Avon Lea Weymouth 2015 Limited

Avon Lea Nursing Home

Inspection report

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Date of inspection visit:
18 May 2017
23 May 2017
25 May 2017

Date of publication:
07 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 18, 23 and 25 May 2017 and was unannounced.

The service is registered to provide accommodation and residential or nursing care for up to 40 older people. At the time of our inspection the service was providing residential care to 21 older people some of whom were living with a dementia.

The service did not have a registered manager at the time of our inspection. The last registered manager of the service had resigned their post in February 2016 after a period of absence that we were notified started in November 2015. The current manager had applied to CQC to take on this role. 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 inspected Avon Lea Nursing Home in February 2017 and there were breaches of regulation related to how people were supported in a personalised way, how risks were managed and how the quality of care people received was monitored and improved. We rated the home as requires improvement and took enforcement action and served a warning notice requiring the provider to ensure people received safe care and treatment by 24 April 2017. The provider wrote to us and told us they would meet the remaining requirements by July 2017. We undertook this inspection to determine if the requirements of the warning notice had been met and we initially planned a focussed inspection to achieve this. This was extended to a comprehensive inspection as additional risks were identified. We undertook a comprehensive inspection to check improvements and to ensure the service had not deteriorated further.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection, we found that improvements had been made in the way people received care in a personalised way and in how some risks were managed but these were not sufficient to ensure people received safe care and treatment. We also found that improvements to how the quality and safety of the care people received were monitored were not yet sufficient.

The risks people faced were not consistently managed or actions taken in order to minimise the risks. We found that risks related to skin damage were not being managed effectively and staff did not always have accurate information about these risks. People were not always able to make staff aware when they needed assistance and checks were not consistently carried out to ensure safety and comfort.

Information received from professionals was not always used effectively to reduce the risks people faced.

People did not reliably receive their medicines as prescribed. We found that there had been errors in stock control that had led to people not receiving medicines and the use of prescribed creams was not consistent.

Auditing systems were in place but they had not always recognised areas that needed improvement. When areas had been identified, actions had been taken to improve outcomes for people.

People were supported by staff who felt supported in their roles. Staff received an induction and on-going training that enabled them to carry out their roles effectively. However, some training was not current at the time of our inspection, the manager shared plans about ensuring this was rectified. Staff had not received training in all areas where we identified shortfalls of practice. We have recommended that the provider seek guidance about ensuring staff develop knowledge about supporting people to maintain their skin integrity.

People were supported by staff who understood most of the personalised information held in their care plans. This remained an area of on going work. People and their families were involved in decisions related to their care.

People were supported by enough staff that had been recruited safely and understood their role in identifying and reporting unsafe practice or potential abuse.

People had access to healthcare when it was needed.

People were supported to have choice and control of their lives and staff supported them in the least

restrictive way possible; the systems in the service supported this practice. Staff supported people to make choices about their day to day care and obtained consent in line with the principles of the Mental Capacity Act. This was not always clearly recorded, which was already being addressed.

Care staff were kind, patient and friendly and largely respected people's privacy and dignity although we identified a need to reflect on issues of confidentiality within communal living. They had a good understanding of what mattered to people and used this information to support meaningful interactions.

People enjoyed the activities available to them. Some relatives felt that more activity was a priority and the manager told us that they were addressing how best to meet people's needs for meaningful activity.

Staff understood the plans people had in place to eat and drink safely. The menu offered a variety of main meals and snacks and catered for individual likes, dislikes, allergies and special diets.

People and staff described the manager and staff as approachable. They knew how to make a complaint and felt they would be listened to and any actions needed would be taken. Staff felt appreciated and understood their roles and responsibilities.

We had concerns about risk management and quality assurance in the home. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People's identified risks were not consistently managed.

People's medicines were not ordered or administered safely.

People were supported by enough safely recruited staff.

People felt safe and staff understood how to recognise abuse and their role in reporting concerns.

Is the service effective?

Requires Improvement

The service was not always effective because staff training had not always been effective in ensuring staff had the skills they needed to work safely.

