the provider was going to take to address this. We were told by the Area Operations Director that flooring had recently been replaced throughout the communal areas and that she would further investigate the offensive odour. There was an overall stale smell throughout the home and we saw that furniture such as dining chairs, armchairs and soft furnishings required deep cleaning, to make sure they were suitable for their intended purpose and that people using the service live in an environment that is clean and free from odours that are offensive and unpleasant.

We checked the daily cleaning record for the kitchen covering, all kitchen surfaces, floors, dry food storage units, and fridge and freezers. We noted that the same person had cleaned the kitchen for 30 days consecutively. We asked this person if they had been in work for 30 days consecutive, they confirmed that the cleaning record had been falsified. This was raised with the Area Director during the inspection.

Infection control and weekly and daily monitoring of equipment record not up to date and recorded by staff as completed even when not on shift.

The above examples demonstrate a breach of regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some parts of the home lacked investment and required redecorating, repair or renewal.

Staff told us they received infection control training and were able to tell us the infection control precautions they took when working with people. All staff, including the management team, wore a uniform. In addition we saw that care staff used tabards, vinyl gloves and other protective measures when completing personal care tasks and cleaning.

We asked one laundry staff and a care worker about the procedures for handling clinical waste and they were able to explain the safe and effective procedure for correct disposal of clinical waste and soiled clothing.

The laundry on the ground floor had a keypad locking system for entry. We found the room to be tidy and well-organised. Clean items were kept separate from those that required laundering minimised any risk of infection. We saw protective clothing was kept in the laundry and hand-washing facilities were provided. A poster showing details of the Control of Substances Hazardous to Health (COSHH) was displayed on the wall for staff to use as a guide. Domestic staff told us that although no infection control lead was employed at the home, staff were fully aware and were able to explain the procedures to be followed in the event of an infectious outbreak at the home.

On the second day of our inspection we found five fire exits were being used to store equipment, which presented a fire risk as they were blocked. We pointed this out to staff and these items had been removed when we returned on the third day.

We asked the Registered Manager to provide us with a copy of the services most up to date Fire Risk Assessment, the copy provided was dated June 2014. When we discussed the currentness of this Risk Assessment with the Area Operations Director, we were informed that the most recent Fire Risk Assessment was completed in June 2015 and had not been updated in the service's fire folder.

A personal evacuation plan (PEEP) had been completed for each person who used the service; this documented the support people would need in the event of an emergency at the service.

A business continuity plan was in place to provide information for staff about the action they should take in the event of an emergency.

Records showed that the equipment used within the home was serviced and maintained.

The home also had hoists on each floor, which had been serviced regularly.

Inadequate

Is the service effective?

Our findings

A relative told us, "I think the nurses and the care workers have the skills and knowledge to support my relative, the care is good." Relatives we spoke with told us they were confident that staff had the skills and abilities to be able to deliver effective care.

Staff we spoke with told us they considered they had the training they required for their role. Staff told us they had training in the form of e-learning and on the job training. We asked the registered manager to provide us with staff training information. We saw that the training matrix indicated all staff training and highlighted where staff needed to undertake refresher courses or any additional training required.

We looked at the training records for 12 members of staff which showed evidence of recent training in a variety of topics including, food safety in care, safeguarding adults, health and safety, dementia awareness, and person centred care. We spoke to five members of staff who all had qualifications in care, and confirmed that they received ongoing training. They provided examples of how they put their knowledge into practice; one person for example was able to describe how they supported people at the end of life, maintaining a person's dignity.

As part of their induction staff were given training in topics such as first aid, fire safety, infection control and moving and handling. New staff told us they had been given the opportunity to shadow more experienced colleagues before being expected to carry out any duties on their own. However, we noted a staff member who had been on long term leave for over two years, who had recently returned back to work had not been re-inducted to the service. This potentially was a risk to people as this member of staff's knowledge and training may not be up to date to ensure delivery of effective care, which reflects best practice.

The unit manager and care staff we spoke with told us that the home operated an 'open door policy' and worked closely with all staff. Our observations confirmed that the unit manager did not confine themselves to the office and supported staff with day to day activities which meant that they could observe practice, and provide visual appearance.

