Avon Lodge UK Limited

Avon Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days on 14 and 15 April 2016 and was unannounced. At our last inspection on 15, 16, 17 September 2015 we found that the provider was not meeting all the standards that we inspected. We identified breaches of regulations 9, 11, 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment for people was not being provided safely. Risk assessments to identify and mitigate significant risks to people were not in place. Manual handling training for staff members had not been completed and we observed instances of poor practice. Care plans failed to reflect people's preference's regarding care and treatment provided. The home provided no activities for people to encourage communication and stimulation. There was a significant level of poor care and risks to people that used the service were not identified or acted upon.

Following that inspection the service was placed into special measures and conditions were placed upon the provider's registration.

Special measures means that the Care Quality Commission keeps the service under review and it is re-inspected within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. At this inspection we found that the provider had failed to improve standards and quality of care over the past six months to an acceptable standard. There were on-going breaches of Regulations 9, 11, 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach under Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Avon Lodge is a residential care home that provides personal care and support for 36 people, some of who have dementia. However, following our last inspection and findings, the local authority placed an embargo on Avon Lodge accepting any new referrals. This means that the service was not allowed to admit any new residents. At the time of the inspection there were 27 people using the service.

The home did not have a registered manager. However, a manager had recently been appointed and was in the process of applying for registered manager status with the Care Quality Commission (CQC). The manager had been in post for three weeks.

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.

Despite new care plan templates, care plans still did not contain enough information to provide personalised, high quality care. People, where they were able, were still not involved in planning their care. Where people were unable to have input into planning their care, there were no records of best interests meetings or decisions. This meant that people's views and opinions were not taken into account.

Risk assessments were not detailed and did not provide staff with guidance on how to mitigate risks that had been identified. Risk assessments had not been completed on subjects such as, high risk medicines or behaviour that challenges. Some risk assessments had not been completed appropriately and important information had been left out. This put people at risk of harm.

Guidance for people with swallowing difficulties was not always being followed. There was no review of some people's swallowing difficulties with a Speech and Language Therapist (SALT).

There were still few meaningful activities in place within the home. An activities coordinator had been appointed. However, there were no activity plans in place. People still did not leave the home and there were no external activities organised. However, following the inspection we were told by relatives and staff that day trips and activities had started to happen.

There was no evidence that complaints were responded to. There was no evidence of learning or changing practice to improve care and communication.

There were no Mental Capacity Act (2005) assessments for any people living at the home, in any area of decision making. We looked at ten people's care files. There was no evidence of best interests meetings or plans. The home's training records showed that staff had received training on the MCA in the past six months. Only two staff were able to explain what the MCA was and how it could impact on the lives of the people that they supported.

The home had applied for Deprivation of Liberty Safeguards (DoLS) for people where appropriate. Where DoLS had been authorised, there were review dates in place. Staff were unable to explain what DoLS was or how it impacted on people.

The service provides care and support to people living with dementia. Staff had not received training on working with people living with dementia or behaviour that challenged.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm.

Overall, we observed caring interactions between staff and people. Staff knew people well and were able to tell us about individuals likes and dislikes.

Staff had been trained in manual handling in the past six months. Manual handling practices were appropriate and staff communicated well with people during these procedures.

People were consulted on the food provided. Daily menus plans were in place that showed a good choice of food available, including vegetarian and halal options.

The provider was redecorating the home and a programme of works was in place. A new treatment room and disabled access shower room had been created.

Avon Lodge has failed to improve standards of care to a level that meets the regulatory requirement. We found significant on-going shortfalls in the care provided to people. We identified breaches of regulations 9, 11, 12, 14, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not always supported to have their medicines safely and on time. As needed medicines were unavailable at night-time due to a lack of competent staff.

Falls were documented. However, there was no evidence of analysis or learning from these to improve care.

Risk assessments did not provided staff with enough information to mitigate risks. Significant risks had not always been identified or had risk assessments completed to mitigate the risk.

There were sufficient staff to support people and appropriate recruitment practices were being followed.

Safe moving and handling practices were used.

Is the service effective?

Requires Improvement

The service was not always effective. Despite recent training the majority of staff were unable to explain what the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS) were, or how it could impact on people's care and their working practice.

Professional guidelines and assessments in relation to nutrition were not always followed.

No person in the home had received an MCA assessment and people's ability to make decisions around their care and treatment was not recorded.

Staff had regular supervision and appraisals.