Staff felt their on-going training was appropriate to support them carry out their roles effectively. Where staff had not updated their training there was a plan in place to ensure this was rectified.

Staff supported people's choices about their day to day care.

People had a choice of food and drinks available that reflected their likes and dislikes, allergies and specialist diets.

People had access to healthcare.

Is the service caring?

Good

The service was caring.

People were cared for by staff who valued and respected them.

Staff had a good understanding of people's interests, likes and dislikes.

People had their dignity and privacy respected most of the time although staff needed to reflect on issues of confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive because people did not always receive care as outlined in their care plans.

Most people had individual care and support plans that detailed how they wished to be supported work was on going to address changes that were needed to ensure this was the case for all the people living in Avon Lea Nursing Home.

People had the opportunity to participate in activities both inside the home and within the community.

People were confident that if they had complaints they would be listened to.

Is the service well-led?

Inadequate

The service was not well led.

Auditing systems were being implemented but they did not always recognise areas that required improvements.

Staff understood their roles and responsibilities and felt involved in the service's development.

The requirements of the warning notice issued by the Care Quality Commission had not been met.

Avon Lea Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on the 18, 23 and 25 May 2017 and was unannounced. It was carried out by two inspectors and a specialist advisor with clinical expertise. The inspection was planned as a focussed inspection to look at how people received safe care and treatment following our warning notice requiring the provider to meet this regulation by 24 April 2017. This was extended to a comprehensive inspection as additional risks were identified. We undertook a comprehensive inspection to check improvements and to ensure the service hadn't deteriorated further.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with social care commissioners and a health professional to get information on their experience of the service. We also looked at information we received in the provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people who used the service and a visiting relative. Some of the people living in Avon Lea Nursing Home no longer used words to communicate, we spent time in communal areas and observed how staff supported and spoke with them. We 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 also spoke with the two owners; one of whom was managing the service, two nurses, six care staff and the chef. We also spoke with a visiting GP. We reviewed records related to 10 people's care. We also looked at records related to the running of the home including: three staff files, management audits, accident and incident records, training records, staff meeting records and records

relating to compliments and complaints.

Inadequate

Our findings

When we last inspected the service in February 2017 we found a breach in regulation in relation to safe care and treatment and the recording of risk monitoring. We served a warning notice that stated the provider must meet the requirements of this regulation by 24 April 2017. The provider had taken action and made improvements in the management of risks related to eating and drinking safely and ensuring staff used appropriate protective equipment to reduce the risk of cross infection. However, we found improvements were still required to ensure people's safety.

We reviewed the risks people faced and the support they received to reduce these risks. We found that the management of some risks and the understanding of staff remained insufficient to keep people safe.

One person's care plan highlighted that they needed two staff with them when they were supported to walk as their mobility was very variable and they could need immediate assistance of two staff with a hoist. We spoke with three staff about how to support this person to move safely and they told us that they were supported by one member of staff. We read an accident record that described the person becoming unstable and being lowered to the ground by one member of staff. The person was not being supported to move by two staff as detailed in their care plan. An audit of hoist slings carried out during our inspection also identified that this person did not have a sling available in their bedroom. This meant the equipment described in their care plan for quick intervention if they could not walk safely had not been available. The person was put at risk because plans designed to minimise their risks were not being followed.

Another person was at high risk of choking when they ate and their care plan detailed that staff should have access to current 'resus council choking guidelines'. We spoke with four staff about how they would respond to a choking incident. Three members of staff told us they would rub the person's back and call for a registered nurse. One member of staff who supported people to eat did not know what they would do and then supplied an unsafe answer. These answers did not reflect the Resuscitation Council (UK) guidance on responding to an adult choking incident. We spoke to the manager about this and they assured us they would revisit this training during handovers and promptly purchased an aid to support this training.

People were assessed regarding their ability to use a call bell to seek assistance from staff. We found that six people who were described by the manager and a nurse as able to use their call bells did not have access to them, whilst in their bedrooms, during our inspection. We raised this as a concern for one person on the first day of our inspection and found they remained unable to reach their bell on both subsequent days. One person described how they had no access to a bell in the evening when they were left alone in the lounge as

there were no mobile call bells available. They described examples of situations when they had needed staff assistance and not been able to summon anyone. They told us they had raised this with staff but it had not been acted on. People were put at risk because they could not seek staff support when they needed it.

