Avery Mews Limited

Avery Mews

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

Summary of findings

Overall summary

This inspection took place on 14 September 2016 and was unannounced. This meant that the registered provider did not know we would be visiting. The home was last inspected on 25 April 2014 and the registered provider was compliant with the regulations in force at that time.

The home is registered to provide accommodation and care for up to 45 older people, including people who are living with dementia. On the day of the inspection there were 44 people living at the home. The home is situated in Heckmondwike, in West Yorkshire. The premises had two floors; the ground floor accommodation had easy access to an enclosed garden and the first floor was accessed by a passenger lift. People had single bedrooms with an en-suite shower and toilet, and there was a communal bathroom on each floor.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at Avery Mews.

People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The registered manager recorded and monitored accidents and incidents so that any patterns that might be emerging could be identified and the risk of reoccurrence could be reduced.

We checked medication systems and saw that medicines were stored, recorded and administered safely. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were very caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff. People's care plans recorded information about their individual care and support needs and their life history, which helped staff to have an in-depth knowledge of people's needs .

A variety of activities were provided to meet people's individual needs, and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were very happy with the food provided. We observed that people's nutritional needs had been assessed and individual food and drink requirements were met. Efforts had been made to make meal times and morning and afternoon snacks an 'occasion'.

The premises were clean, hygienic and well maintained. We saw there was appropriate signage, decoration and prompts to assist people in finding their way around the home.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Staff told us that they were well supported by the registered manager and senior staff group. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

Staff, people who lived at the home and a relative told us that the home was well managed. Quality audits undertaken by the registered manager and senior managers were designed to identify that systems at the home were protecting people's safety and well-being. When quality audits had identified that improvements needed to be made, there was a record of when actions had been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

The premises were clean, hygienic and well maintained.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge they required to carry out their roles.

People's nutritional needs were assessed and the meals provided met people's individual dietary needs.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and they told us their advice was followed by staff.

Efforts had been made to make the premises suitable for people who lived at the home, including people who were living with dementia.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home, relatives and staff. Staff were kind, considerate and patient.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their individual care and support needs and their life history. This helped staff to have an in-depth knowledge of people's needs.

Activities were provided and were flexible to meet the needs of people who lived at the home.

People were encouraged to give feedback about the service they received. There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Good

The service was well-led.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

There was a manager in post who was registered with the Care Quality Commission (CQC), and people told us that the home was well managed. Notifications were being submitted to CQC as required by legislation.

There were opportunities for people's family and friends to express their views about the quality of the service provided.

Avery Mews

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 14 September 2016 and was unannounced. This meant that the registered provider did not know we would be visiting. The inspection was carried out by one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with three people who lived at the home, five relatives, two health care professionals, one member of staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following the day of the inspection we spoke with another two members of staff.

We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe, and this was supported by the relatives who we spoke with. Staff described how they kept people safe. One member of staff told us, "We use the hoist and wheelchairs when they are needed. Two staff assist people with transfers when this is what they need. We make sure corridors and fire exits are clear." We observed staff transfer people from a lounge chair to an easy chair and saw that the correct equipment was used (a hoist and the person's own sling) and the transfer was completed quickly but safely.

Staff told us that they completed training on safeguarding adults from abuse, and that they completed regular refresher training. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager or a senior member of staff and were confident they would be listened to and that appropriate action would be taken. We contacted the local authority safeguarding adult's team prior to this inspection and they told us they did not have any current concerns about Avery Mews. Notifications had been submitted to CQC appropriately in respect of any safeguarding incidents that had occurred at the home.

Staff told us they would not hesitate to use the home's whistle blowing policy and that they were confident the registered manager would protect their confidentiality. Whistleblowing is where an employee reports misconduct by another employee or their employer.

We checked the folder that contained copies of safeguarding alerts submitted to the local authority and associated notifications submitted to CQC, plus additional details of the incident. The same folder also held copies of other notifications that had been submitted to CQC. The safeguarding folder included the home's policy and procedures as well as the policy and procedures of the local authority safeguarding board. The registered manager told us that an alert was not submitted for all safeguarding incidents, such as verbal altercations. However, all safeguarding issues were discussed with the safeguarding adult's team. This was confirmed in the records we saw.

