ARTI Care Homes (Gloucester) Limited

Avalon Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 16 February 2017 and was unannounced. This was the first inspection of the service under its new provider name of A.R.T.I Care Homes (Gloucester) Limited. This had been registered with the Care Quality Commission on 3 August 2015. Although a new registration the management of the service effectively remained the responsibility of the same staff as before.

The service is registered to provide care to up to 20 people. It provides care to predominantly older people who required physical and psychological support with their daily living activities. Some people also live with a diagnosis of dementia.

There was a registered manager in position who was also the owner of the company. They visited the service three times a week. On a day to day basis a senior member of staff managed the service. This member of staff had applied to the Care Quality Commission to become the new registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we identified breaches against three of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. Regulation 9 Person – centred care was not met. People's care and support was not always designed or delivered in a way which met their individual needs. Regulation 12 Safe care and treatment was not met. Risks to people were not always managed appropriately and mitigated. Regulation 17 Good governance was not met. People were at risk of receiving unsafe and inappropriate care because of poorly maintained care records. Also under the same regulation, the provider's quality monitoring processes did not fully protect people from unsafe or inappropriate care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

We also recommended the provider seek appropriate advice relating to one aspect of medicine administration guidance and the staff recruitment process.

People were not always kept safe. Improvements were needed to how risks to people's health and welfare were managed. People received support to take their medicines however, additional guidance was required to ensure all administration practice was safe. Improvements were needed to the fire safety arrangements. A letter of non-compliance was subsequently issued by the Fire Safety Officer who will follow this up. People lived in a clean environment and there were infection control arrangements in place, although staff practice at times, potentially compromised these. A check was needed to ensure all necessary requirements with regard to this were in place and that these were being met. People were protected from potential abuse and discrimination because staff knew how to recognise these issues and report them. There were enough staff in number to meet the needs of the people, although how other tasks were organised needed improvement. Staff recruitment processes needed some improvement to ensure people were fully protected from those

who may not be suitable to care for them.

People told us they felt well cared for. Staff had been provided with training, however, standards of practice varied. We did not always observe staff putting the principles of this training into practice. A more robust system of checking staffs' competencies, knowledge and the effectiveness of the training provided was required. People received support with their eating and drinking and people's weights and appetites were monitored. However, some people would have benefited from more staff awareness when this support was provided. The principles of the Mental Capacity Act (2005) were understood and adhered to. This ensured people received their care and treatment lawfully. Where possible people were supported to make their own decisions. People were supported to gain access to necessary health and social care practitioners when needed.

People's care was delivered in a kind and caring way and people told us the staff were kind to them. People looked comfortable when staff were present and it was clear many had built up a good relationship with the staff that looked after them. Staff interactions with people were respectful, reassuring and mainly helpful. Staff listened to people and were patient with them. People's anxiety or potential distress was picked up on by staff who took action to alleviate this. People were supported to make choices and where they were not able to do this any longer staff knew what people's preferences were and they tried to uphold these. Family members were welcomed. They were involved and consulted about their relative's care, where this was appropriate to do so. They were kept informed of any changes regarding their relatives' health and welfare. On the whole people's privacy and dignity was maintained, however, how people's hairdressing needs were met compromised this.

People's care plans lacked accuracy and were not always relevant. At times people's care was not delivered according to the written care plan. People however, told us they liked the way they received their care. Staff provided people's personal care in a way which recognised people's choices and preferences. Staff were not as responsive as they could be to some people's other specific and individual needs. Although social activities were planned and provided these were poorly organised and executed during the inspection. This limited people's opportunities to spend time with staff and receive the support they needed to take part in meaningful activities. There were arrangements in place for people to raise a complaint and have this acknowledged and addressed.

Staff had not received strong enough leadership. They had not always been supportive of the management arrangements and this had led to policies, procedures and expectations not being fully understood and followed. Action taken had started to address this. Although most people and relatives considered the management staff to be visible and approachable, this was not everyone's view. One relative did not consider their feedback to be listened to or acted on sufficiently enough for them to see improvements in the service. The provider's quality monitoring system, at times, identified shortfalls which were addressed and which then resulted in improvements being made. However, this was also not always the case and the processes were not robust enough to ensure full compliance with relevant regulations. The provider was looking at ways of improving how they obtained feedback from people, their relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. People were not protected from risks and situations that may have a negative effect on their health.

People received support to take their medicines, although arrangements could be improved to ensure people received their medicines appropriately and safely at all times.

Recruitment processes were in place and the majority of required checks carried out to protect people from those who may be unsuitable. However, the service needs to make sure these are fully completed each time.

People lived in an environment which was clean. However, some arrangements, put in place by the provider, to avoid the spread of infection were potentially compromised due to poor staff practice.

There were enough care staff to meet people's needs although, a review was needed to ensure staff were able to complete other tasks, such as the laundry.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

People lived in a care home where some improvements had been made to the building to provide more space and easier access.

Is the service effective?

Requires Improvement

The service was not always effective. People received care and treatment from staff who had been provided with relevant training. However, the principles of this training were not always applied in practice; staffs' standard of practice varied.