Care staff told us they received regular supervision. We reviewed 12 members of staff supervision files, which showed that for four care staff members no supervision notes had been recorded. We identified that when issues had arisen around the conduct or quality of work of a member of staff. This was not discussed in supervision or acted on appropriately and the registered manager failed to record any follow up actions or further training requirements. There was no evidence that nurses received clinical supervision to provide them with the opportunity to reflect on and review their practice, discuss individual cases in depth and change or modify their practice and identify training and continuing development needs. We also found no evidence to support that the registered manager had kept their own clinical practice up to date in order to support and guide the registered nurses employed by the service. Supervision and appraisal meetings support and help staff to discuss their progress at work and also discuss any learning and development needs they may have, in order to ensure the delivery of effective care.

The lack of effective systems in place to ensure staff receive appropriate training, and supervision is a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staff must receive support, supervision and appraisal

Most of the people we spoke with who used the service were positive about the quality of food provided, although one person told us this could sometimes vary. On the first day of the inspection one member of the inspection team ate lunch with people who used the service. The food was appetising and well-presented and flavoursome. We noted the lunchtime atmosphere was relaxed and staff provided appropriate support to people who required assistance to eat.

Staff offered assistance where required, this ranged from helping to hold cutlery, cutting up food and also full assistance to eat. Staff were seated at eye level when assisting people to eat and gave the person their full attention. However we observed one care worker not engaging or speaking with a person who required support with their meal and feeding them at an angle so the person was not able to see the staff member or the food on the spoon until it was near their mouth. This meant that people who required support with their meals may not always receive support in a respectful manner.

People who used the service were offered a choice of meals. Menus were placed in each dining room. Alternative choices of food were available; this was usually a lighter meal, such as sandwiches. Coffee and tea were served between meals. Each floor had a drinks dispenser, which care staff said was always kept topped up. However during our three day inspection, we did not see any of the drinks dispensers being replaced with fresh drinks. We were told by care staff and the unit manager that the drinks dispenser was replenished every three days. We raised this with the area director who immediately communicated to all kitchen staff and the unit manager for the drinks dispenser to be replenished daily.

One person told us "One chef is good, the food is good from him but the rest of the food is not good." We asked another person if they had plenty to eat, they told us "On one occasion I wasn't too well and wanted my tea later in the evening, I was given a small portion of mashed potato, and really enjoyed it but wanted more but was told that they had no more left over." We asked this person if they had been offered any alternative, the person told us "No".

We spoke with the assistant chef who had been responsible for the kitchen area. We asked about their knowledge of the food allergen labelling rules which came into effect in December 2014 to assist people with food allergies to make it easier to identify ingredients they need to avoid. The assistant chef told us they were aware of this change in legislation. We checked the assistant chefs training record and saw he had appropriate training in food safety.

We looked at care records which indicated that people were weighed on a monthly basis. However nutritional assessments did not show what action had been taken to address people losing weight. As an example one person showed a weight loss of 21.8Kgs in 2 weeks. However this potential weight loss was not actioned or investigated to make sure that it was a recording error as opposed to a weight loss. On the second day of inspection we spoke with the social worker who assured us that this drop in weight was in fact a recording error, and that she had visited this resident on a weekly basis and that this person did not appear to have lost weight.

We reviewed nutrition and hydration monitoring records for two people on (PEG) feeding tubes. We noted both records did not have adequate monitoring of Fluid Balance Chart (FBC) for either person. For one person a clear feeding plan set out by the dietician had identified a total of 2500 mills of fluid over a 24 hour period. We reviewed the daily nutritional intake for the previous four weeks and noted insufficient recording

of fluid intake. This meant there was a risk the person might not receive effective care. We reviewed the nutrition and hydration monitoring for the second person. Although this person had their fluid monitored on a fluid balance chart (FBC), it was not recorded contemptuously resulting in potential omissions or inaccurate recording. Further examination of the records for the two weeks prior to our inspection showed wide variation of daily intake, with the majority of 24 hour periods showing less than 1000 mls of fluid consumed. We reviewed the care records for this person and noted "risk of dehydration" had been identified but reviews of monthly care records did not highlight the lack of fluid and risk of dehydration. The unit manager was unable to explain why these records had not been completed or explored further when reviewed.

We discussed this with the registered manager and the area director who told us they would ensure all staff were aware of when and how people's hydration needs should be monitored and update all recording systems to reflect a total amount of fluids taken over a 24 hour period in line with the dietician recommendation.

The lack of effective systems in place to meet people's hydration needs was a breach of regulation 14 (1) (2) (b) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

Care staff told us they had received training in the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. They told us they would always support people to make their own decisions and choices.

