HC-One Limited

Averill House

Inspection report

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Date of inspection visit:
13 November 2018
14 November 2018

Date of publication:
21 December 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 13 and 14 November 2018 and was unannounced.

The last inspection of this service was on 12 and 13 September 2017 where we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not assessed the risks behaviours posed to other people. Following the inspection, we asked the provider to take action and told the home to produce an action plan to address the issue we had found. At this inspection, we found there were improvements to risk assessments to mitigate the risks behaviours posed to others. Further information can be found in the body of the report.

Averill House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Averill House is a modern purpose-built property which can accommodate up to 48 people. There were 44 people living at the home on the dates of inspection. The home is divided into three floors. People are supported on the ground and first floor and a large kitchen and laundry facilities are situated on the third floor.

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a deputy manager, both managers assisted with the inspection.

People felt safe living at Averill House and were aware of how to raise any concerns they had. Staff members were aware of their responsibilities in relation to protecting vulnerable adults from abuse and were confident the registered or deputy manager would act on any concerns they had. All staff had received safeguarding training.

Staff members were recruited safely and received a robust induction to introduce them to their role. Staff received regular supervision and attended staff meetings to ensure they were kept up to date with changes and had the support to carry out their role effectively.

Premises safety was well managed. Regular external checks took place of equipment such as the firefighting systems, the passenger lift, moving and handling equipment and electrical and gas safety. Internal checks on premises safety were completed weekly or monthly and clearly documented.

People had appropriate risk assessments in place to support them. Risk assessments were reviewed regularly or when needs changed. They identified strategies to support people to minimise risk.

Accidents and incidents were fully documented, and lessons learned were shared to prevent future occurrences.

Medicines were safely managed. Audits were in place to monitor the safe receipt, storage, administration and documentation of medicines. Staff received training to enable them to administer medicines safely.

Staff received training suitable for their job role. The provider supported staff to complete diplomas in health and social care to expand their knowledge. We saw all staff received an induction and were given the opportunity to shadow more experienced members of staff.

The service was working in line with the Mental Capacity Act 2005. People received appropriate capacity assessments and decisions were made in people's best interests. People were only deprived of their liberty where applications had been made to do so.

People were supported to eat a healthy and nutritious diet. People were very complimentary of the food and were supported to eat a diet from their cultural background should they wish.

People received input from primary care services such as a GP or dentist. The service was part of a project to enable people in the home to be diagnosed and treated promptly. The project was working to reduce admissions to hospital and involved weekly reviews of peoples health.

We observed caring and dignified interactions between staff members and people living at the home. People told us they felt cared for and staff always ensured their privacy and dignity and encouraged independence.

Care plans captured people's support needs and were person centred. People told us they had been able to contribute to their care plan and we saw people's choices, likes and dislikes were clearly recorded. Care plans were regularly reviewed to ensure they were current.

Activities were varied, and people were supported to attend social groups and one person was supported to enable them to meet people from their own culture.

People were supported to remain at the home at the end of their life. The service worked with district nurses and other professionals to ensure people were supported to be pain free and had their choices respected at the end of life.

Audits to monitor and improve the service were in place. Audits worked to highlight areas for improvements and action plans were then developed to ensure the improvements were made in a timely manner.

People and staff members told us they felt well supported by the registered manager. We observed the registered manager was visible across the home throughout the inspection, and offering support to people, staff and relatives. The registered manager felt well supported by the area manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments highlighted the risks people presented and gave detailed strategies to reduce the level of risk to the person and others.

Robust recruitment procedures were in place to ensure staff were recruited safely.

Staff had received training in protecting vulnerable people from abuse and could describe actions to take should they suspect abuse was occurring.

Is the service effective?

Good

The service was effective.

Staff received the training and supervision required to enable them to carry out their job role effectively.

The service complied with the requirements of the Mental Capacity Act and people had their capacity assessed and any referrals made to deprive people of their liberty were made to the local authority in a timely manner.

People were supported to receive a nutritious diet and people could choose to receive a diet from their own culture.

Is the service caring?

Good

The service was caring.

There were caring, kind and dignified interactions between staff at the home and people who lived there.

People were supported to remain as independent as possible.

Peoples personal information was stored confidentially.

Is the service responsive?

Good

The service was responsive.

There was a varied programme of activities, people could choose to join in with. Activities took into consideration those who may want to network with people from their own culture and the service supported people to access community groups.

Care plans identified the support people needed. Care plans were formulated with people and their representatives and regularly reviewed.