People received support with their eating and drinking and they were able to make choices about what and when they ate. They were provided with a diet that helped maintain their well-being. However, some people would have benefited from more staff awareness when this support was provided.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

Staff ensured people's health care needs were met and supported them to attend health appointments.

Is the service caring?

Requires Improvement

The service was caring but an improvement was needed to ensure people's privacy and dignity was maintained at all times.

People were cared for by staff who were kind and who listened to them.

People's preferences in relation to the delivery of their personal care were explored and met by the staff where possible.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans and other record sometimes lacked the detail staff needed to ensure people's needs were met safely.

People's needs were not always responded to in a way which met their individual needs.

People's relatives had opportunities to be involved in the planning and reviewing of their relative's care.

There were some arrangements in place to provide people with activities. However, some improvements were needed to these to ensure the time spent with people was as effective and meaningful to them.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not as well-led as it could be. The provider's quality monitoring system was not providing people with the protection they required. The audit processes were not robust enough to always identify necessary actions and ensure full compliance with the regulations.

New management arrangements had been in place for a while, but had not always been fully supported by the staff. However, actions had been started to address this.

The management team sought feedback from people and their relatives and ways of improving this were being looked at.

Avalon Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 16 February 2017 and was unannounced.

Prior to the inspection we reviewed all the information we held about the service since its new registration with the Care Quality Commission (CQC) in 2015. The provider had completed a Provider Information Return (PIR) and submitted this to the CQC in January 2017. 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. We reviewed all statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

The inspection was carried out by one inspector. Another second inspector was shadowing this inspector. An expert by experience helped to carry out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case caring for an older person and the experience of accessing similar services. We also gathered feedback from commissioners of the service and other health and social care professionals.

During the inspection we spoke with seven people, some of whom were unable to clearly tell us about their experiences. To understand more about people's experiences we observed how they received their support and how staff interacted with them. We spoke with three relatives. We reviewed four people's care files which included risk assessments and care plans. We reviewed two people's medicine administration records (MARs). We also reviewed people's activity records.

We spoke with staff. This included the registered manager, the group manager and a senior member of staff (known as the care manager). We also spoke with four care staff, one cleaner and the cook/activities co-ordinator. We reviewed one staff recruitment file.

We reviewed records and documents relating to the management of the care home. We requested that some of these be sent to us after our visit to the care home, which the provider did. Documents and records reviewed included: four different audits, the staff training record and records relating to the investigations carried out during the inspection by the registered manager. We also had a tour of the building.

Requires Improvement

Is the service safe?

Our findings

People were not kept safe at all times. Risks to people were not always managed well. People were not always protected from risks that may have an impact on their health and welfare.

Staff helped people to take their medicines. We observed one person being supported to take their medicines. One of the medicines was checked and administered by two staff. Although some medicines were recorded as administered on the person's medicine administration record (MAR), the medicine checked by two staff was not recorded as administered. This record was completed after we alerted a member of staff to this omission. Inaccurate record keeping in relation to people's medicines puts people at risk from potential medicine errors.

Medicines were not always kept securely. Medicines were stored in medicine trollies which were secured to a solid wall. When staff went to administer the above person's medicines they left the trolley doors unlocked and open. The trolley was out of sight of the staff. When we found the trolley doors open we remained with the trolley until it was secured. This practice puts people at risk because they have potential access to medicines which were not prescribed for them. This risk related in particular to people who lived with dementia and who were prone to looking in drawers and cupboards around them.

One person told us they felt supported to take their medicines. They said, "They [staff] give me my tablets, I do not have to worry about that." One relative said, "[Name] gets their tablets put into their hand, they put them into their mouth themselves then crunch them and are given a drink to swallow them down." Another relative said, "I often stumble on an odd tablet that has fallen into the armchair and recording of the application of creams could be better."

In view of the last comment we looked at one person's record for the application of their prescribed skin treatments. Staff told us the administration of these, up to the week of the inspection, had been recorded on a document kept in people's bedrooms. The example of this document viewed by us had not been completed for 28 days. In this person's case, staff confirmed the treatments had been applied daily and the person's skin was in good condition. However, a required accurate record of the treatment given had not been maintained.

Medicines prescribed to be administered 'when required' were signed for when administered and a record of the time also recorded. This ensured staff were aware of when the last dose had been given. This protected people from receiving an overdose of the medicine. Additional guidance, called protocols, as referred to by the National Institute for Excellence in Care (NICE) were not in place. These protocols provide staff with additional guidance about how to use/administer particular medicines prescribed as 'when required'. Proper and best practice guidance was not in place for the use of these medicines at the time of the inspection.

We recommend that the provider seek advice, from a suitable source, to ensure best practice guidance for the management and administration of these medicines is put in place.