People were consulted on their choice of food and there were menu plans on display for people to see.

Is the service caring?

Requires Improvement

The service was not always caring. We observed an unkind interaction with people. However, the provider took action around this. Other positive interactions and effective communication between staff and people was observed.

People's cultural needs were being met. People were offered an opportunity to practice their faith.

People's preference regarding their getting up and going to bed were noted and adhered to. Staff did not get people out of bed in the mornings.

Relatives were able to visit whenever they wanted.

Is the service responsive?

Inadequate

The service was not responsive. People's care plans were not written in a way that was person centred or tailored to meet individuals' needs and preferences.

People and relatives were not involved in creating people's care plans.

There were no activities in the home. People were not encouraged to be part of the local community.

Behaviour charts were not filled in appropriately and there was no analysis of issues that triggered behaviour that challenges.

Complaints were not responded to in an effective way.

Is the service well-led?

Inadequate

The service was not well led. There is no registered manager in post.

There were some audit processes in place but no evidence of learning from these. Audits of care plans and risk assessments were not in place.

The service had not worked effectively with the local authority or the Care Quality Commission to improve standards of care to a level that met legal regulatory requirements.

There was good joint working with healthcare professionals. However, this was not always documented.

A survey of care provided had been sent out to people that used the service and relatives.

Avon Lodge

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, 15 April 2016 and was unannounced. We planned this inspection as a result of the service receiving a rating of Inadequate and being placed into special measures at our last inspection. When a service is placed into special measures, it must be re-inspected within six months. The inspection was carried out by two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and formal notifications that the provider had sent to the CQC. We spoke with the Enfield Care Homes Assessment Team (CHAT), The Local Authority and Enfield Healthwatch to get feedback regarding Avon Lodge over the past six months.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at ten care records and risk assessments, seven staff files, nine people's medicines records and other paperwork related to the management of the service. We spoke with 21 people who used the service, three staff and two relatives. We also spoke with a social worker who was visiting the home during the inspection.

Following the inspection, we further spoke with five people's relatives and six staff members.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "It's pretty safe in here. I've not seen staff do anything that made me ever worry about it." Other people said, "I like it here. No one troubles you. It makes it safer" and "Yes this place is excellent, well looked after. I'm not worried about tripping up over anything. The door is locked so no one can just walk in." Relatives said, "Oh, yeah [my relative] is definitely safe here" and "Yes, because long time [my relative] has been there and I've not seen anything concerning with him." However, the home was not always safe.

The provider used the blister pack system provided by the local pharmacy. A blister pack provides people's medication in a pre-packed plastic pod for each time the medicine is required. It is usually provided as a one month supply. The administration of these medicines was recorded on a medicines administration record (MAR). On reviewing MAR charts covering a two month period and found multiple gaps in the records where information should have been provided to indicate whether medicines had been administered or not. Administered doses had sometimes been overwritten to indicate that the medicine had been refused. The records did not make it clear if medicines had been administered or refused.

Four people's MAR charts showed that they should have been given pain relief four times a day. However, this had been converted to twice daily by the home. Staff told us that people had requested that their medicine times were changed but this was not documented and staff had not sought the GP's consent to change the prescribed dosages. Staff were unaware if changing medicine dosages was appropriate and whether people may have been left in pain. This placed people at risk.

Directions on one person's MAR chart did not match the instructions on the medicine boxes. The person was however receiving the correct dosage. People could be given the wrong dosage of medicines or the wrong medicine given to the wrong person.

Three people had medicines covertly. Covert medicines are where the home administers medicines without the persons consent. The Avon Lodge Residential Care Home Covert Medication Policy stated, 'The care home manager should discuss the case with the service user's GP and relative and obtain written consent and approval prior to any covert administration of refused medication'. There were covert medicine forms in place. Cover medicine forms had been signed by a GP and pharmacist. However, none of the forms had been signed by a relative or advocate. There was minimal information or advice recorded from the supplying pharmacy and there was no evidence that the home had now sought advice or informed the current pharmacy supplying the homes medicines that certain resident's medicines were being given covertly.

People were given 'as needed' medicines (PRN), although the arrangements around this were inadequate. 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious. When 'as needed' medicines were given, the MAR chart was signed. However, there was no record of why this 'as needed' medicine had been given. Care plans did not state if people were receiving PRN medicines, what the medicines were, what they were

used for or in what circumstances they should be administered.