Where people could not use their bells to seek staff support the hourly system of recorded checks in place for all people living in the home was meant to ensure they received help when they needed it. We noted on the second day of our inspection that one person who could not use their bell had not had a check recorded for more than three hours. We also saw that two people who we had observed without access to their bells had not had hourly checks recorded; one person for more than three hours. People were put at risk because systems in place to ensure safe supervision were not being followed effectively.

The management of risks associated with skincare was not sufficient to reduce the risk of people developing pressure sores. People who had been identified as being at high risk of developing skin damage had their fluid intake monitored. This monitoring was designed to ensure they had enough fluid to support their skin integrity. We looked at records related to the care of five people who needed their fluid intake monitored and noted that a target intake was recorded in care plans. However, we found that their intake was not regularly checked and when added up they ranged in total without clear actions. This meant that information necessary to manage the risks people faced was not being used effectively to plan their care and reduce these risks by increasing offers of fluids if a person was not achieving their target intake. We spoke with a nurse about this and they acknowledged that the recording was not adequate and described plans to address this. We observed that fluid intake was raised at a handover meeting and staff were asked to encourage fluid for a person who had not drunk much the day before.

On the first day of our inspection we looked at the air mattress settings for six people who were at risk of developing pressure sores and found that four of them were incorrect. We also found that people's weights had been reviewed but that this had not led to changes in mattress settings. This meant that the air mattresses were not being used effectively to reduce their risk of developing pressure sores. We spoke with the manager and a nurse about this and they undertook a review of the mattress settings to ensure they were corrected. One remained incorrect on the final day of our inspection and the pump was changed to make it clearer for staff.

We looked at care plans related to protecting people's skin and records staff made about the care they provided. We found that people had care plans that told staff how often they needed to be supported to move in order to protect their skin. One person's care plan stated that they should be helped to move every two hours and the position they required was stipulated. Records showed that this person, who had damaged skin at the time of our inspection, was not receiving this care. Records also did not reflect the position they had been supported into and so staff would be unable to determine how to assist them appropriately. A nurse told us: "These charts should log the position ie: left or right or sat up but not all staff are doing this. The chart is currently being reviewed as it is not robust enough." On the 16 May 2017 records indicated that the person's skin on their buttock was "raw". This record then showed that the person's continence aid and sore skin area were not checked by staff for six hours. Their care plan identified they should be supported with their continence every four hours and they were at risk of urine infections and required that their hydration was monitored. We found inconsistent checks on the 17 and 18 May 2017. We visited this person on four occasions on the last day of our inspection. We found them to be on their back on each occasion and they confirmed: "I've been sat up like this all day." At our last visit at 4:06 pm there had been no record of support to move since 7am and they had not received their hourly check at 3pm. The person could not reach their bell so we supported them to call for assistance. A member of staff told us they would get a colleague to come and support them to provide the appropriate care.

Another person had developed a new area of tissue damage on the 17 May 2017. This had been highlighted to the district nurse who was not able to see it at the time but no changes made to their care plan or records kept of the wound.

Two people who were prescribed creams to protect their skin from damage did not receive these as prescribed. One person did not receive them for three days because they had been disposed of in error. The other person had not received theirs for a more than a fortnight. We spoke with a carer who explained that this was because the cream had not been ordered in error and this meant that it had not been added to their Medicines Administration Record (MAR). This had been noticed by a member of care staff who identified the error to senior staff. These people were put at risk because their creams to protect their skin were not administered as prescribed.

We also found that the records relating to creams prescribed to protect eight people's skin were not sufficient to monitor the care and treatment they received. The records included a body map showing staff where creams needed to be applied and detailing that creams should be applied each time a person had a new pad. This did not tally with the directions on MAR and staff reflected this inconsistency and gave differing views as to how often creams should be applied. For example some staff told us creams were applied at every pad change and other staff told us this should be twice a day. We found gaps in recording indicating periods of 24 hours without cream application and this meant that people's treatment could not be reviewed, by reading the records, to ensure it was safe, appropriate and effective. We spoke to a nurse who told us that they were reviewing cream administration as a matter of urgency and had identified a number of actions needed.