Complaints were investigated and responded to promptly and outcomes shared.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff were complimentary about the registered manager and felt they had improved the home.

The registered manager was visible across the service and had oversight and governance systems in place to monitor and improve the home.

Notifications to the Care Quality Commission were submitted as required and the service displayed its current rating which are legal requirements.

Averill House

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 was unannounced and was undertaken on 13 and 14 November 2018. The inspection team consisted of one inspector and an expert by experience on the first day of inspection, and one inspector and an assistant inspector on the second day of inspection.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Averill House, including any statutory notifications submitted by the provider or information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

We contacted Manchester local authority, and Healthwatch (Manchester) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

We 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.

During the inspection we spoke with 14 people who lived at the home and five visiting relatives. We spoke with six members of staff including a nurse, a senior care worker, two care assistants, a house keeper, the cook, the registered manager and deputy manager and the area director.

We looked at training and supervision records for the staff team, staff rotas and the staff files for five staff including their recruitment records. We looked at six medicines administration records in the medicines

treatment room and four people's care files. We also looked at records of staff meetings, quality monitoring records, medicines audits, fire safety records and health and safety records relating to legionella, maintenance of the home and servicing of equipment.

Good

Is the service safe?

Our findings

At our previous inspection in September 2017, we found there was one breach to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the provider had not assessed the risks people's behaviours posed to other people using the service. At this inspection, we found there had been improvements made and this breach was now meeting the relevant requirements.

Risks to people at the home were regularly assessed and reviewed. Risk assessments were in place to support people with the management of medicines, falls, mobility, nutrition, choking, skin integrity and challenging behaviours.

Where the behaviours of people using the service presented a risk to others, the risks were clearly recorded, and additional checks such as room checks were in place to ensure people were safe. Where people's behaviours had escalated, review's had been held and additional strategies were recorded to de-escalate behaviour from becoming heightened.

The service used evidence based standardised risk assessments such as the Malnutrition Universal Screening Tool (MUST) to assess people at risk of malnutrition. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition.

People had their risk of falls monitored regularly. Falls risk assessments were in place and regularly reviewed. We saw when a fall had occurred, an analysis was completed to reduce the risk of future occurrences. Where people were identified as high risk of falls, equipment was available to manage the risk such a sensor mats in people's bedrooms and additional room checks to ensure the person remained safe.

People living at Averill House and their relatives told us they felt safe. One person told us, "I feel safe when some residents get restless, staff keep a good eye on them until they settle down." A relative told us, "The home is very safe, there are things in place to manage risk of falling for [name], it starts with the visibility of staff."

Staff were aware of their responsibilities in reporting any concerns they had under the safeguarding of vulnerable adults' procedures. Staff received regular training to update their knowledge on the signs and symptoms of abuse, and the routes they could take report any concerns. Comments from staff included, "We check who is coming into the building and we don't give door codes to family members, so we keep people safe." and "The training alerted us to all different kinds of abuse and how to look for changes in emotions, I would have the confidence to report anything." Staff had confidence the registered manager would act on any concerns they had.

The service had a safeguarding policy in place. This mean the service was working towards protect people from abuse and empowering the staff to report concerns. Furthermore, a whistle blowing policy was in place

and staff confirmed they were aware of and understood the policy.

Staff personnel files included a fully completed application form, proof of identity and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies whether applicants are barred from working with children and vulnerable adults, and informs the service provider of any criminal convictions noted against the applicant.

We observed that staffing levels at Averill House were sufficient and regularly reviewed using a dependency tool. Dependency levels were reviewed monthly by the registered manager and people were rated at high, medium or low and staffing levels were worked out from the differing levels of dependency. People told us, "If I want staff, I just press the buzzer." Relatives told us, "Staff call me to let me know if [name] is unwell, she is cared for by at least two staff members at all times" and "The staff always potter around to ensure everyone is safe."

Rotas consistently reflected the correct numbers of staff on duty throughout the day and night. People and relatives, we spoke with told us they always found there to be enough staff on duty. Agency staff worked across the home in different capacities and we saw the home aimed to use regular agency staff to ensure there was continuity of care for people living at Averill House.

Accidents and incidents were clearly recorded, investigated and preventative measures put in place to assist in preventing future occurrences. A review of each accident was completed within 48 hours and outcomes to investigations were completed within 14 days.

Medicines were stored, recorded and safely administered. A dedicated, locked room was available on each floor which securely stored the medicines and only nurses or senior staff had access to the room.