There were no records of when people had received medicines reviews with the GP. One person on 'as needed' (PRN) medicine, to support distress, had been prescribed '1mg [of a specific medicine] twice a day when needed'. However, this had been administered every day in the morning for the past month and occasionally in the afternoon without review.

The home did not have any records to show that all senior staff that worked at night had current medicines training or that their competencies were tested yearly. Three day senior staff who administered medicines had competency assessments dated between Dec 2015 and Feb 2016. The home manager had booked the supplying pharmacy to facilitate updated medicines training for staff and a community pharmacy audit.

Three night-time seniors who were responsible for medicine administration as part of their job role had completed e-learning training in medicines. There were no competency assessments in place for the night-time seniors and they were unable to administer medicines at night. The bedtime medicines round was completed between 19:30 and 20:00 by afternoon senior staff. Bedtime medicines were administered to people who did not choose to go to bed at this time. The bedtime medicines were set to the benefit of the staff working pattern and not at the choice of the people using the service. People did not receive support around their medicines according to their individual preferences.

The senior member of staff told us that PRN pain killing medicines or medicines to help with anxiety were not offered by night staff as they had not been signed off as competent and were unable to administer medicines. This meant that people did not receive prescribed PRN medicines at night if they were needed and there was a risk that people were left in pain or anxious.

Periodic medicines audit had been undertaken by the previous manager, the last one in February 2016. The audit identified that night staff had not been signed off as competent to administer medicines. The service had failed to address and resolve this issue. Other issues, such as the significant errors in recording the administration of medicines on MAR charts, had not been identified during the audits.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicines room temperatures were recorded regularly. On the day of the inspection it was found to be 26 degrees centigrade, breaching advisory room temperatures for most room stored medicines of 25 degrees centigrade. This was documented on the day of our inspection and daily recorded temperatures did not breach guidance. However, the home manager confirmed that he had already scheduled a company to install assisted cooling.

People said about their medicines, "I get them two times a day. They are good with bringing them [medicines] around they never forget to give it to me" and " Normally get it [medicine] the same time every day, never been an issue. I have been on the same ones for a long time. I know what they are for." Another person told us, "I can't remember what they do [administering medicines]. They come around a few times a day."

The home last had a community pharmacy audit, which had been completed by the previous supplier, in August 2015. There had been no further medicines auditing by the supplying pharmacist since the home had changed suppliers. The new home manager had already highlighted the need for closer auditing of medicines on a daily basis and had designed a daily medicines audit for medicines that were not in blister

packs and was in the process of deploying the sheets for completion. However, these were not yet in use.

At our previous inspection we noted that there had been a high incidence of falls within a six month period. We asked the provider to send us monthly audits of falls as part of the positive conditions imposed on Avon Lodge following the inspection. The provider had been complying with this condition. At this inspection, records showed that there had been ten falls between 3 December 2015 and 13 March 2016. People who had had falls were referred to the Enfield Care Homes Assessment Team (CHAT) falls clinic to be monitored and equipment such as sensors put in place if necessary. However, whilst people were being monitored, the home did not have an overview of falls or documentation to state how falls were being monitored. Despite the fact that monthly falls audits were being sent to the CQC by the home, the home failed to use these as an opportunity to analyse why falls in the home were occurring and improve the oversight and management of falls.

Risk assessments around falls were in a tick box format. They did not tell staff how risks should be mitigated. Staff did not have enough guidance to ensure that people were safe with regards to falls risks. Falls risk assessments were not always filled in correctly. For example, people can be at higher risk of falls if they are on more than four different medicines. One person's falls risk assessment stated that they were not on four medicines or more. However, we found that this person was on more than four medicines and had had three falls within the last six months. The person had not been noted as being at high risk of falls as the risk assessment had been incorrectly completed.

Risk assessments for people on high risk medicines, such as blood thinning agents or insulin, were not in place. Staff were able to tell us what the risks to people taking these medicines were. However, there was no guidance available to ensure that staff were able to mitigate the risks.

The home recorded people's weights on a monthly basis. However, there was no information or guidance on how staff should manage weight loss or fluctuating weight. The manager told us that people would be referred to a dietician if there was significant weight loss. However, records showed two instances where people had experienced significant weight loss and staff had taken no action. One person had experienced fluctuating weight loss since August 2015 and had been prescribed fortified meals. A monthly review completed on 11 April 2016 stated that 'weight has been stable' but the person was still on fortified meals and continued to have their food and fluid intake monitored. There was no risk assessment in place and this was also not documented on the falls risk assessment. Fluctuating weight can be a contributory factor to falls.