Recording of other medicines was also incomplete and did not support safe administration. We found gaps in recording of two people's medicines and a nurse could not explain the stock records for a person's medicine that was given in variable doses. This meant it was not possible to check if it had been given as prescribed. One person had requested pain relief and records indicated that they did not receive this because they had no stock available. This meant the person remained in discomfort. The management of medicines was not effective and this had led to people not receiving medicines as they were prescribed.

Senior staff were responsive to the concerns we identified and took immediate action to improve systems. However, some risks identified for people had not been consistently managed or actions taken in order to minimise the risks since the 26 April 2017 as stipulated in the warning notice. There was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some areas of risk people experienced were well managed. For example staff understood the guidance that Speech and Language therapists had provided about people's diets. They were also able to describe a range of other risks people faced and described the staff support they required consistently and accurately. People told us they felt safe and we observed staff supporting people appropriately with equipment to help them move safely. One person told us: "I don't like the hoist. . .but they(staff) reassure me and talk to me. This makes me feel a little safer ."

People were supported by enough staff to meet their assessed needs. We spoke with people and they told us that there were enough staff and they did not usually have to wait for care or support. One person said: "There are usually enough staff." When we supported people to call for assistance staff arrived quickly and were able to find a second member of staff without long delays when the person required two staff to assist them. The staff supporting people were recruited safely. We saw that relevant checks were undertaken before people started work.

People told us they felt safe living in the home. One person said "I feel very safe. I couldn't ask for better care." Staff had received training and were aware of how to identify signs of abuse and the actions they would take if they became concerned about a person's welfare both in respect of safeguarding and blowing the whistle on identified poor practice.

Requires Improvement

Our findings

When we last inspected the service in February 2017 we found that mealtimes were not promoted as an enjoyable social experience reflecting individual support needs. At this inspection we found that improvements had been made to people's meal time experience. People were offered a choice of eating at a table where they received the support they needed to eat. However we found that staff training had not always been effective in ensuring staff had the skills and knowledge to keep people safe.

People told us that the food was very good. One person told us: "The chef is just wonderful. They come to see me." Another person explained how they saw the chef regularly to discuss what they liked to eat." We visited the kitchen and spoke with the chef. The information they held about people's dietary needs, likes and dislikes reflected what was in people's care and support plans. The information included people who were having their food fortified to support them to gain or maintain their weight.

We looked at the training records which were updated for our review. We saw that three staff had been identified as overdue training that was deemed essential for their roles by the provider and there was a plan in place to ensure they received this training. The plan was not appropriate in one case where a member of staff who was working at the time of the inspection had been told they would not be able to work if they did not undertake manual handling training. They were booked to attend this two weeks after our inspection and there was no record of them receiving this training during their employment at Avon Lea. This put people at risk of receiving unsafe support to move. The other two staff had undertaken training with different providers and did not have their training records available. The competency of these staff had been assessed through their induction process and they were booked on the next available training session.

We saw that if staff were identified as needing further training this was provided. For example where a member of staff had made a medicines error they were redoing their medicines competency assessment. We spoke with the provider manager about training plans. They explained they were about to receive regular training from a healthcare professional to support the development of good practice in the home. They also told us they would be continuing to receive specialist dementia training focussed on the needs of people living in the home. Whilst the provider manager told us they were assured that all staff had the appropriate skills to undertake their roles we highlighted our concern about staff understanding of choking guidance. The manager responded immediately to rectify this and assured us they would review this knowledge will all staff at handovers. We also noted, in light of concerns identified during the inspection, that only one member of staff had specific training about pressure sores.

We recommend you seek appropriate training and guidance for staff to ensure their understanding of good practice in supporting people to maintain their skin integrity.