We checked the recruitment records for three members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. These checks meant that only people who were considered suitable to work with vulnerable adults had been employed at Avery Mews.

We noted that interview questions and responses had been retained with people's recruitment records. This gave the registered manager information about the applicant's level of understanding as well as their training needs. New employees were issued with a staff handbook and a job description; this meant they were clear about the role for which they had been employed.

The registered manager told us that they used a dependency tool to determine staffing levels, and that this was reviewed each month to ensure the needs of people who currently lived at the home could be met. They said that the dependency tool currently identified that six care staff were needed but they actually had seven staff on duty. We saw copies of dependency tools in the care plans we reviewed.

We observed that there were sufficient staff members on duty to enable people's needs to be met. We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention. The registered manager told us that the standard staffing levels on day shifts were one senior care worker and two care workers on the ground floor, and one senior care worker and three care workers on the first floor. Some days staff worked a twelve hour shift and others worked from either 8.00am until 2.00pm or from 2.00pm until 8.00pm.Overnight, there were four care staff on duty plus an additional member of staff who worked from 8.00 pm until 2.00 am in the dementia area; this had been identified as the time during the night when people were most unsettled. The registered manager and the deputy manager were on duty in addition to care staff. We checked the staff rotas and saw that these staffing levels had been consistently maintained. Most staff absences were covered by permanent staff working additional hours, and the organisation also employed bank staff, so agency staff were not used.

In addition to care staff, there was a chef, a kitchen assistant, two domestic assistants and a laundry assistant on duty each day. There was also an administrator, activity coordinators and a hostess employed at the home. The role of the hostess was to help with serving tea in the morning, helping to serve lunch and assisting people to eat their meals. This meant that care staff were able to concentrate on supporting and caring for people who lived at the home.

Staff told us that there were usually enough members of staff on duty. One member of staff said, "Staffing levels are ok. They try to cover any vacant shifts with bank staff" and another told us, "Most of the time we have enough staff. The manager tries to cover short-term and late notice absences."

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for pressure area care, the risk of choking, the risk of malnutrition, infection prevention and the risk of falls. The registered manager told us that senior care workers had an iPad and that they recorded the details of any falls or incidents as they occurred. The registered manager or deputy manager received an email immediately to inform them of the incident. They said that this information was used to monitor falls and incidents, and was discussed at health and safety meetings. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

A risk assessment had also been completed to identify any risks in respect of the safety of the premises. Areas assessed included moving and handling equipment, waste disposal, the water boiler, catering equipment and the cleaning trolley. This risk assessment was last reviewed in July 2016.

We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage these behaviours to diffuse such situations. This information was recorded in a positive behaviour support management plan that contained details of the behaviour that could occur, any triggers to the behaviour, strategies for managing the behaviour and the people who should be involved in supporting the person. Staff told us they had attended training on behaviours that could challenge the service. Although this was not considered to be essential training by the organisation, we noted that most staff had completed this training. Staff told us that they never used physical restraint at the home and were able to describe some of the diversion techniques they would use. Comments from staff included, "We get to know people and use diversion and distraction before issues arise" and "I would talk to people quietly and use diversion techniques to diffuse the situation."

We checked the arrangements in place for fire safety. There was a fire risk assessment, a fire evacuation plan, a list of fire wardens and bedroom fire risk assessments held in an emergency box. In addition to this, there were details of each person's next of kin and a personal emergency evacuation plan (PEEP) for each person who lived at the home. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist. Weekly checks were carried out on the fire alarm system, fire doors, fire extinguishers, break glass units and emergency lighting. Fire drills were taking place; the most recent one was held in July 2016. A poor response time was noted and time was spent explaining to staff the importance of their role if a fire broke out.

There was a business continuity plan in place that provided staff with advice on the action to take in the event of an emergency such as staff shortage, fuel shortage, utility failure and severe weather conditions. There were details of important contact telephone numbers and a 'grab bag' that included emergency equipment.

We observed that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to denote the time of day when they needed to be administered. In addition to this, white blister packs were used to store 'as and when required' (PRN) medication.