We checked the prescribed medicines of six people and found stock levels to be correct. We checked two stocks of controlled drugs which were also correct. Controlled drugs are prescribed medicines controlled under the misuse of drugs legislation and there are legal restrictions on the storage and administration of them.

All medicines were stored in a locked medication trolley. Both the fridge and room temperatures were recorded daily. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. We saw all medicines were dated on the day of opening.

Prescribed medicines were record on medication administration records (MAR). We viewed six MAR charts and found them to be appropriately completed and people received their medicines at the correct time. Where people were prescribed creams or ointments, they were clearly recorded for people with body charts in place to identity where it should be applied. Stock balances were all correct.

People who were unable to communicate had protocols in place for the safe administration of "when required" medicine. When required medicine is a medicine such as paracetamol, which is not routinely required. The protocols gave guidance to staff for the signs and symptoms people may display when in need of this medicine. The guidance included monitoring of temperature, skin pallor and looking for changes in peoples' general health.

Staff with responsibility for administering medicines had completed training and competency checks to ensure they had the knowledge and experience to administer safely. Competency checks included a number of observations on the staff member.

Records showed that equipment and services within the home were maintained in accordance with the manufacturers' instructions. This included checks on gas safety, portable appliance testing, electrical safety, fire prevention and detection, inspections of the passenger lift and emergency lighting.

The service has a fire risk assessment in place which was regularly reviewed. Weekly and monthly internal checks were completed of the fire escape route, the fire alarm system, call points, fire extinguishers, fire door checks and emergency lighting. Regular fire drills were undertaken to ensure staff and people were aware of what was expected of them in an emergency.

There were procedures in place to support people to leave the building in an emergency. These were detailed in personal emergency evacuation plans (PEEP). Each person living at Averill House had a PEEP in place. These gave guidance to staff in relation to how to evacuate people safely should the need arise. PEEPs described if the person required one or two people to evacuate and if they required the use of an evac chair.

The service had a legionella risk assessment in place. Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. The guidance in the risk assessment was being followed with regular checks of water temperatures taking place.

A maintenance person was employed by the service who had oversight of the checks required to ensure the building was safe.

The home was clean and well maintained. Housekeepers completed daily audits to ensure rooms had been cleaned. The laundry was managed by a laundry assistant. We saw personal protective equipment (PPE) such as gloves and aprons were freely available throughout the home.

Good

Is the service effective?

Our findings

People received a full assessment of their needs prior to admission to Averill House. Care plans and risk assessments were formulated from the assessment and there was recorded information from a host of professionals including social workers and other health professionals.

People had access to primary health care services such as GPs, dentists, podiatry and opticians. We saw evidence that where people became unwell, appropriate medical advice was sought and treatment provided. One person told us, "Staff get the GP to check on me when I am unwell." Relatives told us, "Staff will call me when [name] is unwell or when she has been seen by someone" and "Every time we come to visit, [name] always looks healthy and well cared for."

The service was currently part of a pilot working with the clinical commissioning group (CCG) and the GP to provide early diagnosis and treatment to prevent hospital admissions from people in care homes. The pilot included a weekly ward round to discuss people's health needs and prescribe treatment.

As part of the pilot, people had pro-active primary care and pharmacy medicines support plans in place by heath professional's. The care plan had reviewed peoples baseline such as blood pressure, weight and oxygen levels as well as the difficulties people faced such as mobility, nutrition and skin integrity. The plan then formulated further care plans to assist in improving people's wellbeing such as a referral to speech and language therapy to assist with nutrition and swallowing advice or gave advice to improve on mobility.

Staff told us and records showed they received training to enable them to carry out their job role effectively. Training was a mixture of e-learning and face to face training including safeguarding, dementia awareness, health and safety, mental capacity, moving and handling, food safety, fire safety, infection control and equality and diversity. Staff told us they were encouraged to complete diplomas in health and social care. We saw 97% compliance for all training courses. Staff told us that training was good and relevant to their role. This meant staff had the appropriate skills to support people in their care.

People told us they felt staff were well trained. Comments included, "The staff are brilliant, if they can look after a grumpy old man like me, they must be well trained" and "Staff are well trained, they make an effort."

The induction process for new staff included completion of the care certificate. The care certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care over a 12-week period. This included written work as well as practical's and observations. New staff shadowed other more experienced members of staff prior to working independently.

Staff received regular supervision and appraisals. Verbal and written handovers were given at the end of every shift. This meant communication between staff and managers was effective.