Risks to people's health were recorded on risk assessments. Associated care plans then outlined how these risks would be managed. We reviewed one person's risk assessment and associated care plan in relation to their risk of choking. This person lived with dementia and their records stated they could no longer distinguish between appropriate and inappropriate items to put in their mouth. The risk assessment stated this person was therefore at risk of choking. Records stated that certain items should be removed out of sight. These items were seen readily available and to hand during the inspection. The records stated the person was to be monitored at all times. We observed this person take items, which staff later, told us should have been out of sight, put these in their pocket and walk away with them. We alerted staff to this and they did not act on our reported observation so a member of the inspection team followed the person. Once they met up with them, the person was already spitting the debris from the items, out of their mouth. On this occasion this person did not experience any ill-effect. However, staff had not ensured this person's identified risk had been managed appropriately.

Another person had previously developed pressure ulcers. Although now healed and free of pressure damage, they had been assessed as still being "at risk" of developing further pressure ulcers. A pressure reducing mattress had been provided by the health authority to reduce this risk and was on the person's bed. When we entered the bedroom the person was not in bed. The pressure reducing mattress was switched on at the wall socket but off at the mattress pump. We asked if it was normal practice to switch the air mattress pump off when the bed was not in use. We were told it was not normal practice and staff would not be expected to do this. We asked the management staff to investigate why this had happened and inform us of their findings. The investigation was unable to determine how long the mattress pump had been switched off. There were no checks in place to ensure equipment such as this was working before it was used. Again, on this occasion this person did not experience any ill-effect. However, staff had not ensured suitable arrangements were in place to ensure the person received the support they required to mitigate this risk.

Managers later told us they planned to address this by introducing a system where pressure reducing equipment would be checked, as working correctly, before it was used.

We reviewed another person's risk assessment in relation to their risk of falls. The falls risk assessment had assessed the person as a "Low" risk. This had been reviewed monthly and records stated there had been no falls in the last six months. A stair gate had been fitted at the top of one flight of stairs to deter this person, and others, from attempting to use the stairs unaided. This person's personal emergency evacuation plan (PEEP), which would be followed in the event of fire, stated the person was "unable to negotiate stairs". Staff however, told us the person used the stairs regularly and we later observed the person coming down the stairs. In the event of a fire the lift would not be used, so in this case, the information on the PEEP was potentially misleading. This could place this person, and others, in unnecessary risk in the event of needing to evacuate the building.

Staff informed us that another person was "sometimes" moved by using a mechanical hoist. Information about this, in the care records, was unclear as to when this should be used. We therefore asked staff how they moved the person and when they would use the hoist. Two staff told us the person required the assistance of two care staff to stand, but once standing, the person walked with a walking frame. Another two staff told us they did not use a hoist because the person had not yet been formally assessed for this. They told us however, that the person did not stand well. Another member of staff told us they used a hoist when the person was unable to take their own weight. This person's PEEP stated the person could walk unaided.

A document called "Safe Systems of Working" was seen in some people's care files and it gave staff guidance

on how to move a person safely. For the person above this was not in place. Managers explained they were waiting for an occupational therapist to visit and formally assess the person for a hoist. They told us they had explained to the staff that if the person could not stand and hold their own weight, a hoist should be used. This guidance had not been clearly recorded and staff had an inconsistent understanding of how the person should be safely moved. This put the person and staff at risk of potential injury.

We observed a steep step up into the main hallway from the front entrance porch. This was black in colour and was the original front door step before the porch had been added. This step blended into the colour of the surrounding floor. There was no warning sign, no warning paint/tape or additional lighting to highlight the fact this step was there. This area was a frequently used thoroughfare. There was no risk assessment in place with regard to this hazard. We also observed window restrictors in place where there was access to the screw which held these in place. These could potentially be unscrewed and the window fully opened. We fed back our observations to the management team.

A number of specific risks were not managed appropriately to ensure people's safety. This put people at risk of receiving unsafe and inappropriate care or treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The processes in place for the recruitment of staff needed improvement to ensure people were fully protected. The staff recruitment record included an appropriate clearance from the Disclosure and Barring Service (DBS) prior to the staff member's employment. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been obtained. We were told gaps in employment history were explored during the recruitment process but a four month gap was seen on the application form. We were told that this gap had been missed and had not been explored.

We recommend that the provider, seek advice from an appropriate source, to have a system in place which ensures robust recruitment checks are always completed.

There were some arrangements in place to prevent the spread of infection. At the time of the inspection a hospital acquired infection was being managed correctly. There were some appropriate restrictions in place. Personal protective equipment (PPE) such as plastic gloves and aprons were available and in use. There were correct disposal arrangements in place for the used PPE. Managers told us these precautions would remain in place until clearance had been given by medical staff. Staff also wore PPE to prevent cross contamination when delivering other people's personal care and food. We observed staff using hand sanitiser solution as well as washing their hands. Cleaning equipment was colour coded, so for example, equipment used to clean toilets was not used to clean the dining room. The kitchen had been awarded the top rating of '5' by the Food Standards Agency following refurbishment of the kitchen approximately a year ago. This rating meant systems were in place to maintain a good standard of kitchen cleanliness and food safety.