People told us the staff had the skills they needed. One person said: "They know how to do their jobs." Another person said: "Oh they are very good as gold." Staff received an induction and on-going training and they told us this training supported them to carry out their roles effectively. They also told us they had been assessed to ensure they were competent when giving medicines or supporting people to move safely. One member of staff explained they were changing their role and were receiving support and guidance through this process. Another member of staff spoke enthusiastically about specialist training about communication with people with dementia and how it impacted the way they worked. The care certificate was available should staff require it. The care certificate is a national induction programme for people working in health and social care who do not already have relevant training.

Staff told us they felt supported. One member of staff described the support they received concluding: "These are important to me, if I have an issue I can discuss them. I am able to open up and seek support."

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working within the principles of the MCA. Staff supported people's ability and choices about their day to day care. Most of the people living in the home were able to make some decisions about their care and they did so throughout our inspection. We observed staff giving people time to make decisions. Staff were able to explain that they always assumed that people were able to make decisions and supported people to make these. Whilst not all care plans had been signed by people who were able to consent to their care we saw evidence that their views and wishes were incorporated. When people had not had the capacity to sign for themselves families had been involved in decision making.

People had access to healthcare when it was needed. Records were kept of professional visits and included the GP and district nurses. People told us they were supported in accessing the healthcare they needed. One person told us: "If I am ill they call a doctor for me." We spoke to a GP who visited the home regularly and they told us they felt increasingly confident in the information they received and the coordination of care.

Good

Our findings

When we last inspected the service in February 2017 we highlighted concerns about inconsistent communication between staff and people with dementia and recommended that appropriate guidance was sought. At this inspection we found improvements in the consistency of communication, posters around the home reminded staff about appropriate interaction and staff were receiving training from specialist professionals during our inspection.

People mostly had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes were clean and they had been supported, and encouraged, to maintain their appearances. We noted that staff met and discussed their handover with the door to the communal area open and this was closed by the specialist advisor on the inspection team. A personal letter involving some sensitive information was also read out to a person and their reply discussed in the communal area. The person was clearly engaged with this and pleased however they were not afforded the opportunity to do this in a private space. Whilst their experience was overwhelming positive we also observed that care records were left open in a communal area. This meant that staff should be more mindful of confidentiality.

People described the care staff as caring and kind. People made comments such as: "The staff are good as gold really." and "The staff are lovely – they do their best." We saw that relatives had taken time to send compliments in to the staff team after their loved ones had been cared for in the home. One highlighted the "care, dedication, dignity, compassion, empathy, friendliness and professionalism" they experienced from the staff team.

Staff liked and cared about the people living in the home and this was evident in many interactions and the way they spoke about people with us. This was demonstrated in all the interactions we saw during our inspection. Staff had a good understanding of people's interests, likes and dislikes. We observed that this provided the basis for conversations about people and places that mattered to people.

People told us they felt involved in day to day decisions. People were offered choices that promoted their independence such as: where they sat; which rooms they spent time in; whether they spent time with the activities coordinator and/ or joined in communal entertainment and what time they got up and went to bed. A member of staff described how they supported people to make choices: "I bear with people and give them time to make choices and decisions. I give them the information and I show them the objects ie dessert options. This works well…"

We saw staff taking time to talk with people to develop positive relationships by making a connection in ways that were meaningful to people. For example we observed people whose mood could change quickly being supported by staff who understood how to reassure them. We also saw staff communicating with people within the reality the person was experiencing. This person centred approach had a visibly calming and mood enhancing effect on people.

Requires Improvement

Our findings

When we last inspected the service in February 2017 we found that care was not designed to meet people's preferences and needs and there was a breach of regulation. The provider told us that they would meet the requirements of this regulation by July 2017. At this inspection we found improvements had been made and work was on going to ensure that care plans accurately reflected the needs of people living in the home and that staff understood these plans. Whilst there was no longer a breach of regulation this remained an area for further improvement.