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

At the time of our inspection 25 people were subjected to DoLs. We looked at a random sample of DoLS applications and authorisations, all had been completed appropriately with the Local Authority, and we saw best interest meetings had been held and the required assessments had been completed. We also received the notifications.

We saw evidence of external practitioners such as the speech and language therapist and dietician's visiting the service. During the inspection we spoke with a dietician about the skills and knowledge of the staff team. They told us, "Staff are really good here. They call us instantly about swallowing problems and staff know the residents really well. I have no concerns". We also spoke to a community social worker who commented "Excellent home, staff are very friendly and engage with residents. Residents looked cared for here, I have no issues."

We observed handover from night staff to day staff at 8am. The handover was given by night staff nurse to the day staff nurse, as well as the care staff. The verbal handover also included the completion of a record sheet which the staff signed to say they had handed over all information and keys to the drugs cabinet. This showed staff were communicating peoples care needs and reporting any changes on each shift handover.

We were aware from our contact with the local authority commissioning team that the provider had been

asked to make a number of improvements to the fabric of the building and to provide amenities for people who used the service. During the inspection the registered manager was unable to tell us the timescale for any planned refurbishment. Following the inspection the provider sent us some information about plans to improve the building and the internal environment of the service planned for 2016.

Inadequate

Is the service caring?

Our findings

Avalon Park has two dedicated Dignity Champions. A Dignity Champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this. However we saw that staff did not always consider people's dignity and respect and recognise when this may be compromised. We observed members of the care staff place aprons around people who were about to eat, without speaking to people to tell them what they were doing. In the lounge on the ground floor we observed one staff member turn on the television without speaking with anyone and without asking anyone what they wanted to watch. We saw from activity records reviewed that staff did not always consider people's dignity and respect and recognise when this may be compromised. For example activity records documented derogatory comments about people such as '[person] is not easy to please, [person], [person], [person] what to do for [person]. It is a climb that I don't think we can manage,' and comments like 'The face is one!' We raised these concerns with the Area Operations Director, who immediately commenced an internal investigation, and raised the concern with the local safeguarding team.
The above examples demonstrate a breach of Regulation 10 (1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Some people who used the service and their relatives spoke positively about the unit managers and nursing staff. Comments people made to us included, "The nurse is good, and the staff change a lot but my mother doesn't complain. I don't know who the manager is but they do look after her" and "I know who the manager is but if I have a problem I always speak to the nurses or unit managers."

One relative told us "[care staff] is remarkable, and [care staff] is excellent." We asked another visiting relative if care was good, she told us "It's half and half – to some it's just a job. Majority of people are treated kindly and with dignity, but staff do leave people and don't come back to them". One relative told us "the care is very bad" and one person said "Some good staff in here, but I can count them on one hand."

Some people we spoke with during the inspection provided positive feedback about the attitude and approach of staff. Two people on the residential unit told us staff respected their privacy and dignity and supported them to be as independent as possible.

During the inspection we noted visitors were welcomed into the service. People who used the service were able to meet with their visitors in the communal areas or in their own room if they preferred.

We also saw that approximately 80% of care staff had undertaken the Open Hearts and Mind dementia course which covered, a person centred approach to dementia, creating therapeutic relationships and understanding and resolving behaviours. Care staff told us they would always support people to make their own decisions and choices.

We asked people who used the service if they felt able to make choices about the care they received and whether staff respected their decisions. Most people told us staff asked for their agreement before providing

care but one person said that this was not always the case. One person commented, "Mostly the staff ask before beginning any care activity but not always and I am not sure whether or not I have seen my own care plan. It is the same with making personal choices, mostly I given a choice and mostly I do not feel restricted in any way.

The unit manager and care staff we spoke to knew people well; they were able to tell us about people's routines, their likes and dislikes.

Although the registered manager told us people were asked their opinion of the care they received, care records we reviewed did not provide any evidence that people had been involved in reviewing their care plans. People we spoke with told us they were not sure that they had seen their care plans or had any opportunity to discuss how their care was provided with staff. The registered manager told us they would consider how they could improve engagement with people who used the service in care plan reviews.

We looked at the comments people had made regarding the service their family member had received in Avalon Park and saw these were all very positive. One person had written, "We would like to thank you for all your love and care towards [relative]. You all were patient and I thank you so much for caring for [person]" and "We would like to express our great appreciation for all the sensitive support offered, Staff couldn't have done more for us."