We checked the arrangements for the management of laundry and waste. A contract was in place with an appropriate waste contractor for the removal of certain waste. For example, the safe disposal of used continence pads. A specific waste bin with a lid which opened automatically when approached had been recently purchased. This avoided the need for contact with the bin. A specific bin liner indicated this bin should only be used for the disposal of this kind of waste. During the inspection we found the bin without the lid and we were later told it had been lost. Used continence pads were therefore exposed. The bin also contained rubbish which should have been in the regular household waste or recycling. We also found laundry, ready for washing, in one of these bin liners on a person's bedroom floor.

We asked the registered manager to investigate these issues. During investigation, one member of staff said there had been a "backlog" of laundry the day before and this had caused a shortage of laundry bags. No particular reason was given for the dirty laundry stored in the bathroom. The inappropriate management of laundry and waste potentially compromised the good actions which had been put in to place to reduce the risk of infection spreading. Managers told us there had been on-going issues with getting some staff to follow the provider's expectations with regard to this. Actions had already been taken to address this which had included more monitoring checks on staff practice.

We reviewed staffing numbers. The senior member of staff confirmed there were enough staff on duty each day. They confirmed that during the week they were also available to provide care and help with other tasks. A review of the service by commissioners in February 2016 confirmed staffing numbers had been increased following the last CQC inspection in March 2015. The senior member of staff said, "Staffing is better than it was." We observed there to be enough staff to provide people's personal care, support them with their eating and meet some people's particular preferences. These included getting up later in the morning and having breakfast at a time which suited them.

However, care staff were also responsible for managing the laundry, providing people with activities and preparing the evening meal. As reported above staff had not been able to complete the laundry the day before the inspection because the priority had been to deliver people's personal care. We therefore questioned if there were enough staff to complete all necessary non-care tasks. We were told there were but the registered manager also told us they would ask the cleaner if they would like additional hours to help managed the laundry. Other observations during the inspection showed that staff spent little time with people. However, there were other reasons for this other than a lack of staff. One activity session was poorly organised and at other times staffs' time was not used effectively as reported on in "Is the service Responsive?".

There were arrangements in place to keep the environment clean. We observed cleaning taking place and there were no offensive odours. One relative told us they were concerned about the lack of cleanliness, especially at weekends, when they told us bins were not emptied. We were told "essential cleaning" was carried out at weekends. This included the cleaning of toilets, main communal areas and the emptying of waste bins. Some cleaning was carried out at night if the night staff had time. The cleaning tasks for the day were decided on, in the morning, by the senior member of staff with the cleaner. A record was kept of the cleaning tasks completed. On one of the inspection mornings one person's bedroom carpet needed cleaning so this was done. The senior member of staff told us she monitored the standard of cleaning completed by carrying out spot checks. These checks were recorded.

We were told by the management team they carried out visual checks to ensure the environment was safe. These were not recorded, although, an external health and safety company carried out an annual audit (last completed in September 2016). Some actions required following this had been completed but some were still outstanding. These related to fire safety. During the inspection we were concerned with several areas of potential risk relating to fire safety. We requested that the fire safety office carry out a visit to ensure the care home was fully compliant with the Regulatory Reform (Fire Safety) Order 2005 and associated regulations. They subsequently issued a letter of non-compliance and gave the provider advice, which will be followed up by the fire safety officer in due course.

People were protected from the risk of potential abuse. The provider's policy and procedures on this had been reviewed and updated in January 2017. They stated clearly what is currently recognised as abuse and what action should be taken to protect people. The provider's policy and procedures made reference to the local county council's safeguarding policy and protocols and stated these would be complied with. Staff had

received training on what abuse was and what to do if they witnessed abuse or it was reported to them. Management staff shared safeguarding concerns appropriately with relevant agencies that also had a responsibility to safeguard people. When necessary staff worked with other health and social care professionals to safeguard people. One such example was discussed during the inspection.

Improvements had been made to the environment over the last couple of years. For example, we were shown bedrooms and a bathroom which had been re-decorated and refurbished in the last year. A large extension had been added to the side of the building which provided additional kitchen space and a large dining room. An extension had been added to the front of the building to provide a care office as well as a sloped wheelchair access.

Requires Improvement

Is the service effective?

Our findings

People were looked after by staff who had completed relevant training. One relative said, "I think staff are well trained" and another said, "A couple of the staff are well trained but the majority of them are not knowledgeable, especially about dementia." Our observations showed that staff did not always apply the principles of that training in practice. We observed that staff did not always respond appropriately to people's behaviour and needs. The findings reported on in "Is the service safe?" and "Is the service Responsive?" in particular demonstrate this. We were told staff practice competencies were checked but, only recorded, when related to medicine administration. Staff had received support session known as supervision. These were meetings with staff where observations on their competency, their training needs, any other support needs and future aspirations were discussed.

The training record showed that training was initially provided when staff were new to the care home and then provided on an on-going basis to keep them updated. Update training was provided in subjects such as: safe moving and handling, safeguarding, food hygiene, infection control and fire safety. The training record showed that some staff had also achieved nationally recognised qualifications in care. Some had also completed training in subjects which included: allergies and allergens, dementia care, first aid, nutrition and medicine administration. The training record showed that not many staff had completed training in subjects such as end of life care, managing people's behaviour and the mental capacity act and deprivation of liberty safeguards had been completed by very few staff.

