Nursing Home Management Limited

Avenswood Nursing Home

Inspection report

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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

Overall summary

The inspection took place on 27 October 2015 and was unannounced.

Avenswood Nursing Home provides nursing care for up to 19 people. The home is situated in Blundellsands area of Merseyside, conveniently located for shops, parks and public transport. It is a detached house with both single and double rooms. Some have ensuite facilities. Accommodation is provided over three floors accessible by using a stair lift. There is a garden to the rear of the building. There were 15 people living in the home on the day of the inspection.

There is a registered manager in place. 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.

Staff understood how to recognise abuse and how to report concerns or allegations.

There were enough staff on duty at all times to ensure people were supported safely.

Summary of findings

We saw the necessary recruitment checks had been undertaken so that staff employed were suitable to work with vulnerable people.

Staff said they were well supported through induction supervision, appraisal and the home's training programme.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority.

People told us they received enough to eat and drink. However there was no choice of meal offered each day. They were encouraged to eat foods which met their dietary requirements.

People's physical and mental health needs were monitored and recorded. Staff recognised when additional support was required and people were supported to access a range of health care services.

People told us they had choices with regard to daily living activities and they could choose what to do each day. The home did not provide much in the way of activities for people.

They told us staff treated them with respect. Staff we spoke with showed they had a very good understanding of the people they were supporting and were able to meet their needs. We saw that they interacted well with people in order to ensure their received the support and care they required.

We saw that staff demonstrated kind and compassionate support.

We saw that people's person centred plans and risk assessments were regularly reviewed. People had their needs assessed and staff understood what people's care needs were. Referrals to other services such as the dietician or occupational therapist or GP visits were made in order to ensure people received the most appropriate care.

People living at Avenswood were involved in the decisions about their care and support, and in choosing what they wanted to do each day.

The home had a complaints policy and processes were in place to record and complaints received to ensure issues were addressed within the timescales given in the policy.

The registered manager provided effective leadership in the home and was supported by a clear management structure.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs.

The service had a quality assurance system in place with various checks completed to demonstrate good practice within the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Medicines were administered safely to people.

Staff understood how to recognise abuse and how to report concerns or allegations.

Recruitment checks were undertaken to ensure staff were suitable to work with vulnerable people.

There were enough staff on duty at all times to ensure people were supported safely.

Good

Is the service effective?
The service was effective.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

Staff said they were well supported through induction, supervision, appraisal and the home's training programme.

People told us they received enough to eat and drink and chose their meals each day. They were encouraged to eat foods which met their dietary requirements.

People's physical and mental health needs were monitored and recorded. Staff recognised when additional support was required and people were supported to access a range of health care services.

Good

Is the service caring?
The service was caring.

People and their relatives told us they had choices with regard to daily living activities and they could choose what to do each day.

People told us staff were caring and treated them with respect.

We saw that staff demonstrated kind and compassionate support.

Staff we spoke with showed they had a very good understanding of the people they were supporting and were able to meet their needs. We saw that they interacted well with people in order to ensure their received the support and care they required.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People had their needs assessed and staff understood people's care needs. We saw that people's care plans and risk assessments were regularly reviewed.

Referrals to other services such as, the dietician or occupational therapist and GP visits were made in order to ensure people received the most appropriate care.

The home had a complaints policy and processes were in place to record complaints received.

There was little in the way of stimulation for people. Not many activities were currently provided for people who lived in the home.

Is the service well-led?

Good

The service was well led.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs.

The service had a quality assurance system in place with various checks completed to demonstrate good practice within the home. Checks for medication administration were not robust enough to correct errors when they were identified.

Avenswood Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 October 2015 and was unannounced. The membership of the inspection team included an adult social care inspector, a specialist advisor and an expert-by-experience. A specialist advisor is a person who has experience and expertise in health and social care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service before we carried out the visit. Prior to the inspection we usually request the provider complete a Provider Information Return (PIR) to us. The PIR is a document the provider is required to submit to us which provides key information about the service, and tells us what the provider considers the service does well and details any improvements they intend to make. We had not requested a PIR on this occasion.

We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted also one of the commissioners of the service to seek their feedback about the service.

During the inspection visit we spoke with seven people who lived at the home and four visiting relatives. We also spoke with three care staff, the registered manager, the nurse manager and the cook.

We spent time observing the care provided to people who lived at the home to help us understand their experiences of the service.

We viewed a range of records including: the care records for four people who lived at the home, three staff files, records relating the running of the home and policies and procedures of the company.