The provider used the 6 steps programme which promotes dignified End of Life Care. People on end of life are placed on a care register. This register is reviewed on a monthly basis with 3-4 staff so no-one feels they have to make decisions alone. We were told by the unit manager that the service works closely with the person's General Practitioner's to obtain the best for the person. "We have access to the Macmillan team and all the necessary multi-disciplinary team to promote good end of life care. Our district nursing team are phenomenal supporters if we need any support. We include families and try and establish where our resident's needs will be best met to try and reduce the need for hospitalisation at the end of life, so our residents can remain in our care."

We saw that care records were stored securely, which meant that personal information about people was kept confidential.

Requires Improvement

Is the service responsive?

Our findings

A relative told us "I have no confidence in the manager to act on complaints. This is why I visit my [relative] every day to ensure he is safe, we stay in the lounge to keep warm. I don't complain to staff or the manager anymore as staff make comments like 'oh look the boss is here' and there will be repercussions" These comments were addressed with the area director during the inspection and immediately responded to family and people's concerns.

We saw there was a complaints procedure in place, which was available to people who used the service and their relatives. Some of the relatives of the people we spoke with told us they would feel able to raise any complaints or concerns with the registered manager and were confident they would be listened to.

A relative approached a member of the inspection team to show them their relative's empty wardrobe. The relative explained that all their relative's clothes had gone missing and despite numerous complaints to the manger, "They are ignoring me. They say the clothes are in the laundry." We questioned the registered manager about the missing clothes and found the registered manager had not logged these complaints or investigated them. We addressed the same concern with the Area Operations Director who immediately conducted a meeting with this person and their relative and took action to resolve the complaint.

We asked the registered manager about the system for recording and responding to complaints received by the service. They told us there had not been any complaints received but records we looked at from the most recent staff meeting referred to a complaint being made by a relative regarding the attitude of staff towards their family member. When we raised this with the registered manager we were told they had not considered the comments of the family member to be a complaint, although it was clearly recorded as such in the staff meeting minutes, and had therefore not recorded it in a complaints log. The registered manager told us they had not conducted a formal investigation into the complaint although they had raised it at the staff meeting and spoke with the family of the person concerned.

The above examples demonstrate a breach of regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records for four people who used the service. We saw an assessment of needs had been completed on all the files we reviewed; this helps ensure the service is able to meet people's needs. We found care records included good information about people's needs, wishes and preferences and the level of support they required from staff. However, three of the four care records we looked at had been reviewed and changes identified, had not been followed up or actioned. This meant there was a risk staff would not have access to the most up to date information about people's needs.

One person visiting their relative told us that people in the lower lounge did not have access to call bells. We observed in both lounges that the call bell was not connected therefore people were unable to call for assistance. One person said that some people shout out to raise an alarm to staff nearby. They told us there were rarely staff in the lounge and we saw this to be the case during the inspection. We asked staff how

residents called for attention if there was no call bell; a care staff member told us "Usually one person will shout them." One person told us "I have never seen a buzzer in the lounge, one night they moved my buzzer out of the way so I couldn't buzz."

We heard one care staff say loudly "Oh stop buzzing" and then laugh when questioned by the member of the inspection team.

The above examples demonstrate a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some positive interaction between staff and people.

The home employs dedicated activities staff to support the delivery of activities across the home's units. We asked people who used the service how they spent their day. People we spoke with told us that staff helped them take part in activities and pastimes they enjoyed. People on the residential unit told us about going out and seeing their visitors, and we saw that activities were going on in the dementia unit. A relative told us, "They do put on activities that have improved". People told us it was their choice whether they joined in or not.

On the first day of the inspection we saw the activities coordinator supported a small group of people to take part in a karaoke sing-along. One person told us, "We have karaoke- I enjoy that – anyone can come- you can watch TV instead but I prefer singing." However one person told us "I don't like karaoke, as it's too loud and there's nothing else that is offered to me". Some people we spoke to told us there was a lack of meaningful activities provided for them. We spoke with the activities coordinator about this and were told that plenty of activities go on during the course of the week, it was difficult to get some people involved in activities and that no activities were offered on an individual basis. There was no evidence that a regular programme of activities was in place, which reflected the individual preferences of people.

Inadequate

Is the service well-led?

Our findings

The service had a manager in place who was registered with the Care Quality Commission (CQC) as required under the conditions of their registration. The Registered Manager, Unit Manager and Area Operations Director were available on the first and second day of inspection. The Registered Manager was not available on the third day of inspection.