We observed lunch time and found the food looked and smelt appetising. People were very complimentary

of the food and told us, "The food is lovely, it's always hot." and "We can have as much as we want, there is always plenty of home cooked food here. We noted tables were set with cutlery and had condiments available.

We saw people had enough to eat and drink and people told us they were always offered extra portions. Fresh fruit, biscuits and drinks were always available. Hydration stations were situated across each floor where people could help themselves to water. Throughout our inspection, we saw fluids and snacks offered and taken.

We spoke with the cook who could describe people's diets. The cook was very knowledgeable about people's likes and dislikes and told us they met with people and their families to ensure their food preferences were catered for. The cook was able to describe how meals are fortified for people who were losing weight, and how they managed to provide low sugar options for people who were diabetic.

The cook was aware of who required a soft diet, or who may need their fluids thickened. Thickening of fluids was completed by staff who had received training from the thickening agent provider. People who required their fluids thickened had the information recorded in their care plan. Additionally, the cook also was able to review people with the speech and language therapist (SALT) to ensure they were involved in any changes to people's diets.

On the second day of our inspection, the cook had been on a course about managing soft and blended diets. The cook was enthusiastic about their learning and told us about the plans they were going to put in place to make meals for people on alternative diets more appealing. This was to allow people to try different foods while still ensuring the persons swallowing ability remained safe.

People who preferred an alternative cultural diet were catered for and one person told us, their requests for particular foods had always been delivered.

We observed staff supporting people into the dining room and offer encouragement to eat and drink. The atmosphere was calm and meal times were a sociable occasion with friendly chats and people sat with people they were comfortable with. Staff were aware of people's preferences as we heard one staff member request soya source for a person's soup as that was their preference.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 authorisation's to deprive a person of their liberty had the appropriate legal authority and were being met.

People had their capacity regularly assessed. The majority of the assessments were based upon people's understanding of the decision to remain at the care home or consent to care. We saw where people were

unable to consent or make decisions, a decision had been made in their best interests and included, where possible the views of the person and their representatives. DoLS referrals were made to the local authority for review and any restrictions from the outcomes of the referrals were captured in peoples care plans.

Staff members were spoke with were aware of who had DoLS in place and any restrictions placed upon them.

Averill House is a three-storey purpose-built home that was well decorated. The ground floor and the first-floor housed peoples' bedrooms and communal areas. A large kitchen and laundry facilities were on the third floor. Each bedroom had its own bathroom and toilet and were furnished to peoples' own requirements. There were walk in showers and assisted bathrooms on each floor which were bright, clean and well maintained. There were two communal lounges on each floor which were decorated in calming colours and a large dining area.

There was a passenger lift to the first floor as well as stair wells. There was a dedicated hairdressing and pamper room for people to access which was spacious and well lit.

The home is surrounded by gardens and a smoking shelter was available for those people who wished to smoke. The gardens had planters available for people to plant their own flowers in. The registered manager told us they were looking to purchase raised planters to enable people in wheelchairs to be able to access them. We will review this on the next inspection.

People had their photos on their front doors, this helped people living with dementia to identify their bedroom.

Good

Is the service caring?

Our findings

The environment was friendly and relaxed. People freely moved within the home from communal areas to their bedrooms and people sat outside the dining room and enjoyed the interaction of people, visitors and staff members walking by.

Interactions between staff and people living at the home were kind and dignified and we observed friendly joking with people throughout the visit. People frequently entered via the open door of the registered managers office and had discussions about anything from the weather to their favourite music.

People told us they felt well cared for at Averill House. Some of the comments included, "Everyone is nice, we are all friends."; "The place is nice and quiet, and the staff are very friendly."; "The atmosphere is homely." and "I like it here, its brilliant."

Relatives told us, "Since [name] came here, she had never looked back"; "It's a very quiet place, just right for [name], she is settled." and "You can come in and ask questions anytime, that's how confident I am about this place."

Calls bells were not audible, and staff had a pager in their pocket. All staff we spoke with said they could feel the strong vibration when someone was calling for assistance and all people we spoke with said the staff responded promptly when call via the call bell system.

We observed staff knew people well. Staff were patient with people and we observed a staff member encouraging a person to walk with a walking aid as part of their physiotherapy plan. The staff member was giving lots of support and praise and we overheard them say to the person, "Well done, we are so proud of you."

People told us they were encouraged to do as much as they could for themselves and this gave them opportunity to retain their independence. One person said, "Staff encourage me to do what I can for myself."