We carried out a tour of the premises, viewing communal areas such as the lounge and bathrooms. We viewed some of the bedrooms. We also looked at the kitchen and laundry facilities, and medication storage area.

Good

Is the service safe?

Our findings

People who lived in the home told us they felt at ease with the way the staff supported them. One person said, "Yes, they're pretty decent". Another person told us, "(Staff are) very, very nice, they couldn't be better". We asked what they would do if they felt they were being treated unfairly. Their comments included: "I'd tell them off myself", "I'd tell my son", "I'd speak to my family", "I wouldn't stay if I wasn't feeling loved", and "I feel very safe living here."

All of the relatives we spoke with told us they thought their family members were safe living at Avenswood. We asked if they felt the home provided a safe service. One person said, "I've never observed anything that's unsafe". Another person said, "I've never seen anything to worry me". Another person said "Definitely feel (relative) is safe here. Every member of staff seems to be aware of the residents' state".

Staff understood how to recognise abuse and how to report concerns or allegations. There were processes in place to help make sure people were protected from the risk of abuse. Risk assessments and support plans had been completed for everyone to help ensure people's needs were met and to protect people from the risk of harm. Care staff we spoke with had a good understanding of how to keep people safe.

We looked at how medicines were managed in the home. Everyone had a lockable cupboard in their room which contained all their medication and eye drops (unless it had to be stored in the fridge or controlled drugs cupboard). Some medication stocks and homely medication were stored in the medical room in a locked trolley. There was no thermometer in the medical room. In several of the rooms there were no thermometers on the wall. This issue was discussed with the manager and they agreed to address the matter. In the rooms with thermometers the temperature was under 25°C. The fridge in the medical room had a thermometer attached to it to ensure medicines were stored safely. Medicines need to be stored correctly so that the products are not damaged. The appearance of the medicine may not change by incorrect storage but it may not be effective any more. In some cases, it may harm the person who takes it.

We observed the nurse manager complete the lunch time medication round. We saw this procedure was done safely; the nurse manager told people it was time for their tablets and what they were for. We saw that people were given time to take their medication in a safe, unrushed manner. People were also asked if they had any pain and appropriate PRN (as required) analgesia was given and recorded. We found the nurse manager was knowledgeable about what medication each person was taking and who was on PRN pain relief.

Medication administration record (MAR) sheets were completed accurately: We did not find any gaps in the records and saw that appropriate codes used and all medication was signed for.

Medicine audits were carried out. The senior nurse counted the tablets several times a week and the totals were recorded on the MAR sheets. We checked two people's tablets and PRN medication with the senior nurse and these were both correct. A monthly audit was carried out for the documentation of medication. We found some gaps in the audit; the nurse manager was made aware and agreed to address this issue immediately. The fridge temperature was audited twice a weekly.

The nurse manager informed us of one incident when a tablet was destroyed because it had been dropped on the floor. This incident was found to have occurred during an audit. Staff had followed correct guidelines regarding re-ordering one more tablet with the pharmacist but did not record the incident. The nurse manager agreed that if any similar type of incident occurs in the future the incident would be documented.

At the time of our inspection nobody was prescribed controlled drugs. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Legislation. End of life drugs were stored correctly. We looked at past records in the controlled drug book. We found they had been completed accurately according to the policy. Nobody received their medication covertly (hidden). This means that medication is disguised in food or drink so the person is not aware they are receiving it.

A sample of nurse's signatures, their initials and printed name was stored inside the audit file. This enabled the person who administered drugs to be identified more easily. All information leaflets from the medication were stored in the cupboard for staff to refer to if required.

Good

Is the service safe?

The manager could not find up to date copies of the provider's medication policies for us to look at. Old polices existed but these had been replaced with new ones. However the new medication policies could not be provided.

We looked at how the home was staffed. We asked people who lived in the home if they thought there were enough staff. One person said, "I don't think so, they're always busy". Another person said, "I think so, I never have to wait". Another said, "it's adequate, that doesn't mean they've got plenty". Everyone we spoke with said the staff were kind and compassionate and requests for help were answered in a timely manner.

We asked the visitors about staffing levels. One person told us, "Occasionally they might be a little bit short e.g. in the afternoons. For a couple of hours there's only 2 carers". Another told us, "There have been days when I've noticed there's not many staff". Another visitor told us, "I think so (enough staff), I'm very appreciative of the hard work of the staff."