The registered manager was responsible for the overall running of Avalon Park.

All the staff we spoke with told us they enjoyed working at Avalon Park and considered the registered manager was approachable. One staff member told us, "[registered manager's] door is always open. But I always go to the unit manager if I need anything." Another staff member commented, "We all support each other and the senior carers and the unit manager are very approachable."

We found the registered manager was reactive in their approach to managing the service rather than actively identifying where improvements needed to be made and ensuring the necessary actions were taken to improve the quality of the service provided. For example during the inspection we identified concerns raised by a person, these were shared with the registered manager who acknowledged the concerns but needed prompting to deal with it immediately.

The registered manager's way of dealing with the culture of the home was to address matters publicly rather than on a one to one basis, team meetings, or supervision. One relative pointed out to a member of the inspection team a public notice board displaying staffs personal information and concerns about night staff sleeping on duty. We immediately brought this to the attention of the registered manager and the Area Operations Director who agreed this information was inappropriately shared publically.

We found that there was a lack of consistent leadership and communication systems between the manager and staff lacked clarity and clear guidance.

We asked the registered manager to tell us about the quality assurance systems in place to assess and monitor the quality of service provided. The registered manager told us there had recently been a quality monitoring visit from the Local Authority Contract Monitoring Team and the service was working to improve standards. We advised the registered manager that a copy of this quality assurance report had been shared with CQC as part of our pre-inspection information gathering process. The report identified several areas that required action to be taken in order for the service to meet the requirements of the Local Authority.

We asked the registered manager about the service's own internal systems for monitoring and reviewing the service so that areas of improvement were identified and addressed. The registered manager referred us to the organisation's "23 Cornerstones," which was the system used to monitor and review all elements of the service. The "23 Cornerstones", covered topics including Quality Assurance, Regulatory and external monitoring, care plan audits, meds managements, falls management, One to One, Colleague Supervisions and Appraisals, Residents/ Relative feedback & Involvement, Accidents and Incidents and Safeguarding.

Relatives we spoke to told us of incidents that they were aware of and when we checked the services records these were not recorded. We reviewed the accidents and incidents and found that recording was ad hoc, where they had been recorded only a summary of the incident had been provided. There was insufficient detail about what had occurred before, during and after the incident. Whether there were any witnesses and if people received the right support following the incident/accident. This meant that there was a lack of information available to effectively analyse potential risks and triggers to enable appropriate action be taken to prevent them from happening again.

We found evidence in "Cornerstone 1" of monthly reviews undertaken by the Area Operations Director completed over the previous 6 months; it was not clear from these records if the actions identified during these visits had been actioned.

Although quality assurance systems were in place, which recorded and analysed performance data to identifying where improvements needed to be made to the service, we found evidence that the Registered Manager was not using the systems in place to record issues and to monitor the quality of service that people received, resulting in the shortfalls and breaches of regulations we found during the inspection process.

The above examples demonstrate a breach of Regulation 17 (1) (2) (a) (b) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Area Operations manager had identified that there were significant shortfalls in aspects of the service provision and the management structures and lines of accountability in the home. They had in place detailed action plans to address the areas identified as requiring improvement and were working with commissioners, stakeholders and maintain the required improvements. Progress was being monitored as part of the local authority quality monitoring procedures. Practical support was being provided by commissioners of the service.

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 did not take formal enforcement action at this stage. 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 The provider had not ensured that the care and treatment received by people was appropriate, meet their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with respect and dignity at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to the health and safety of people receiving care and treatment and taken/ followed action to mitigate any such risks. The provider had not protected people against the risks associated with the safe administration and storage of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have an effective system in place to meet people's hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Some areas of the service were not clean and free from unpleasant and offensive odours.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems in place to protect people who used the service from abuse and in proper treatment.

The enforcement action we took:

Warning Notice sent and actions to be completed by 22.06.2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system in place for identifying, receiving, recording, handling and responding to complaints.

The enforcement action we took:

Warning Notice sent and actions to be completed by 22/06/2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to regularly assess and monitor the quality of service that people received and to maintain securely accurate, complete and contemporaneous records

The enforcement action we took:

Warning Notice sent and actions to be completed by 22/06/2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure sufficient numbers of staff. The provider did not have suitable arrangements

in place to ensure that people employed for the purposes of carrying on the regulated activity are supported by receiving appropriate induction, training and supervision and appraisal.

The enforcement action we took:

Warning Notice sent and actions to be completed by 22/06/2016