People were treated with respect, and dignity. We observed staff knocking on doors and gaining permission to enter and people we spoke with confirmed this always happened. Personal care was delivered in people's bedrooms or communal bathrooms to ensure privacy. We saw information in care files confirming how people liked to be known as, this could include nick names and other names.

Records showed that staff had received training in respecting people's equality and diversity. Staff could describe to us how the protect people from unfair treatment and told us, "We report any concerns we have, we don't allow people to be treated unfairly, even from visitors. People here are respected as they are."

People's care files and other personal related documented were stored securely in a locked cupboard in an office on each floor. Staff personnel files and premises related records were stored securely in the administration office. This meant that the service was working to ensure people's personal information was

kept safe and secure.

Good

Is the service responsive?

Our findings

Activities at the home were varied and people told us they enjoyed attending. There was a wellbeing (activities) co-ordinator employed by the service and another co-ordinator had been recruited and was awaiting the return to their pre-employment checks.

Activities were planned for the whole month ahead and included visits by singers and animals, cards and games, pampering and light exercises and trips out. We observed people engaged in flower arranging and others enjoying drawing and creative writing. When there wasn't co-ordinator on duty, large trolleys were stocked to keep people busy with games and twiddle objects which were used to keep people's hands busy.

People we spoke with said, "I like doing pottery and sewing and knitting." and "I like to go shopping and do puzzle and quizzes."

We found the wellbeing coordinator to be very knowledgeable and passionate about their role. They told us, "At first I just wanted to try new things and was not sure if it would work, but without the support of management and staff, I don't think I would be enjoying it the way I do. Doing things with residents, has been the most amazing experience for me. I try and engage them in group activities such as today we are doing some creative drawing and writing."

We saw people had one to one sessions with the wellbeing co-ordinator. The sessions included reminisce work and people were supported out on activities in the local community. On the afternoon of our first day of inspection, one person was being supported to visit an organisation where they could communicate in their own language.

People told us they could get their hair attended to by the hairdresser who made the visit to the salon and have a hand pampering session. This was extremely popular with the ladies.

Care plans were fully completed and regularly reviewed with people's needs, choices and wishes captured throughout. Each care plan described what actions staff needed to take to support each person in detail. Care plans recorded what people could do for themselves to enable them to remain as independent as possible.

Each care plan confirmed what help people needed with any cognitive impairments such as dementia or support with challenging behaviour. For example, where a person could be vocal towards others, the care plan documented strategies for staff to follow to diffuse situations to keep people calm and safe. Where people required support with managing a particular health condition such as Parkinson's or Huntington's disease, clear guidance was recorded in the care plan to assist in the management in the illness.

People and families were involved in the care planning and six-monthly reviews had begun to take place with people and their representatives. Reviews looked at the support people required and identified goals for people to work towards.

Peoples life stories were recorded within each person's care file. Information included details of people's family history, employment history, any hobbies and memorable events. Staff told us they would use this information for one to one time with people, to promote conversation and memories.

People told us they were involved in the care planning and had also been able to attend meetings with the registered manager to discuss aspects of the home such as activities, menus and other general discussions.

Peoples wishes at the end of life were recorded with preferences and choices captured. End of life care relates to people who are approaching death; it should ensure that people live in as much comfort as possible until they die and can make choices about their care. The service worked closely with the MacMillan service to ensure end of life care was well managed and the registered manager told us they were looking to link to an accreditation to provide excellent end of life care.

We saw from care plans that discussion had taken place regarding people's future wishes so that staff would be able to meet people's needs and preferences when the time came. We found do not attempt cardio pulmonary resuscitation (DNACPR) instruction were in place for some people and this information was recorded in the front of each person's care file and a separate list kept in the registered managers office.

Staff members were able to tell us who had a DNACPR in place and told us they feel well supported by the management team when caring for people who are at the end of their life.

People told us they would make any complaints to the registered or deputy manager, the staff team or their family. We saw the service had received and responded to any complaints made in a timely way, and outcomes had been shared to all involved and for the wider learning.

The service had a complaints policy in place and people and relatives told us they would have no hesitation in raising a complaint if they felt they needed to. People told us, "[Registered manager] comes around daily, if I had a bone to grind, I will tell them"; I would speak to the home manager, they are very friendly" and "I don't have any concerns, if I do, I will tell the staff or the [registered] manager, the door is just there."