One person had a weight loss risk assessment and had been assessed as being at low risk. However, they were having their food and fluid intake monitored by staff. The area manager was unable to explain why the person had been put on food and fluid monitoring. Such inconsistencies put people at risk of receiving inappropriate care.

Risk assessments were not reviewed regularly. This put people at risk as changes in people's circumstances may not be identified or mitigated against. Four out of ten risk assessments that we looked at had not been reviewed since August 2015. Where there was a review, the outcome was often noted as 'on-going'. One person had a falls risk assessment in place but this had not been reviewed or updated since July 2015. A moving and handling risk assessment was also in place but again this has not been reviewed or updated since July 2015. The person also had a history of displaying behaviour that challenged. There was no information available in relation to the person's behaviour management, any risks associated with their behaviour or aggression or the triggers that may lead to an incident. The person also had a history of refusing personal care and there was no risk assessment or direction available for staff to follow especially

when they refused personal care. This placed the person and staff members at risk.

Risk assessments did not provide staff with enough guidance on how to mitigate risks. The home had not completed risk assessments around significant risks such as high risk or covert medicines. Some risk assessments were filled in incorrectly and did not contain important information. Information on the risks to people was, in some instances, contradictory which placed people at risk of receiving inappropriate or unsafe care.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they would keep people safe and understood how to report it if they thought people were at risk of harm. Staff were able to describe different types of abuse. One staff member said, "It [safeguarding] is about abuse. If we see any type of abuse, we need to report it". Another staff member said, "It's [safeguarding] about protecting people that are vulnerable." Some staff understood what whistleblowing was and how to report concerns if necessary. However, other staff were unsure on what whistleblowing was. Whistleblowing is where staff are able to report concerns within the organisation, often to the local authority, without fear of being victimised.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

At our last inspection, we saw that people did not have individual slings for moving and handling and we were told that slings were re-used for different people. This could cause cross infection and is not best practice. At this inspection we found that the provider had not purchased individual slings for people. We discussed this with the manager. Individual slings for six people that required manual handling were purchased during our inspection. Hoists were clean and there were records of regular maintenance checks for the hoists.

We had previously observed poor manual handling techniques. However, at this inspection we observed three occasions where people required hoisting. This was done appropriately and staff members communicated with people throughout the process, making sure that they understood what was happening and checking they were comfortable. Records showed that all staff had received manual handling training within the past six months.

There were four staff in the morning and four staff in the afternoon with three waking night staff. From our observations and conversations with staff, people and their relatives, we found there were sufficient staff on duty to meet people's needs. Needs assessments were carried out on people when they moved into the home. However, these needs assessments were not being regularly monitored and updated as and when people's needs changed. Whilst there were enough staff at the time of the inspection, it could home could not definitively demonstrate that staffing levels were appropriate to meet people's needs and staffing levels were not planned in response to people's changing needs.

Records showed that there had been an environmental heath visit in 2015 and the service given a three star rating. The service was unable to tell us if there had been any requirements from this inspection and could not find paperwork pertaining to this visit. Some areas of the kitchen were unclean or not maintained in a good condition. In the kitchen, we found that the spice cupboard was dirty. There were broken tiles that

needed to be repaired and shelves in dry food cupboards were in a state of disrepair.

Daily recording of cooked food temperatures, fridge and freezer temperatures were kept appropriately. Opened food in the fridge was dated and stored appropriately. Halal meat was kept separately in accordance with guidance around storing halal products. Staff were aware that halal meat was stored separately and the reason why.

The home employed two domestic staff. On inspection, the home was observed to be clean and tidy. The provider was in the process of re-decorating the home and there was a programme of works in place.

We walked round the home and looked at people's rooms. Rooms had been recently decorated and had been personalised for each individual. We saw photos, pictures and items that made people's rooms more homely and personalised. A relative told us that his family member was an avid artist and the manager was sourcing picture frames so that the person could display their artwork on their bedroom wall.

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Requires Improvement

Is the service effective?

Our findings

A number of people in the home required special diets. They had been assessed by a Speech and Language Therapist (SALT). Information about special diets for these people was available to staff. There were clear signs in the kitchen for each person noting what type of diet they needed, how food and drinks should be prepared. This included information about whether food should be mashed or pureed and whether the person liked to be assisted with feeding. There was also guidance for people who had diabetes and food allergies.