Blister packs and medication supplied in boxes or bottles were stored in the medication trolleys. There was a trolley for each floor, and they were stored in the medication room when not in use. We saw a member of staff administering medication after lunch. They had water and beakers on the trolley so that they could give people a drink to take their medication, and we saw that they only signed the medication administration record (MAR) charts when they had seen people take their medication. We saw that staff asked people discreetly if they would like their pain relief medication.

We saw that controlled drugs (CDs) were stored securely. CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD books and the corresponding medication and saw that the records and medication held in the cabinet balanced. Staff signed the MAR chart and the CD book when administering CDs. We also saw that CDs were audited regularly to ensure no recording or administration errors had been made.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the medication room was checked to ensure that medication was stored at the correct temperature, although there were a small number of gaps in these records. The medication fridges were also cleaned each week. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy.

We looked at MAR charts and found that they were clear, complete and accurate. We noted that MAR charts were colour coded to match the colour of the blister packs; this reduced the risk of errors occurring. MAR charts recorded where on the body creams needed to be applied to avoid confusion.

Only senior care assistants and the deputy manager were responsible for the administration of medication. The training record showed that these people had completed medication training, and this was confirmed by the staff who we spoke with. One care assistant told us they had been responsible for the administration

of medication at another care service, but they would have to complete training at Avery Mews before they were allowed to administer medication at this home.

We checked the accident and incident records in place at the home. We saw that these recorded accidents such as falls and also incidents such as weight loss. There was a record of any immediate action taken, a check of relevant documentation and whether any other organisations needed to be informed. A relative told us that their family member had fallen during the night and that staff had accompanied them to the hospital and had also accompanied them to hospital on other occasions. They were impressed that staff accompanied their family member to ensure they were safe and so they could share appropriate information with the hospital about the person's condition. We noted that people were observed hourly following any falls so that staff could monitor the person's well-being. We also saw that, on one occasion, a service user fell and was admitted to hospital. The registered manager carried out a full investigation and wrote a letter to the service user to explain the outcome of the investigation.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the passenger lift, mobility and bath hoists, gas equipment, the fire alarm system, emergency lighting, fire extinguishers and the electrical installation. We noted some areas that required action were listed on the electrical installation certificate. The registered manager sent us information on the day following the inspection that confirmed these works had been carried out.

In-house checks were carried out on window opening restrictors, profiling beds, carbon monoxide alarms, wheelchair safety, the emergency call system, portable electric appliances and hoists and slings. These measures helped to monitor that the premises remained safe for the people who lived and worked at the home. There was a maintenance book in place where day to day repairs were recorded and the maintenance person signed to record when the repairs had been carried out.

The home was maintained in a clean and hygienic condition. We saw that the home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

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 MCA 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 found that the DoLS principles were being adhered to and we saw the details of one DoLS application that had been authorised. The registered manager told us they were still waiting for authorisation for other applications that had been submitted.

The training record showed that all staff had completed training on MCA / DoLS. Staff who we spoke with understood the principles of the MCA and DoLS and one staff member added, "If I am unsure, I ask the trainers to explain things in plain language."

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that recorded people's consent to their care provision, including taking photographs. Some of these had been signed by a relative and, in the care plans we reviewed, there was a record that the person had the authority to do this as they acted as the person's power of attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "I don't overload people – I might pick out two outfits and ask them to choose one. I show them the meals and ask if they would like a small, medium or large portion" and "I open the wardrobe door and show them things to give them a choice." One person's care plan recorded that the person should be offered a small, medium or large portion at mealtimes but added that 'traditionally they have chosen a medium portion' to assist staff if the person had difficulty making a decision.

Staff carried out a three day induction programme when they were new in post. Staff confirmed that they had induction training before they commenced working 'on the rota' and that this included moving and handling and fire safety as well as shadowing an experienced member of staff. The registered manager told us that new members of care staff had commenced the Care Certificate; the Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

We checked the home's training record and this showed that the organisation considered essential training to be health and safety, infection prevention, fire safety, fire drills, food hygiene, safeguarding adults from abuse, medicine competency (for senior staff), moving and handling, information governance, accredited food hygiene (for catering staff), MCA / DoLS and the control of substances hazardous to health (COSHH). Records showed that all staff had completed this training, although some refresher training was overdue. The registered manager confirmed that refresher training had been booked for health and safety, safeguarding vulnerable adults from abuse, information governance, food hygiene, MCA / DoLS, fire safety and moving and handling; we saw the list of dates and names of staff due to attend this training.