Assessments had been completed and this information had been used to form people's care plans. These contained information about people's assessed needs including how they communicated and the actions staff needed to take to support people. The newly appointed project nurse was systematically reviewing all care plans to ensure they contained appropriate information to ensure person centred care. We saw that where they had undertaken this work information contained in the care plan gave staff clear guidance regarding both meeting and monitoring changes to the needs of people. The project nurse and owner manager acknowledged that this work was on going and we were not able to judge its sustainability at this inspection. Staff were able to describe people's care needs although we found examples of changes to care plans that staff had not been made aware of. For example one person's care plan describing how they should be supported when they sat down had changed and staff were not aware of this. Another person's care plan had been altered to reflect a change in their health and staff were still following their previous care plan in respect of this area of their wellbeing. This meant people were not always receiving care that was appropriate to their needs. An audit of care plans had identified areas of care plans that needed updating and this work had started and was ongoing. We also observed people receiving care as outlined in their care plans. For example people were supported to take part in a range of activities and received support to get up and go to bed at the time of their choice.

Care plans were reviewed monthly and staff told us they provided them with the information they needed to provide person centred care. One member of staff told us "Monthly care plan reviews take place. We involve people and their relatives. They are a lot more person centred now." Another member of staff said: "There are regular assessments of people's needs because they can change regularly." We saw that personal information was recorded such as information about individual's histories and staff told us this helped them to build relationships. We also saw that changes in people's needs were reflected in updated care plans with clear guidance for staff. For example one person needed different support with their eating and this was recorded alongside guidance for staff.

There was a handover each day to ensure that important and emerging information about people's care needs was shared. We observed discussions included feedback from relatives and professionals alongside changes in people's care needs. Attention was paid to people's physical and emotional needs at these handovers. For example a person's needs were changing as their health declined and their family had been supported to contribute to important decisions and were enabled to discuss their loved one's care with their GP. These evolving changes were communicated effectively to staff during the handover.

Social opportunities were provided through both group and one to one activities that were meaningful to people. The member of staff who coordinated this work explained that they spent time with people when they first moved in and gathered information about their lives and what they enjoyed. We spoke with people who spent most of their time in their bedrooms. They told us that staff spent some time with them and we saw that the member of staff who did one to one activities with people spent time with them doing things they enjoyed. The staff member told us they usually offered up to three different activities and encouraged people to choose what they wanted. Some people enjoyed being read to others liked to have their nails painted. One person told us: "There are things going on – I think we are doing a quiz today". There were a range of activities available and staff had recently taken advantage of good weather to support people down to the seafront. Entertainment was also provided by outside organisations and musicians. The member of staff who organised activities was liaising with a local group of performers who had learning disabilities about providing a performance. They told us: "We are always looking for new ideas."

A complaints procedure was in place. Whilst no complaints had been received since our last inspection people told us they were comfortable talking to any of the staff about any concerns or complaints they may have. One person said: "I say if I need something I get it." Another person said;" you can always say about anything. They listen" Another person gave an example of how they had recently changed their mind about how they wanted to take their breakfast. They told us they mentioned this and it was acted on immediately. People and relatives were invited to provide feedback on sheets left in the reception area of the home. The sheets made it clear that they welcomed all forms of feedback and would use it to help the service learn and improve.

Inadequate

Our findings

We inspected Avon Lea Nursing Home in March 2016 and judged the service required improvement. There were breaches of regulation because people's care was not person centred and they did not receive safe care and treatment.

When we last inspected the service in February 2017 we found continued breaches of these regulations and an additional breach in regulation related to quality assurance processes. We judged that Avon Lea Nursing Home required improvement overall and rated the service as inadequate within the well led domain. We served a warning notice requiring that the service meet the regulation relating to safe care and treatment by 24 April 2017. We also received an action plan outlining how the requirements of the regulations related to person centred care and good governance would be met by July 2017.

In February 2017 we found that records were difficult to find and not kept securely. Audits were not completed or were ineffective in securing positive outcomes for people. At this inspection we found that improvements had been made in the ways staff worked to provide person centred care which meant that the service was now compliant with that regulation. Other improvements had resulted in three of the key question areas we look at being rated as good.

The provider organisation was made up of two directors, both of whom worked in the building. One provider took a more business development role within the organisation and the other provider who was also the nominated individual had an active role managing the service. An action plan had been created addressing the issues identified by our inspections and input from the clinical commissioning group following monitoring visits and this plan had been implemented and updated by the provider who was directly managing the service. A project nurse had recently been recruited and their role included the further development of quality assurance systems. Quality assurance tasks were carried out by nursing and senior care staff with oversight provided by the provider.