We recommend that the provider seek advice, from a suitable source, to ensure that the training and support being provided to staff is sufficiently effective.

People received support at mealtimes but in places a better awareness by staff, of people's needs, would have benefitted. During one lunchtime people were asked if they would like a drink. They had a choice of drink however, not many people accepted the opportunity of a drink. Where some people would have benefitted with a little more encouragement this was not provided so they went without a drink at this point. Some people's meals were served on red plates. This helped people who lived with dementia in particular, to distinguish the plate from the table and the food on the plate. Some people required plate guards to help contain their food and staff attached these. One member of staff sat down and helped a person to eat their food. This was done in a way which maintained the person's dignity and without rushing them. Staff were observed removing plates from people who had stopped eating. This was done on occasions without first checking if the person was pausing or with some encouragement would eat some more.

People had the option of eating their meal where they wanted. Some ate in the dining room, some in the lounge and others in their bedrooms. This was an improvement from the previous inspection in 2015. We observed some breakfasts going out late in the morning. One person's was taken to them at 10:45. It was explained to us that they had been offered an earlier breakfast which they had declined. People sitting in their bedrooms had drinks and snacks within easy reach.

People's weight was monitored and any concerns about this were discussed with the person's GP. The cook

told us they got to know who was losing weight and knew needed additional calories by the care staff either telling them or through attending staff handover meetings. There was no written information about this passed to the kitchen. The cook said, "I do fortify foods." They did this by adding additional cream, butter and dried milk to foods. Some foods however were fortified as a matter of course, for example, the custard on the day of the inspection had cream added to it. The cook provided food in different textures and accommodated other dietary needs. We were told that dietary choices and preferences, determined by religious belief, had been respected in the past. There were no related preferences at the time of the inspection. Information on food allergens had been put together by the cook who had completed relevant training on this. One person's food allergy, for example, had been identified and was considered when preparing their food. The cook was keen that people's choices and preferences regarding their food were identified and met. They said, "I listen to the residents". They went onto tell us what specific foods they cooked to meet some people's particular likes. The cook confirmed staff had access to food which they could prepare for people if needed during the night. Care staff prepared the evening meal.

Comments from two relatives about the food varied. One relative said, "The food always smells nice. They [staff] watch [name] and help if they cannot manage to eat it. They make sure [name] has plenty to drink." Another relative said, "At times the food is shocking." The options provided for the main course at lunch time on one day of the inspection were faggots or sausage casserole with mashed potato and carrots. We observed that the sausage casserole did not look overly appetising; pink sausages sitting in thin gravy. We did not receive any feedback on the standard of the food from the people who ate it.

People who could not make specific decisions about their care and treatment or their accommodation, had their mental capacity assessed with regard to this. Where this determined a lack of mental capacity to make these decisions, staff adhered to the principles of the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We therefore observed people receiving support to make independent decisions; about day to day activities and their care. Staff recognised that people's ability to make decisions may alter from time to time and subject to subject. We observed staff explaining to people, what support it was they wanted to provide and then waiting for the person's agreement. One person was feeling poorly and several options, about what to do about this, were discussed with them quietly and in an unrushed way. Medicines were seen to be administered to people after obtaining their consent. Where people had not been able to make specific decisions, these had been made on their behalf and in their best interests. In one person's case, appropriate people had been involved in this process such as a health care professional, senior care staff, the person's designated representative and the person.

Where people's liberty was restricted in order to provide them with the care and treatment or level of supervision they required, managers had applied for Deprivation of Liberty Safeguards (DoLS). 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). Several applications had been completed which had not yet been authorised by the supervisory body (the County Council). One person had authorised DoLS in place and they and their family were aware of this and the conditions of this were met.

People had access to health care professionals and other specialists as needed. One relative spoke with us about their relative who lived with dementia. They explained their relative's abilities and health had

deteriorated because of the condition. The relative said, "[Name] has not needed to see the GP since being here, but I am sure they [staff] would ask him to call if it was necessary." Other people's care records recorded visits by and referrals to health care professionals and other specialists. These included: GPs, community nurses, physiotherapists and mental health specialists.

There was evidence of people being supported to attend various hospital appointments and clinics. For example, optician appointments and the diabetic clinic. People also had access to regular chiropody treatment. One person had been poorly prior to the inspection and staff had called for an ambulance to attend. We observed this person returning from their stay in hospital. They said, "I'm home, I'm home." Staff responded to this by saying, "Yes, you're home darling." We later asked the person if they minded being called "darling" and they told us they did not mind. Staff were going to organise a review with the person's own GP now they had returned from hospital.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was compromised when hairdressing took place. After having their hair washed people were seated in the middle of the main lounge to have their hair attended to by the hairdresser. When we observed this the lounge was full with people sitting around the edges of the room. We fed back our view of this practice to the senior member of staff. They told us there was no-where else to do this and people did not mind. We asked if that meant each person had been individually asked if they didn't mind and they had not been. The registered manager was also surprised this practice was taking place. They told us they would talk with people about this, but that a more suitable place for hairdressing would be found.