However, during lunchtime we observed a staff member making a drink for a person. The person had swallowing difficulties and there was guidance that they should have thickened fluids. On asking the staff member how much thickener they had added they explained, "two flat scoops." The persons care plan noted SALT recommendations and that the person was to have 'one scoop of thicker per 200mls'. Inspectors asked the staff member to remake the drink with the right amount of thickener as even after it had been pointed out, she left the resident with the over thickened liquid. This left the drink much too thick to be consumed and was not in line with the guidance provided for this person. The staff member also told us that they had used another person's prescribed thickener as the person did not have their own. There was a risk that the thickener that was being used may not have been appropriate for the person as it had not been prescribed to them. There was also a risk that the person that the thickener belonged to may run out before the next prescription was due.

The person's care plan contained specific instructions provided by the SALT. The person was to receive 'a fork mashable diet and there should be no loose fluid, pouring gravy'. At lunchtime, we observed that the person was being served fish in un-thickened sauce. This put the person at serious risk of swallowing difficulties and choking. The chef was unclear about thickening sauces for people with risk of aspiration or swallowing difficulties and unaware of the guidance for this person. The chef confirmed he had not received special training or support in this area. We raised this issue with the manager. At our request, immediate actions were taken to ensure that this person was no longer at risk of serious harm. The manager told us that the person had been re-referred to a SALT. The person's GP had prescribed a thickener. A review of staff training around swallowing difficulties was being undertaken. The person's risk assessment had been updated and evidence of this was provided to us.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food and fluid charts were in place for nine people. None of the food and fluid charts that we looked at had an explanation as to why they were required. There was no guidance for staff on how much fluid intake a person should have in a 24-hour period. Staff were not adding up how much fluid intake there had been and if someone had a reduced amount of food or fluid what action had been or should be taken in response to this to support the person. Food and fluid charts did not provide staff with enough guidance and information to ensure appropriate monitoring of people's daily intake. For one person, food and fluid charts were implemented on 29 December 2015 and ended on 23 January 2016. There was no explanation as to

why they had been introduced and why it had been stopped. There was inconsistency in recording and some charts had not been filled in daily. We noted in the morning handover on 14 April 2016 that a comment had been made about someone not drinking enough. There was no recording of how this judgement had been made and what action had been taken as a result. The area manager was unable to tell us why food and fluid charts had been put in place for these nine people and how these records were used to appropriately monitor people and identify concerns.

There was a rolling four week menu plan in place. People told us, and records showed that they were consulted around what they wanted to eat by the chef on a daily basis. People said, "They bring you a sheet around at breakfast and ask you what you would like to eat. Usually has two to three choices on it" and "Food is alright we get a choice or three or four things and it tastes okay." There was a menu board on display in the main lounge that showed what options were available for breakfast, lunch and dinner. Vegetarian options were also available. Whilst comments from people about the food were generally positive, although the comments from some people were negative, such as, "I really like the food, but sometimes it does come a bit cold. I can get someone to heat it up for me but I usually don't ask" and "Food is alright, rough and ready. It reminds me of the army there's no difference. Usually get the same grub as everyone else."

A staff member said, "We could have more access to food at night [for people] especially fruit and other variety of food." Some people also told us that they would like snacks to be available at night if they wanted them.

Food did not always look appetising. Some people required special diets such as pureed or soft food. When we asked what people on special diets thought about the food, one person said, "Not really [appetising] it's liquidised food. It all tastes the same." The service catered for cultural needs around food. One person told us, "I get halal food which I told them when I came here. The food is nice." We observed the chef preparing halal food in an appropriate way.

Fridges and freezers were well stocked and the manager told us that the service completed weekly food shop.

At our last inspection, we were concerned that people did not have access to drinks outside of prescribed times. At this inspection we saw that people had better access to drinks. We observed staff making tea, coffee and juice for people when people requested. People told us, "They bring around tea a few times a day and I can get another one whenever I want.", "I like blackcurrant which they bring around all the time" and "Those two jugs are placed on the table for us. We can get it refilled whenever we want."

We observed that, at lunchtime, drinks were given. However, we saw that no one was given a choice what was offered. People that had poor mobility were given their meal where they were sitting and not encouraged or given a choice to use tables.