Relatives told us, "I deal with the [registered] manager most of the time as I see them in the office when we come in, she is nothing short of brilliant" and "I wouldn't say I have had concerns or complaints before, only voicing my opinions. In all case, where I have said my opinion, the [registered] manager has responded positively and sensitively."

People were given information in a way they could understand. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. In care plans, methods to communicate with people were clearly described. Large signage was used to highlight areas of the home such as the bathroom and communal areas and some signs were additionally written in braille. This meant the service was working to meet the standards of AIS.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. A deputy manager supported the registered manager and the provider was in the process of recruiting a clinical manager. There was also additional support from the area manager and quality assurance manager who were visible throughout our inspection.

The registered manager was available throughout our inspection. We observed that they interacted with people, professionals and visitors during our visit to Averill House and people frequently popped into the office to have informal chats.

People we spoke with were complimentary of the registered manager. Comments included, '"[Registered manager] is lovely, she's really nice." and "Yes, I know [registered manager], she's in there (points to the office). She's always about and talks to me."

Relatives told us they felt the registered manager had improved the home in the short time they had been there. Relatives told us they felt confident the registered manager would address any concerns they had and felt listened to respectfully.

Staff told us they felt supported by the registered manager and comments included, "We've had quite a few managers. [Registered manager] has been here the longest and is probably the best. It's running much better now since when I first got here" and "One of the best we have had, very approachable, great with the residents, comes in every meal time to see if they [people living at Averill House] enjoyed it and makes them laugh. She always has the door open, never shut, she is brilliant."

Relatives meetings had been held at three monthly intervals and staff meetings were held every other month. We saw minutes recorded for meetings that were well attended. Meetings were used to share information, for training sessions and for updates to the service.

Daily changes across the home were communicated to heads of departments promptly. The registered manager held an 11am 'Heads of' meeting daily where the heads of each department, nurses, seniors, maintenance, housekeepers and catering would meet to discuss any concerns or comments they had.

The service had received many compliment cards thanking the staff team for their good care. These were displayed in the reception area and were recorded in the registered managers office. The service had also received an overall score of 9.6 out of 10 for reviews on care home website care.home.co.uk. There were 17 comments describing the care their relative had received at the home.

The service gained feedback from people and their relatives and staff to monitor and improve. The most recent survey in December 2017 had been analysed and 80% of people said staff were excellent or good. 80% said the food was excellent or good and 80% said the cleanliness of the home was excellent or good. As part of the learning from feedback, the provider completed a 'You said, we did' analysis where people had

commented on the layout of new dining tables after the refurbishment. People felt the layout didn't give enough room for manoeuvring around the dining room and with peoples input, the layout was redesigned.

Of the staff survey 89% of staff said they were proud of the quality of care at the home and 88% said they felt people at the home were involved in all aspects of their daily living.

The area manager and quality manager visited the home regularly. They spoke with people, relatives and staff. They also completed their own internal inspections linked with the Care Quality Commission's, key lines of enquiry. The inspections highlighted what the home did well and where there was room for improvement. The registered manager was given time sales for such improvements to be made. We saw actions from the inspections were completed within time scales and reviewed to ensure the improvements were sustained.

The registered manager ensured they had oversight of the management of medicines, falls, people with or at risk of pressure sores, weights and accident and incidents. Monthly audits to monitor such concerns were completed which highlighted any key areas for improvement. This could be by providing additional monitoring for someone who was becoming a frequent faller or by obtaining additional nutritional support for someone whose nutritional intake was poor and therefore put them at risk of weight loss and pressure sores.

HC-One Ltd used a corporate management system at Averill House called Cornerstones. It combined tools designed to improve the management and monitoring of the service. The manager's diary sets out the key tasks and activities of the registered manager on a daily, weekly and monthly basis. It guided them through their working day, helping them plan time, make notes and ensure that all the essential tasks were completed and evidenced.

The provider was proactive in planning for any emergencies that may arise. We saw that a business continuity plan was in place to assist in managing the service in the event of a power cut, flood, fire or if at any times, people needed to be moved to a place of safety

The provider had policies in place for the admission and discharge of people, managing end of life care, medication, infection control. recruitment, mental capacity and whistle blowing. This meant there was guide in place to ensure and endorse the wellbeing of all people, employees and any others connected with the service.

We saw that the service was displaying the last inspection Care Quality Commission (CQC) rating within the home. This is a legal requirement for any premises providing a regulated activity.

The registered manager had submitted notifications to CQC of events that had occurred at the service. We found all notifications had been received. This meant the registered manager was aware of the responsibilities of their role.