The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. They told us they had attended training on moving and handling, safeguarding vulnerable adults from abuse and MCA / DoLS during the last year.

A separate training record showed the percentage of staff that had completed Qualifications and Credit Framework (QCF) training. The QCF award replaced the National Vocational Qualification (NVQ) and is the national occupational standard for people who work in adult social care. 50% of care staff had achieved this award at Level 2 and some staff had also achieved this award at Level 3 and 4.

Staff told us that they had supervision meetings with the registered manager or deputy manager and that they felt well supported. One member of staff added, "In the last 18 months I have never felt more at ease or comfortable with a manager. I can ask them anything. I feel very well supported."

We saw that any contact with health care professionals was recorded in the person's care plan. We noted that the form recorded detailed information, including whether the care plan required updating following the visit or contact. Health care professionals told us that staff asked for advice appropriately and then followed that advice. For example, they made sure people's legs were elevated and that people were repositioned when this course of action had been advised. Health care professionals told us they trusted staff to follow their direction, and that they could sometimes give advice over the telephone and be confident that staff would carry this out, such as reapplying dressings.

People told us that they could see their GP whenever they needed to. One person told us, "When I needed to see a GP, this was done quickly." People said that they were also able to see other health care professionals, such as chiropodists. Any communication from NHS departments was retained with people's care records so that it was available for staff. We saw that some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place and that these had been signed appropriately by their GP.

We saw that people's nutritional requirements were recorded in their care plan; this included any special dietary requirements to meet health care needs and their likes and dislikes. Charts were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored. Fluid had been recorded in millilitres and totalled for the day, so there was a clear record of their daily fluid intake. We noted that referrals had been made to GPs and the Speech and Language Therapy (SALT) team when this monitoring had identified significant weight loss.

A trolley was used from which to serve people with morning coffee and afternoon tea. We saw that homemade biscuits, cakes and other snacks were displayed on cake stands and that attractive crockery was used. This made the serving of tea and coffee seem like an 'event' and we could see people enjoyed choosing something to eat. Those people with diabetes or swallowing difficulties were offered a choice of alternative snacks so they did not miss out on the occasion. A relative told us that staff always knew when their family member had missed a meal, and they were offered a snack mid-afternoon instead.

We observed the serving of lunch in one of the dining rooms. We noted that staff created a social atmosphere and encouraged people to chat to each other. Tables were set with tablecloths, napkins, wine glasses (for people who wanted wine), condiments and cutlery, giving the feel of a hotel dining room. The cook told us that there were two choices of main meal and that people were asked at breakfast time which choice they would prefer, including whether they would like a small, medium or large portion. They had a list recording this information and used it to ensure they served the correct meal to people.

People told us that the meals were nice and that they had a choice of foods at each mealtime. They confirmed that they were asked at breakfast time each day what they would like for lunch. One person said, "I think they would make something different for you if you asked for it." We saw that people were able to eat at their own pace and when they had finished their meal, staff asked them if they had enjoyed their meal and if they would like any more. Staff gently encouraged people who were reluctant to eat.

There were two floors at the home; people receiving residential care were accommodated on the ground floor and people who were living with dementia were accommodated on the first floor. Although the registered manager assured us that people who were accommodated on the first floor were supported to use the garden, it was acknowledged that they would require assistance from staff or a family member to use the lift and access outside space.