There appeared to be a relaxed, enjoyable atmosphere during lunchtime. One staff member was assisting a person to eat. She was talking to the person on a first name basis and was joking and chatting with the person as well as others sitting around her. We saw that the person was being assisted appropriately and not rushed. We observed a second staff member assisting someone to eat, gently encouraging and communicating well.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

At out last inspection we found that staff had not received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). At this inspection, records showed that all staff had completed this training over the past six months. However, staff understanding of the MCA was mixed. One staff member told us, "It's [MCA] the residents' right to make their own decision. We can act on behalf of the person but if the person can they should make their own decisions. You would need an assessment." However, another staff said, "It's [MCA] when they start shouting and swearing. Someone who can't take care of themselves. Like dementia, they need assistance." Regarding DoLS, the majority of staff that we spoke with were unable to explain what DoLS were. Staff said, "it's [DoLS] about their property" and "I don't know." Whilst staff had received training in both MCA and DoLS, it was clear that it had not been fully understood by some staff. Management had not checked if staff had understood the training and able to apply what they had learned.

We saw that where people required a DoLS, these were in place. There were dates noted for when the DoLS needed to be reviewed. However, care plans that we looked at stated that people 'needed help to make certain decisions'. There was no information around what decisions people may have been able to make and what they needed support with. The home did not complete MCA assessments to ensure that people's needs around decision-making were met. Where people were unable to make decisions regarding their care there were no records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. The home was unable to demonstrate how people were involved in decision making and what they were able to make decisions on.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had not been signed by people, relatives or staff. One relative said, "No, I have never been asked to be involved in [my relatives] care but I think I should be."

At our last inspection we found that people were not always being supported to maintain good oral hygiene. The majority of bedrooms that we checked had a toothbrush that had become dry and hard and either no visible toothpaste or toothpaste that was dry. At this inspection, we checked six people's bedrooms and found that toothbrushes were often inaccessible under sinks, toothpaste not always present and toothbrushes were dry. Care plans had been updated to say whether people needed dentures or support to maintain their oral hygiene. There was no documentation to show that this was happening. Staff had not received training around oral hygiene.

Avon Lodge provides care and support to people, all of whom have a level of cognitive impairment or dementia. Staff had not received training in working with people living with dementia and behaviour that challenges. The service failed to ensure that staff had been appropriately trained to provide care to people

with dementia or behaviour that challenges.

Staff told us and records confirmed that they were supported through regular supervisions. Supervisions covered reviews of performance, future work targets, training, support and development and any other matters arising. The providers' supervision policy stated that staff should receive, 'At least 6 supervision sessions per year and a minimum of 4 per year'. We saw evidence of this in staff files. There was also evidence of appraisals. Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures and shadowing more experienced staff before being allowed to work alone.

Requires Improvement

Is the service caring?

Our findings

People and relatives felt that staff were caring. People said, "Oh yes, everyone here is very polite and I think they are very interested in making sure I am ok,", "Yes, I like them knowing my name and they talk nicely to me", "Staff are fine. Busy doing other things but quite helpful when you need them" and "They are all very kind and talk nicely to me. They care for me really well." A relative said, "They [the staff] seem great, very pleasant and welcoming."

On the second day of this inspection we observed the homes activities coordinator interacting with people in the main lounge. We observed the staff member say to a person, "Shut up, just shut up" and walking away from the person. We immediately raised this with the manager and area manager. A safeguarding was raised around this issue by the home to the local authority. Following the inspection the manager informed us that disciplinary action had been taken.

We saw some positive interactions between staff and people who used the service. We observed staff being caring and supportive to people who became distressed. One person was walking around and a staff member walked with him whilst chatting and ensuring his safety. We observed an incident between two people. Staff intervened appropriately and managed the situation well. However, one person was removed from the area to help calm the situation down and the other person became very distressed and aggressive. Staff talked with the person but were laughing. This was not appropriate and inflamed the situation

At our last inspection, we visited the home early in the morning as we had received concerns that people were being got out of bed from 04:30am. At that time we found eight people were up and had received personal care by 06:00am. People had told us that they had not wanted to get up and had been woken by staff. At this inspection, we arrived at the home at 05:45am and found that three people were up. Two further people were up by 06:20am and everyone that was awake had been given tea or coffee. However, four people told us that they had wanted to get up and staff had not woken them. People's care plans had been updated in the last six months to reflect people's waking and sleeping preferences. Staff told us, "Oh no, we don't wake them up. They get up when they are ready now" and "People are not woken up. They are checked on. People who are up have chosen to get up." Another staff member told us, "The manager is looking at introducing two day care staff to start at 7am to support the night staff. People will have the choice to get up when they want. People show you they are ready to come out. They request not with words but with expressions."