Throughout the day, there appeared to be adequate numbers of staff to meet people's needs and to support them safely. People stayed in their rooms during the day. Most bedrooms were situated on the ground floor, with others situated on the first and second floors. We observed the call bell being answered promptly by staff. People who lived in the home told us that call bells were answered "quickly" or "quite quickly."

During our inspection the registered manager was on duty with a trained nurse and three care staff until 2pm and two care staff until 8pm. In addition care staff provided 'one to one' support for one person from 8am to 10pm; we saw this support was provided over a number of short shifts throughout the day to enable staff to engage more meaningfully with the person. The care team were supported by a cook, kitchen assistant, two domestic staff, a laundry assistant and maintenance person. At night the home was staffed with a trained nurse and one care staff. We looked at the staffing rota which confirmed this.

We looked at how staff were recruited. We saw three staff recruitment files. We found application forms had been completed and applicants had been required to provide confirmation of their identity. We found that DBS checks had been completed and returned. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We saw that the staff concerned had since received a clear DBS. The provider had received two references for staff prior to them commencing the job. References are required to confirm staff are of good character and suitable for the work.

The kitchen was located in the cellar accessed by a door from the hall via some steep stone steps; there was a bar that is placed across the top of the steps approximately 3 feet from the floor. We observed on several occasions throughout the day the kitchen door was open and the bar was not in place. The manager was informed of this. They said staff usually place the bar across for safety. We observed that at the time of our inspection there were no people who lived in the home who mobilised around the home without someone to support them. This meant the risk of people using the steps down to the kitchen was minimal.

Systems were in place to maintain the safety of the home. This included health and safety checks and audits of the environment. A fire risk assessment had been completed and people who lived at the home had a personal emergency evacuation plan (PEEP). This helped ensure their needs for evacuating the building had been assessed and the information was readily available to be shared when required.

Safety checks of equipment and services such as, fire prevention, hot water, legionella, gas and electric were undertaken; maintenance work was completed in a timely way to ensure the home was kept in a good state of repair.

Relatives we spoke with thought the home was clean and well maintained.

Gloves, aprons, hand wash, paper towels and rubbish bins were available in people's room sand bathrooms. Clinical waste was bagged separately. Staff were observed to use personal protective equipment (PPE) and regularly wash their hands after carrying out personal care, administering medication to people who lived in the home or helping them with meals. This practice promoted good infection control.

Accidents and incidents that affected people's safety were documented and audited (checked) to identify trends, patterns or themes. The manager advised us of the actions

Good

Is the service safe?

taken in respect of incidents that affected people who lived at the home. The actions had been taken in a timely manner to reduce the risk of re-occurrence and help ensure the person's on-going safety and wellbeing. We saw that risk assessments had been updated after any incident.

Good

Is the service effective?

Our findings

Relatives told us they felt the staff had a good standard of training which provided them with the skills to care for their family member. They commented on the good communication which existed in the home. A relative told us, "I've never had any problems, they keep me informed". Another said, "Definitely."

Staff had had a good awareness and knowledge of people's needs, and when assistance was needed. People appeared comfortable and relaxed with the staff.

Records showed that people were seen routinely and when required by a range of health and social care professionals including the GPs, community psychiatric nurses, dieticians and speech and language therapists. Care reviews included input from health care professionals which meant they took account of people's physical and mental health. The care plans recorded detailed investigations/tests taken by the GP and with the result. There were documented contacts with relatives recorded in the care plans. Some people had Do Not Attempt Resuscitation (DNR) forms completed and kept in their care records. Records showed people's wishes or that of their family had been recorded and agreed by the GP.

Many of the residents were nursed in bed and throughout the day we observed staff going into rooms to encourage people to drink and to turn them. People were moved two hourly to help maintain good circulation and promote good pressure area care. Throughout the home there were people nursed on pressure relieving mattresses and some had cushions as well. This helped to ensure regular care was given to people to help prevent skin break down. People we saw sat out in a chair had a table near with the call bell and drinks accessible to them. This meant they were able to summon assistance if needed.

The manager had a training plan and the training matrix which we looked at showed us that staff had received mandatory [required] training in a number of areas. For example, moving and handling, safeguarding, infection control, health and safety and food safety. Some staff had attended medication, palliative care, end of life and Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. Other training records we looked at showed 64% of staff were trained at National Vocational Qualification (NVQ)/Diploma level 2 or level 3. A further 21% were undertaking either the NVQ/Diploma at level 2 or level 3.

The staff personnel records we looked at confirmed an induction took place for newly appointed members of staff. One new staff member confirmed this. They told us, "I was not thrown in at the deep end. When I started I had three days induction shadowing someone else."