People's privacy and dignity was maintained when personal care was delivered. This was done in private behind closed doors. Conversations about people's care were carried out discreetly and away from other people's hearing. Information about people was held confidentially and all paper records were kept in an office which was locked when vacant. New electronic records were password protected and there were different levels of access to these. Information stored on these was accessed on a needs to know basis. People were treated with respect when staff spoke with them. One relative's comment on their feedback form, about their relative's care, referred to staffs' "unfailing patience, kindness and always having regard for [name's] dignity."

People told us the staff were kind and caring and those we spoke with were happy with their care. One person said, "I could not be in a better place, they [staff] are nice to me all the time, they are wonderful. I call them Avalon Angels." Another person said; I do not think staff could be better, they are there when I need them, but I try to do what I can for myself. I can please myself when I get up and when I go to bed. I have a bath on Sunday and they all treat me nicely." Another person said, "Everybody is really lovely, they are nice to me and do everything I want. I am happy here, they always ask: is there anything else I can do." Comments from relatives included: "Staff are very caring in their attitude, they are always smiling. I cannot help but praise staff for the way they do things for [name]." "[Name] is always clean and tidy when I visit, although I have seen [name] wearing another person's clothing." "Very good, so friendly [the staff]. I think it's five stars, lovely. I know [name] is being cared for." One relative spoke to us about their on-going concerns relating to their relative's care. This person's care records showed there had been meetings with this relative to try and resolve these.

People appeared to have a good relationship with the staff around them. They looked at ease when staff approached them. We observed staff laughing with people and generally chatting with them about their day or their family. Some people, at times, showed signs of confusion and bewilderment about what was going on around them. Staff reassured people and were patient with them if things needed further explanation. One person was 'shooed away' by another, but staff quietly intervened. They suggested the person who had been unwelcomed go with them. Staff then asked another person if the person could sit with them. Staff stayed and chatted with both until they were settled. One other person became anxious and a member of staff suggested they both go for a walk in the sunshine, which they did. We therefore observed staff being kind, caring and thoughtful towards people. Staff showed they were interested in what people had to say and they took action to alleviate people's anxiety or upset.

People were supported to make choices and we observed people making simple day to day choices. For example, they chose what time they got up and what they wanted to wear. One person had wanted a lie in on one of the inspection mornings and this had been respected by the staff. Staff told us people got up at various times during the morning. One member of staff said, "They get up when they want to." This showed staff aimed to deliver people's care at times it suited the person. There was a chart in each person's bedroom with comments on about the person's personal likes, dislikes and life history. Relatives had helped provide this information in many cases. This helped staff to personalise people's care and in particular, when the person could no longer easily express their choices or wishes.

People's records showed that relatives were consulted with [if appropriate to do so] and updated about people's health and welfare. They were able to be involved on behalf of their relative. One person's care records showed evidence of care reviews and other meetings with the person's closet relative. One relative told us the designated member of their family was kept well up to date by the staff.

We observed people visiting at various times of the day and there were no known restrictions on visiting. Care records and relatives told us staff supported people's right to a family life.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to admission and their care needs identified. Plans of care (care plans) were devised around these identified needs. However, records relating to people's care were not accurately maintained. We found care plan reviews were recorded as completed. However, when we either read additional information or asked staff about the care a person needed or observed the care being delivered, the guidance in the care plan was not always relevant. In other cases, the guidance was relevant but was not being followed. The standard of the care planning detail also varied. The senior member of staff told us they were particularly aware that care plan information needed to be more specific and personalised. The Provider Information Return (PIR) stated that it was hoped that by transferring care records on to a live web system, would mean that people's care records could be more easily monitored (by senior management staff) and required improvements made more quickly.

We saw several examples of care plans which were not relevant, absent or not accurate. For example, one person's care plan review recorded their deterioration in their ability to make decisions and complete their personal care. However, no alteration had been made to the relevant care plan telling staff how to support these changed needs. Another person's behaviour had altered and it had been identified that staff had found this more challenging to manage. A specialist mental health professional had been involved. However, there was no relevant care plan or behaviour management plan outlining how this person's distress/frustration was to be managed. Another person's care records stated they should be seen by their GP, which they had been. However, there was no recorded follow up with regard to the GP's visit or the subsequent prescribed treatment. Another person's care plan relating to the support they needed at mealtimes had not been updated to reflect their current needs which were discussed with the senior member of staff. One associated assessment recorded the fact the person had a significant visual impairment. There was no relevant care plan telling staff what impact this had on the person and how they needed to support this. We were told this piece of information had obviously been missed when the care plans were written. Poorly maintained and inaccurate care records potentially put people at risk of receiving inappropriate or unsafe care and treatment.