The oversight of the home since the February 2017 inspection had not, however, been sufficiently effective in making adequate improvements to the quality and safety of care people received. As a result there were continued breaches of regulation related to the safety of care and treatment and the governance of the home and the requirements of the warning notice had not been met.

The provider who was not managing the service spoke with us and stated that they had not understood that the warning notice had to be met by 24 April 2017. They told us they thought they had until July 2017 to

meet its requirements as with the breaches they had addressed in their action plan sent to the CQC . This reflected a management failure to understand the statutory framework the service was operating within and put the service at risk.

The provider had failed to recognise areas that needed improvement to ensure the best outcomes for people. This included failing to have an understanding and complete oversight of issues related to the safe care and treatment of people that had been identified twice in previous breaches of regulation and resulted in a warning notice being served. The systems in place to review and audit the care and treatment people living in Avon Lea Nursing Home received had not been effective. We found examples of these highlighting issues and leading to appropriate action such as care plan updates, information added to people's medicines records and mattress settings being corrected.

There was a system in place designed to ensure that there was oversight of the care received by each person living in the home on a daily basis. This was completed by senior care staff for people receiving residential care and nursing staff for people receiving nursing care. We reviewed these records to ascertain if they had ensured oversight of issues identified during our inspection. We found they did not accurately reflect people's experience and so failed to provide a focus for safe and appropriate care. For example it did not pick up where a person's fluid intake had not been checked it did not reference another person's fall stating 'nil' for any accidents or incidents. Where a person had a skin tear their record identified no incidents or skin concerns. A new sore was not recorded for another person. The oversight of repositioning and continence reflected what the care plan said and not the people had received. This meant that where people were not receiving safe care as outlined in their care plan this had not been picked up.

People's care plans were now kept in cupboards in a locked room and we found that they remained secure throughout our inspection. However daily records related to the care and treatment of individuals were not kept securely and were left unattended on tables in the communal area.

Whilst the provider who was managing the service told us they kept up to date with current practice through discussion with relevant professionals, information received from professionals was not always utilised to improve the quality of care people received. A health professional undertook a monitoring visit on 20 and 21 April 2017 and highlighted that a mattress setting was wrong for a person at risk of skin damage. This did not lead to a review of mattress settings despite highlighting that the oversight in place was not adequate. This failure to use information effectively meant people remained at risk between this monitoring visit and our inspection. We received positive feedback from a social care professional who had offered senior staff guidance about care planning, however liaison with other professionals was also not effective in ensuring timely quality developments. An announced inspection undertaken by infection control experts on the 17 May agreed a number of pieces of information provided had resulted in a list of actions which required completion by the manager by 25 May 2017. This was not provided on time which then delayed plans to rectify the deficits.

Systems and processes were not always effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
A number of new quality assurance systems had been instigated just before, and during, our inspection by the newly recruited project nurse and included a care plan audit, MAR audit, sling audit and mattress audit.

It is a condition of the registration of the home that it has a registered manager. At the time of our inspection this condition was not being met as the last registered manager of the service had resigned in

February 2016 after a period of absence that we were notified started in November 2015. The current provider manager had applied to the CQC to take on this role.

People's feedback was sought as part of the quality improvement processes in the home. This included in relation to specific issues such as the menu and food provided and more generally. People were particularly positive about their input into the menu and how responsive the chef was to their opinions.

The staff all described the manager as someone they could talk to and felt involved in changes in the home that they identified were having a positive impact. All the staff told us that they sought to provide people living in Avon Lea Nursing Home with person centred care and felt that they were increasingly achieving this. Staff meeting minutes reflected a culture of open discussion with agenda items related to improving care practice and organisational issues. One member of staff said: "The manager is awesome. They are here all the time, very supportive and very hands on. They are the best manager I have had; very passionate about staff, people and the home." We saw that the manager knew people as they walked around the building and that people were comfortable to talk with them.

Senior staff understood their responsibilities for sharing information with CQC. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.