Staff we spoke with confirmed they received regular supervision and an appraisal each year. One staff told us they felt very supported and felt able to raise any concerns with manager should they arise. We evidence that most of the care staff had received one supervision session in the last three months. However the provider's policy for supervision did not state the required frequency for these meetings. Appraisals had not yet been completed for 2015.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw from the care records that staff sought consent from people and their relatives and involved them in key decisions around daily life and support and holding 'best interest' meetings for specific decisions around people's care and welfare. This follows good practice in line with the MCA Code of Practice. The registered manager advised us that one person living at the home was subject to a Deprivation of Liberty Safeguards (DoLS) plan. The reasons why were reflected and documented in a care plan. We advised the registered manager to take advice

Good

Is the service effective?

from the local authority regarding people in the home who used bed rails to keep them safe as to whether a DoLS application was required for individuals who lacked capacity.

We asked people for their views about the food provided in the home. Everyone we spoke with said they got enough to eat and drink, although some were unsure if they could request snacks. There were mixed responses from people we spoke with. Some of the comments included: "It's not bad, I get enough, I doubt I could ask for a snack". "It's OK, I get enough, I don't think we get fresh fruit", "It's fine", "The food's quite good, I get enough" and "I enjoy what I eat."

People's dietary requirements, preferences and choices were recorded and known by the staff. Information was recorded in people's care records and the kitchen staff had their own record book of people's likes dislikes, allergies and dietary needs. A diary was used by the kitchen staff to help ensure information regarding any change to people's dietary needs or information about new people in the home was communicated to all of the team. Meals were served individually to people on trays. A different coloured tray indicated people's need for assistance with eating.

The menu was displayed in the hall; however the majority of people who lived in the home did not have access to it.

There was no choice for the main meal served at lunch time and people were not informed of what the meal was beforehand. Staff's knowledge of people's preferences helped ensure they were given an alternative meal if they did not like the meal planned for the day. We saw the two week rolling menu and this offered a hot meal at lunchtime, two lighter options at dinner time as well as desserts. People were offered plenty of hot and cold drinks through the day and snacks such as, biscuits and cake mid-morning and afternoon.

We spoke with the cook. Despite being new in their post they showed they already had a good knowledge of people's dietary needs. They told us they discuss the menus with the home manager and spent time with the people who lived in the home to ask what they liked and disliked.

The home was fully accessible and aids and adaptations were in place to meet people's mobility needs, to ensure people were supported safely and to promote their independence. Access to front door of the home was via some steps. Ramp access was available at the rear of the building. There was access into the garden via a ramp. Stair lifts were in situ on each stair case for access to the first and second floors of the home.

Good

Is the service caring?

Our findings

Interactions between staff and people living at the home were caring, gentle, positive and respectful. We saw staff with people who lived in the home on numerous occasions throughout the day and they always spoke to the residents in a cheerful manner. A person who lived in the home told us, "I have everything I want here, I'm not well enough to be in my own home, it is alright here."

During our inspection one resident was unwell and become very distressed because of how they were feeling. We saw the one of the staff sat with the person and gave an explanation of why they were feeling like they were. The staff member informed the person they had to "Press the buzzer (to alert staff) and it did not matter how many times they did someone would always come to her." The person asked them, "Are you sure?" They were again reassured by the staff member.

People who were sat up in bed were well supported with the use of cushions. People we saw sat out in a chair had a table near with the call bell and drinks accessible to them.

Relatives we spoke with told us they felt the home was caring and compassionate. Their comments included, "Definitely without a doubt", "They can't do enough for [relative]" and "Absolutely".

We asked relatives if their family member was treated with dignity and respect. They told us they were. One person told us, "They close the door and the shutters". Another relative said "Yes." We saw that some people preferred to have their bedroom doors open during the day. However we saw that staff closed the door when they were supporting people with personal care. This ensured the person had privacy.

People received care, as much as possible, from a consistent staff team. This meant people had the opportunity to build relationships with staff and that staff had the opportunity to get to know the people they supported well. Many of the staff had worked at the home for a number of years. The manager told us they had a good staff team and the staff had a good level of knowledge and understanding of people's individual needs. We observed this during our inspection.

The manager told us no one living at the home required the services of an advocate at this time.

Good

Is the service responsive?

Our findings

Two relatives told us they were involved with their family member's care, this included the care plans. A relative told us how responsive the staff were when their family member's needs changed. Care documents however showed little evidence of people's involvement and/or relative involvement in the plan of care.