People told us it was easy to find their way around the home. We saw that there was signage to assist people to find toilets and other key areas of the home. Doors had numbers and the person's name displayed; they were made to look like 'front' doors although they were all painted white. The use of different coloured doors might have made it easier for people to identify their own room. Some doors had memory boxes beside them, and others had family photographs. Handrails were painted blue so they were easy for people to identify. These prompts helped people who were living with dementia to orientate themselves within the home.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. A relative told us, "Staff genuinely care – we are very happy with them." They mentioned a particular staff member by name and said, "[Name] is fantastic. They know [my relative] very well and have told me that they love them. They have such a good relationship." Another relative said, "Staff go over and above." They added, "Staff also care about family - they notice if we are ok and care about us." The two health care professionals who we spoke with said, "Staff are brilliant. It's a lovely home and staff really care."

Staff told us they were confident everyone who worked at the home genuinely cared about the people who lived there. One member of staff said, "Staff definitely care. You can't do this job if you don't care. I go home knowing I have made a difference." One member of staff had put together a pack so that staff could accompany people to the hospital at short notice; it included money and snacks. This showed that staff also cared about each other.

People who lived at the home told us that staff were "The right kind of people to do the job." We saw positive interactions between people who lived at the home and staff on the day of the inspection, and this was confirmed by the Short Observational Framework for Inspection (SOFI) that we carried out. We noted that people were comfortable in the presence of staff, and that staff were polite and sensitive to people's needs.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve. A member of staff told us, "We encourage independence. For example, we would suggest that a person should wash their own hands and face if they were still able to do this." Relatives told us that staff respected their family member's privacy and dignity, and also encouraged them to be as independent as possible.

There were areas of the home where people could see their visitors in private. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. Staff told us that they respected people's privacy when they were assisting them with personal care, such as making sure doors were closed and by covering people up when they were undressed. One member of staff said, "I make sure the bathroom door is locked. I ask if they want bubbles. I make sure I have everything ready before we start, including having towels to cover people." People who lived at the home told us that staff were respectful when assisting them with personal care and that they "Have never felt embarrassed."

The registered manager told us in the provider information return (PIR) that they had appointed a dignity champion and two dementia champions. These staff members were responsible for becoming knowledgeable about their topic and sharing this information with the rest of the staff team.

We asked the registered manager if anyone needed the support of an advocate. They told us that no-one currently required this type of support as they had relatives who could act on their behalf. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard

on issues that are important to them. There were leaflets on display to inform people about services available locally, including the Alzheimer's society, Dying Matters (for people who had been bereaved) and Cloverleaf, who provided an Independent Mental Capacity Advocacy (IMCA) service. IMCA's offer an advocacy service for people who lack capacity to make decisions for themselves.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included capacity and consent, medication, mobility, nutrition, continence, personal care, skin integrity, wound care, social interactions / mood, communication, sleep, infection prevention, cognition, breathing and end of life care. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, a falls assessment and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

Each person's care records included a photograph, information about their GP, their medical conditions, their current medication and any current physical or mental health care concerns. We saw that care plans were also person-centred. Some records included a document from the 'Forget Me Not' scheme; this contained information about the person's childhood, occupation and things that were important to them. Some relatives had provided information to be included in care plans, such as the person's daily routines and what tasks they required assistance with. This information helped care staff to get to know the person. We asked staff how they got to know about people's individual needs. They told us that they were encouraged to read care plans. Comments included, "We read all care plans. We sit with residents and talk to them about their lives. This can help to reduce their anxiety" and "We read care plans and we ask people and their families." We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery.

We saw that 'alerts' were recorded at the front of care plans so there was a clear record for staff of any important information, such as the risk of falls, DNAR documentation and the person's level of capacity.

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information. Following one review a sleep chart was introduced for the person, as it had been identified they had a disturbed sleep pattern. Their medication was also changed. A review was planned in two weeks' time so that the person's sleep pattern could be reviewed again to see if there had been any improvement. This showed that action was taken to address any areas for improvement identified during care plan reviews. More formal reviews were held six monthly. Records evidenced that the person and their relatives were invited to the care plan review and that any changes in the person's care needs were discussed and recorded. We could see that care plans had been updated when a person's needs changed but we reminded the registered manager that any updates in care plans needed to be dated.

Daily records in care plans recorded care interventions, general information about food and fluid intake and how the person spent the day. More detailed food and fluid charts were completed when this had been identified as an area of concern.