This is a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People's social needs and behaviours were not always sufficiently met and responded to because of how the staffs' work and their involvement with people was organised. During a period of 45 minutes we observed three staff on duty, sitting in the dining room and talking together. There was one person sitting in the dining room at this time but most other people were seated in the front lounge area and a few in a smaller lounge. People in the front lounge were not visited by any staff during this period of time. We initially thought these staff were taking a break, however, we were later told they had been completing their daily care records. One relative had provided feedback in a survey carried out by the provider in December 2016. They had commented, "Staff spending too much time in the dining room". We spoke with the senior member of staff about this comment and our observation. They explained it had been the above scenario which had concerned the relative and which action had been taken in response. They told us staff had been

directed to write their care records discreetly, either individually or in two's whilst seated in the same room as people. This way they were able to provide supervision and reassurance where needed. At the time of the inspection this had not happened.

Following this observation we decided to see how and when staff spent time with people and how they organised the planned afternoon activity. The activity shown on the activity planner for the afternoon was 1980's music. The activity shown for the morning was the hairdressing. Care staff prepared afternoon tea just before 2.45pm and served this and then two members of staff started to organise the activity. The staff were unsure which music was to be used so they decided to provide a music and movement session instead. One member of staff did not know how to operate the CD player and then it was decided it was not working and a replacement was found. At 3.35pm a CD was put on which staff decided was not appropriate so this was altered. Eventually music was found and one person got up and started dancing. Staff responded well to people's enthusiasm for a dance and danced with others, therefore adapting the activity. A further two members of staff came in and one sewed name tags into a person's clothing. At 3.50pm, so 15 minutes after the music and dancing had started, all staff except one left the room. At 3.55pm a CD of wartime songs was put on and people continued to sing. This particular observation showed the activity was poorly organised and that very little quality time was spent with people supporting them with meaningful activities.

During this time two particular situations were observed and showed that staff were not as responsive as they should have been. In one situation staff did not respond effectively and in another they were not present to be able to respond. One person who lived with dementia walked around the lounge drinking from other people's beakers and taking a bite from the scone of a person who was sleeping. Staff did not attempt any form of distraction or any other action to resolve this. Whilst this person was not being restricted, the act of allowing this person to do this showed staff had not considered several important factors. The impact on this person was: they did not have their dignity maintained, it put them at potential risk of a negative response from other people and it was unhygienic. The second situation happened when staff were not present. Between 4.15pm and 4.30pm there was no staff in the lounge. At 4.30pm a person stood up, quite unsteadily and attempted to mobilise unsafely. We sought assistance from staff for them.

Whilst people continued to sing after the dance activity one member of staff returned to the lounge to ask them what they would like for tea. At 4.40pm the senior member of staff sat in the lounge to supervise people whilst doing paper work. Other care staff carried on with tasks elsewhere before they prepared the evening meal.

We spoke with the cook who was also the activities co-ordinator. They told us they spent approximately six hours a month planning and arranging activities. They told us care staff predominantly provided the activities, although, they also told us they spent time doing this. The time they spent doing this was unclear and depended on their availability. The Provider Information Return (PIR) stated that the cook/activities co-ordinator was a member of a local forum for activity co-ordinators and they would continue to attend this. It also stated that it was planned for another member of staff to help take a role in the planning and organisation of meaningful activities.

The cook/activities co-ordinator devised the weekly activities planner which the staff followed, or adapted. For the week of the inspection activities on the planner included: the 1980's music session, pamper time; music and movement, quoits, armchair aerobics, card and board games. The activities co-ordinator/cook also organised other activities and events which included a monthly church service as well as external entertainers. They also baked cakes and organised "special teas" to celebrate people's birthdays. However, they told us they wanted to see more individualised activities taking place. Records were kept of activities but we were told that individual activities were not always consistently recorded. This had made it difficult

to evaluate what was being provided in relation to this and determine if it was meeting people's needs and more individual preferences. People's care and support was not always designed in a way which met all their individual needs.

This is a breach of regulation 9 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

Organised for later in the inspection week was a Valentine's Party. This had been advertised as a "fabulous high tea" with bingo and prizes, a quiz and music. Family and friends could attend at a cost of £5 each as this was also a fund raising event for the care home's amenity fund. This money was put towards trips out and other social entertainment. Ideas for activities and the main summer trip had been explored at the last 'resident and relative' meeting. People had decided that 2017's summer trip would be to Weston-Super-Mare.

People were unable to tell us about their involvement in the planning of their care. Relatives, as well as people's care records, informed us they had been able to speak on behalf of their relative when their care had been reviewed. People who were able to discuss their care with us told us they were happy with the way it was delivered.

There were arrangements for people to be able to raise a complaint and have this listened to, investigated if required and responded to. The Provider Information Return (PIR) stated there had been two complaints in the last year. We discussed these with a senior member of staff during the inspection and these had been responded to.

Requires Improvement

Is the service well-led?

Our findings

People were not protected by a robust and effective quality monitoring system. Following on from our findings reported on in the rest of this report, in particular in "Is the service Safe?" and "Is the service Responsive"?, we reviewed how the provider assessed and monitored the services performance. We looked at a selection of audits and checks to see how these identified actions for improvement, how these were managed and if they led to improvement.