We found that people received the care and support they needed. Before people came to live in the home the registered manager and nurse manager visited them and completed an assessment. This was to ensure that their care needs could be met at Avenswood before they were admitted to the home.

We looked at the care plans for four people who lived in the home. We found that care plans and records were very detailed and person centred and reflected people's identified needs. They had been completed for many aspects of peoples care and health needs. We found the actions plans easy to understand. The home had devised a code system using coloured stars which were on the care plans so it was easy to see at a glance which resident was on, for example end of life care, or had diabetes.

Records showed that risk assessments were completed and measures to manage risks were detailed in the care plans. All care plans and risk assessments were reviewed at least on a monthly basis by nurses and were up to date. The care plans had detailed and completed risks assessments within the folders: MUST (Malnutrition Universal Screening Tool), Waterlow, (a tool used to assess the risk of a people developing a pressure ulcer), moving and handling, falls, mental capacity were up to date. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

All the nursing care records which were completed daily were kept in one file with details of MUST and they use the Gold Standard Framework Prognostic Indicator Guidance for people nearing their end of life for all the residents. This system made it easy for new staff to get a quick overview of the needs of all the people who lived in the home and then make reference to the care plan for further details.

The care plans contained signed and verbal consent from the residents or their next of kin for meals in their room, taking photographs, sharing of information with other disciplines on a need to know basis. These forms were also witnessed by a member of staff from the home.

We found that many people who lived in the home had three charts in their rooms for staff to complete for diet/ fluid intake, turns and positions and pressure area care given. The nurse manager informed me they were in the process of putting all these domains onto one sheet of paper which would make it easier and less time consuming for all staff to complete. All the charts we looked at had been completed in a timely manner. One relative told us, "My family member is at risk from dehydration; they (staff) are on the ball and give them extra liquids."

There were very few activities happening on the day of the inspection. The manager told us that the activities co-ordinator had recently left. People spent the day in their bedrooms; the small lounge area is rarely used. The home does have 'pamper' days and this includes giving residents who want one a foot spa. One carer takes a person who lived in the home to the local café/ shops on a regular basis. I spoke with person. They said, "I like going out, she (staff) looks after me."

We asked other people who lived in the home how they spent their time during the day. A person told us, they read the paper and did the crossword, Another said, "I read and watch TV. I have a basket close to hand with my remote and magazines in". Other people's comments included, "I don't enjoy sitting in my room on my own, but I never feel lonely. There's nothing much to do", "Most of the day, I read and watch TV", "When the weather's nice I get out if I can. It's a change from the four walls. I very rarely sit in the lounge."

We asked relatives about the activities in the home. One person said, There are none directly for my family member, they have a singer occasionally. [Relative] has the TV; we do simple jigsaws, other than that [relative] is limited". We asked this person if they were bored and they said, "yes". Another relative told us their family member, "reads and watches TV". Another told us, "There's no activities listed, it would be nice to have more socialisation."

One relative told us they paid for someone to come in once a week and talk to their relative. Another relative told us they were thinking about doing the same thing.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. They were supported by a nurse manager. We found the nurse manager knew all about the people who lived in the home in their care in respect of people's medical history and diagnosis, the care people required, what and when medication was used or was due.

Staff told us they received positive and on-going support from both the registered manager and nurse manager.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to show us a series of quality assurance processes both internally and external to Avenswood Nursing Home to ensure improvements were made and to protect people's welfare and safety.

The home had received a 5 star [very good] food hygiene rating in November 2014.

We saw that the nurse manager completed monthly checks of medication stock and medication administration records. The registered manager told us they completed a monthly health and safety audit, which included checks of bedrooms. The registered manager told us they completed an audit of care records but did not record this.

We observed quality audits had been completed during 2014/2015 related to gas and electrical appliance testing, fire prevention equipment, passenger lift and the heating and water system. This assured us that people who lived in the home were living in a safe environment.

A process was in place to seek the views of the people living at the home about their care and was carried out by an external auditor. Questionnaires had been completed in June 2015 by 10 people who lived in the home. Responses were positive in relation to the cleanliness of the home, staff attitude towards them. Responses regarding the food and social activities were less positive.

Staff completed an annual questionnaire. The results showed their opinions about their work environment, the support they received. From the 12 staff who completed the questionnaire they rated the home's induction and communication in the home from basic to very good; the staff rating for how they met people's care needs was rated very good to excellent.

Staff meetings were held for both care staff and the trained nursing staff team. We saw that meetings had recently taken place September for care staff and in October 2015 for trained staff.