We saw the 'handover' sheet that was used by staff to pass information from one shift to the next. A

handover meeting took place at 7.45 am each day and again when the night shift came on duty. The registered manager said that the team leader on shift would give another handover to any staff who came on duty in the afternoon. Each person who lived at the home was discussed so staff had the latest information about their care needs. People who had a DoLS authorisation or DNACPR in place were listed in red as a constant reminder for staff.

In addition to handover meetings, there was a '10 @ 10' meeting each day. Staff talked about 'the resident of the day', any GP visits, people who were receiving end of life care, accidents, safeguarding, planned activities and any medication issues. Resident of the day was when one person who lived at the home was provided with a 'special' day, including inviting a relative for lunch. The person's bedroom was 'deep cleaned', and their medication and any incidents were discussed.

A relative who we spoke with confirmed they felt there was good communication between themselves and staff at the home. They said they were always kept informed about any events that involved their family member. We observed that care plans included a 'discussion with significant others' form that recorded information shared with relatives either face to face or over the telephone, such as hospital appointments or admissions.

Relatives told us that they could visit the home at any time and were made to feel welcome. This was confirmed by the people who lived at the home who we spoke with.

There were previously two activity coordinators working at the home, but one had recently left. A member of staff told us that this "Left them a bit short at present" but that staff were doing their best when there was no activities coordinator on duty. They said there was no set activities programme apart from when entertainers had been booked. They asked people who lived at the home what they would like to do. There was a hairdressing salon and a hairdresser was present on the day of the inspection. People told us that a hairdresser regularly visited the home and that they enjoyed taking part in a reading group and the church service; a church service was held on the day of the inspection. We saw that people were able to walk around the home uninterrupted and go to their bedrooms to relax if that is what they preferred. Any activities people had taken part in were recorded in their care plan. We saw that there was jewellery and clothing displayed around the home for people to try on or use and staff told us that some people who lived at the home enjoyed this pastime.

The registered manager told us about the home's vegetable garden. This was created by staff and the people who lived at the home, and the vegetables were used by the cook to prepare lunches.

A relative we spoke with said their family member was accommodated on the first floor. They said they joined in monthly exercise classes and church services, but they added that they would appreciate it if their family member was invited to some of the activities on the ground floor. We shared this information with the registered manager following the inspection.

We saw the newsletter for 14 September 2016; staff told us that this was produced by the organisations head office every day and sent to each home. Staff printed off several copies that were displayed around the home. We saw that people were reading the newsletter; it contained facts about the date, pictures of vintage tins, a quiz and a song with missing words that people were invited to complete. Another newsletter was produced at Avery Mews. We noted it was colourful and easy to read. It included details of the Macmillan coffee morning that was planned for 30 September 2016, an update on the garden refurbishment, birthdays of people who lived at the home and staff, a recipe for gingerbread men, and explanation of 'resident of the day' and details of the 'employee of the month' and the reason they had been nominated. The newsletter

also included the statement, 'Feel free to speak to any member of staff if you have any ideas or you have any issues you would like to discuss. Your opinion is always valued'.

The complaints policy and procedure was displayed around the home and we saw there were two forms ready for complaints to be recorded; one for verbal complaints and one for written complaints. Complaints were recorded in the complaints log and we saw there had been two complaints in December 2015 and one in February 2016. Records showed that the complainants had received a letter giving them details of the investigation or an explanation of events. Two complaints were about fee increases and these complainants received a response letter from the regional manager.

People who lived at the home told us that they felt able to express their concerns, and they told us who they would speak to. They said they were certain any concerns or complaints would be "Put right". Staff told us that, if someone complained to them, they would try to rectify the situation. However, they would still inform the senior member of staff on duty. They were confident people's complaints were listened to and dealt with. Relatives told us they had not needed to raise any concerns, but they were confident that they would be listened to if they raised any issues and that staff and the registered manager would try to improve the situation.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

Several quality reports were completed each month as part of the quality assurance system. For example, reports on tissue viability, nutrition, recreation and activities, health and safety / kitchen and human resources were completed in January and repeated in September. In June quality reports included falls, continence and physical health, out of hours GP service, meals, training and marketing. Reports on safeguarding adults from abuse were completed in March and November.