We observed people waking at different times throughout the morning and being supported by staff. People said, "I've had a lovely sleep" and "I wake up when I want." Staff told us that the morning handover between night staff and day staff included information about who was still asleep. Staff were ensuring that people's preferences around waking and sleeping were met.

We observed some caring interactions between staff and people who used the service. Whilst staff were busy, we still observed them sitting with people for a chat and generally asking how they were or discussing various topics. The staff knew people well and were able to discuss their likes and dislikes. One staff member

said, "I know what my residents like, we're like a little family here. We get to know them well." Another staff member said, "There is a way of supporting people. There is a way to do it, not about just spending five minutes with someone. It's the way you approach people." Some staff members were also able to communicate with particular residents in their native language.

At our last inspection we found that people's faith and cultural needs were not being met adequately. One person had wanted to attend a local mosque but had not been supported to do so. At this inspection we saw that the person had been offered opportunities to attend. For other people, a local priest had begun attending the home and holding services for people that wished to attend. Details of services were clearly displayed in the hallway.

We asked staff how they would work with gay, lesbian, bisexual or transgendered people. Staff told us that this would not make any difference to how the person was treated. One staff member said, "It's no different. People's lifestyles does not matter, we work with people without discrimination. We also give the right treatment according to the Equalities Act 2010. I would have no issues working with people undergoing gender reassignment either. We're all human."

Staff told us that relatives could visit whenever they wanted and relatives we spoke with said; "Oh yeah, I just drop in when I want" and "They [the staff] always make me welcome". We observed family and friends visiting throughout our inspection. We observed staff talking to visitors and offering them tea or coffee.

Inadequate

Is the service responsive?

Our findings

At our last inspection we saw that the complaints procedure was displayed by the front door. It was written in a small font and there were no alternative formats, such as large print or pictorial, to make it easy for people to read. At this inspection we found that this was still the case. A complaints box had been installed by the front door for people and relatives to use. There were four documented complaints. However, there was no noted outcome or response to the complaints recorded. The home had not analysed the complaints and identified any areas of learning or how care practices could be improved as a result of complaints. Relatives said that they had not received information from the home on how to make a complaint.

This was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that relatives could visit. However, people told us they were bored and did not go out. We saw that there were no organised activities within the home. During three days of inspection we did not observe one person going out, except to a medical appointment. People were brought into the main lounge in the morning and often did not move all day. At this inspection we found that this had not been addressed by the provider adequately. An activities coordinator had been employed and we observed them in the main lounge throwing a foam ball from one person to another. However, there were still no planned activities within the home. We observed a person hoisted into a chair at 05:45am and, aside from toileting, they did not move all day. Other people were brought into the main lounge and sat in armchairs. Unless people were mobile they did not move all day. Most people ate where they were sitting.

People's care plans did not record what people enjoyed doing in any detail. The majority of care plans noted what people wanted to watch on television or had done in the past. There was no detailed information on what people's like and dislikes were around activities. One person was walking around the dining and lounge area humming and other people were becoming distressed by the person. The person's care plan gave no guidance for staff on how to support the person appropriately. We observed people wandering around the home with nothing to engage them or provide any form of stimulation.

We asked people what they did during the day. People told us, "I get to draw and colour things. I also read the paper. I usually just sit down in the lounge as there is nowhere else to go. I go to church", "Just usually sit around doing nothing" and "They leave us alone and we can do whatever we want." We spoke with the new manager, who had been in post for three weeks. The manager told us that he had plans to improve activities for people in the near future.

Following the inspection, we spoke with staff and some people's relatives. Staff told us, "We went on a trip to Broxbourne, Paradise Wildlife Park [zoo]. This was the first trip since I've worked here in over a year. He's [the manager] organising a lot of activities. He's even organised a garden party for people" and "Now the weather is getting nicer, people are having their morning tea in the garden if they want. There's going to be a BBQ too." Relatives told us, "I was going to visit today but they went on a day trip to the seaside" and "They [the staff] are encouraging [my relative] to do some painting. My only gripe was that they didn't do trips. The

old management were not doing any activities."