We asked to see the infection control audit. We were shown a recorded check, carried out by a representative of the provider, on areas which had been cleaned. We were also shown an audit headed "Infection Control Audit" completed on 10 February 2017. However, this also predominantly referred to the checking of the cleaning and did not reference any infection control arrangements. We referred to the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. It is this guidance that providers have to be able to demonstrate they are complaint with. The content of Code was not known to the senior member of staff and could not be found in the care home. There was no designated infection control lead for the service. The registered manager confirmed that an audit, in line with relevant parts of the Code, would be put into place. This would enable the provider to check if they are fully compliant with the relevant guidance. They also confirmed that an infection control lead for the care home would be identified.

Some other audits reviewed were not robust enough and had not identified the shortfalls we identified during the inspection. Two audits had identified actions for improvement and one of these had resulted in an improved audit score. For example, an audit on medicines in November 2016 identified that some actions were needed to improve the accuracy of the medicine records. An audit in December 2016 showed that relevant actions had been taken and this had resulted in an improvement of the overall score for the medicine audit. These audits had not however picked up on the lack of best practice with regard to protocols in place for certain medicines. This was because they did not include this in the audit content. An audit of the care records in January 2017 identified a need to personalise people's care plans. Actions required had been verbally fed back to the staff and there was evidence of some improvements in the scores for care plan audits over a period of time. Although these audits showed improvement being made they did not identify some of the shortfalls identified in this report. Care plans were to be transferred over to the electronic records and it was at this point that these actions would be completed. The senior member of staff however explained that some staff lacked sufficient care planning skills.

Based on other observations during the inspection and the comment above it was necessary for the provider to be sure staff had the right competencies, knowledge and to know if the training provided was effective. Staff competencies were only formally assessed and recorded against medicine administration. There was a need for a more robust and regular audit/check of these.

Due to the level of non-compliance reported on in this report the arrangements for monitoring the service were clearly not effective enough. The auditing process had sometimes shown that actions had been identified, completed and that these had led to improvements, but this had not always been the case. The

provider's quality monitoring process had not ensured that risks to people's health, safety and welfare had been successfully mitigated as a result of this process.

This is a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

The current registered manager for Avalon had been in this role since December 2015. The plan was to pass this role to a senior member of staff so they could concentrate on running the overall business, which they owned. Support and mentorship for this role had been provided to the senior member of staff over the last year. This member of staff managed the service on a day to day basis, with support from the registered manager, who visited the service three times a week. This member of staff had completed relevant, additional courses and had obtained a qualification in management and leadership. They had already applied to the Care Quality Commission (CQC) to be the new registered manager. At the time of the inspection an interview with the CQC was imminent. The registered manager and the group manager shared the quality monitoring responsibilities on behalf of the company. We met both these managers during the inspection. We fed back our findings of the inspection to the current registered manager (company owner) and to the senior member of staff.

People knew who the senior member of staff was even if they could not remember her name. The senior member of staff confirmed they visited each person on a daily basis as part of their checking and monitoring responsibilities. One person told us they attended meetings (along with other people) held by the senior member of staff on a monthly basis. They told us these meetings discussed what people felt about things and asked them what changes they would like to see happen. They were able to put forward ideas and suggestions they had, for example about the activities. They also confirmed that a member of staff had helped them complete a satisfaction questionnaire. The senior member of staff confirmed they held monthly meetings with people who lived at Avalon. These meetings were used to pass on any relevant news to people and their relatives but also to seek feedback from them. Feedback had also been sought in December 2016 from people and relatives by using satisfaction questionnaires. The Provider Information Return (PIR) stated that the management team were looking to see if they could improve the questionnaires and in how people and relatives could be more involved in the decisions made.

Family members, on the whole were positive about the current leadership. One relative said, "She [senior member of staff] is very pleasant, always flying around, but asks me how things are and, asks about me too." Another said, "I would feel comfortable going to her [senior member of staff] if I was worried, but so far everything is fine and I think I am very lucky that [name] is here." One relative was not so positive about the management arrangements. They commented that there needed to be a change in these in order for things to improve.

People lived in a care home which would benefit from stronger leadership. In particular, there was evidence to show that some staff were disengaged and not supportive of the current leadership. There was evidence to show that the senior member of staff had frequently communicated her expectations in staff meetings and at other times, but this had remained ineffective. This had necessitated additional monitoring visits to ascertain why expectations were not being met, when and by whom. Some individual and significant conversations with staff had followed these visits and more support had been provided to some staff, to help them meet their responsibilities. The registered manager discussed with us how the company's HR policies and procedures were now being used to help resolve and manage this situation. The Provider Information Return (PIR) stated that ways of improving feedback from the staff and their involvement in decision making were being looked at.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support was not always designed in a way which addressed and met all their individual needs. Regulation 9(1) 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Not all practicable actions had been taken to mitigate risks to service users' health. This included potential risks relating to the use of equipment and the premises. Regulation 12 (1), 12(2)(b), 12(2)(d) and 12(2)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and assess the quality of services provided were not always operated in a way which ensured compliance with the necessary regulation. These arrangements had not always led to overall improvements in the service. Regulation 17 (2)(a). Care records were not sufficiently completed and were not always accurate in respect of service users' care and treatment needs. Regulation 17(2)(c).