The registered manager carried out a 'manager's daily walkabout'. They spoke with five people who lived at the home, five staff and carried out checks of the environment. The MAR charts for the same five people were checked, as well as the temperature of their bedroom and that the emergency call bell was within reach. Relatives told us that the registered manager knew all of the people who lived at the home and was occasionally 'hands on'. They felt the home was well managed.

Audits were carried out by the registered manager to monitor whether staff were following the policies, procedures and systems in place at the home. They included a medication audit, a dementia / mental health audit, a resident admission / transfer audit a maintenance audit, a training audit, a restraint audit, a falls audit and a 'whole home' audit. The medication audit identified five questions for people who lived at the home and five questions for staff, such as 'Can you identify the process for reporting medication incidents?' Some action was identified, such as a new photograph for a person who lived at the home, and the date that this was completed. The dementia / mental health audit the registered manager asked staff questions, such as "Can you identify three different types of dementia?" and "What does DoLS stand for?" so that staff's level of understanding could be measured.

The regional manager carried out an additional audit. Their audit covered the dining experience, care records, quality assurance information and medication, and they also spoke with staff and people who lived at the home.

Relatives described the home to us as "Homely", "Friendly", "People feel at home" and "Absolutely

marvellous". Staff described the culture of the home as "Friendly, warm and inviting", "Welcoming, happy and caring", "A brilliant atmosphere", "Genuine people who really care" and "A lovely place to come – I enjoy coming to work." They told us that staff would learn from any accidents, complaints or incidents as they would talk about the issues and how they could make sure they did not occur again. One member of staff gave an example of someone who had fallen out of a wheelchair and sustained a skin tear. Following discussion, staff decided the person would have sustained a lesser injury if they had been sitting in a dining chair, and the person was now transferred to a dining chair at mealtimes. This showed that consideration was given to how people's care could be improved.

Health care professionals told us that they had made suggestions to the home and these had been listened to. For example, they had discussed the storage of dressings, and as a result each person's dressings were kept in a secure place in their own bedroom. It was acknowledged by staff that dressings were for the use of the named person only.

We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that these interactions were positive and friendly. Staff told us that there was good management and leadership at the home. Comments included, "I have no complaints. If I need support, I get it" and "I have recently been supported by the manager, seniors and my colleagues."

A satisfaction survey had been distributed to people who lived at the home and relatives by the organisation's headquarters, and a smaller survey had been distributed by the home. The responses to this survey had been collated. The outcome had been recorded in a 'You Said / We Did' document. The document highlighted the most common themes for improvement, and the action that had been taken to address these areas. The document recorded, 'This will be reviewed in December 2016 at the next relatives / residents meeting'.

We saw that meetings were held for people who lived at the home and relatives; the most recent meeting had been on 7 September 2016. Twelve people who lived at the home and seven relatives attended the meeting. People were informed that hostesses had been employed and that a 'twilight' shift had been introduced. Other topics discussed included meals, lift repair, refurbishment, occupancy and feedback from the latest satisfaction survey. Another meeting was held in July 2016 for people who lived at the home. People were asked for feedback on the spring and summer menu and if they had any ideas for new activities. People were also asked if they felt staff were taking good care of them. One person responded, "I like the fact that we can always speak to somebody if and when we need to." These meetings gave people and their relatives an opportunity to express their views, make suggestions and ask questions about care provision. Relatives told us that they were aware of or had attended relative meetings. They said that they would not hesitate to raise issues and were confident they would be dealt with.

Staff meetings were held on a regular basis and staff told us they could ask questions and make suggestions at these meetings. We saw the minutes of the staff meeting held in July 2016. The topics discussed included positive feedback that had been received, supporting colleagues, incontinence pads, care reviews and the forthcoming CQC inspection. The registered manager told staff that they had received some feedback about night staff having low morale. They asked staff to be honest and say what they were feeling. A previous meeting was held in May 2016. There were separate staff meetings for senior care workers, domestic staff, kitchen staff, a health and safety committee and staff involved in organising activities. One member of staff said, "The manager gives us information and then asks if anyone has anything they want to say or ask. If we raise issues, we get honest answers."