At our last inspection we found that care plans were not person centred, often contradictory and did not provide staff with enough information to provide high quality care. The home had been working with the local authority around care plans and had been provided with a new care plan template. Care plans were better organised and clearer. Personal information and life history lacked sufficient information. Care plans documented who people's keyworker was. A keyworker is someone who is responsible for an individual and makes sure their needs are met and reviewed. One person told us, "Yes, I know who my designated carer is. I like her."

Care plans were not person centred. There was insufficient guidance for staff on how to ensure care and treatment was personalised. For example, one person's care plan stated that they were, 'A devout Muslim' but there was no direction on how this should be supported, if the person attended mosque, what their dietary requirements were or if they needed support to pray. Another person's care plan stated that the person took a blood thinning medicine and required regular blood tests. There was no information on how the person was supported to have their blood tests or how staff should manage the person's condition. Some care plans that we looked at stated that people required help with personal care and dressing but no further information was recorded on how this should be carried out for each person. There was no guidance for staff on the type of support the person required or how the person wanted to receive personal care.

People were still not involved in planning their care. Where people were not able to have input, there were no records of best interests meetings or decisions. A best interest's decision is when a person is unable to have input into their care and healthcare professionals and relatives are consulted on the best way to care for that person. No care plans that we looked at had been signed by people, their relatives or healthcare professionals.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that staff had been pre-emptively writing the morning reports the night before. At this inspection we found that this had been resolved and progress reports were written at the correct times of day. Daily records for people showed that entries had been made in relation to support given including personal care and whether they had eaten well or not. However there was no recording of any participation in activities.

When we looked at daily recording notes we saw that one person had been refusing personal care on a regular basis. We also noted that an incident had taken place where the same person had thrown a cup of tea over a member of staff. We looked at behaviour charts for this person and found that there had been no recording of this incident in the behaviour charts and no incident form had been completed. We further looked at three behaviour charts for people. There was lack of consistency in recording and staff were recording people's positive interactions rather than their negative experiences. There was no analysis of these charts to note any patterns, triggers for people's behaviour or guidance on how staff could effectively support them. There was no guidance for staff on how to use behaviour charts effectively to improve and guide how care and treatment could best be delivered for people.

Inadequate

Is the service well-led?

Our findings

The home currently does not have a registered manager. The registered manager had left in February 2016 and a new manager had been in post for three weeks at the time of our inspection. The new manager had applied for registered manager status with the Care Quality Commission (CQC).

Following our last inspection, we took enforcement action against the provider and imposed conditions on their registration. This is a set of requirements that the provider must adhere to, including sending the CQC monthly updates on progress following our findings at the last inspection.

Despite the conditions which required the home to make improvements and a high level of input from the local authority, the home had failed to improve standards to a level that met regulatory requirements.

At our last inspection, we found that there were difficulties between staff and management and staff morale was low. At this inspection staff told us, and we saw, that they felt happier and more supported. Staff said, "I feel very much supported. We work better than we have before", "Residents have become our priority". Another staff member said, "The new manager is working with us, guiding us and training us. He speaks to us every morning. It's going really well."

People said about the new manager, "He's the boss, he's new but it's going good since he's been here" and "I think we have a new one, I've seen him in here a few times and he says hello. But I don't remember his name." One relative told us, "The new manager's not been there long but he seems to be getting stuff done."

At our last inspection we found that the home was not competing regular audits of risk assessments, care plans and medicines. At this inspection, we found that audits in these areas were still not being completed. Records showed that fire systems were checked regularly. However, there were no health and safety audits completed for the home. The area manager told us that the provider completed health and safety audits. However, there was no documentation to show that this had been happening. Accidents and incidents were not always documented. We found information regarding incidents in handover notes written by staff. However, these had not been recorded in the accident and incident file. This meant that the home was not learning effectively from accidents and incidents.

During out last inspection, we observed that there was good joint working with healthcare professionals and saw that people's healthcare needs were dealt with promptly. However, details of appointments and visits were not always recorded in people's care files. At this inspection we found that details of healthcare appointments were still not documented in people's files appropriately.

There was a medicines audit in February 2016 that identified that staff had not been signed off as competent to administer medicines at night, management had not addressed this. Management had failed to address that people may have been left in pain or anxious as a result of not having access to PRN medicines throughout the night.

Training records showed that staff had received training in MCA and DoLS. However, staff had been unable to explain to us what this meant in theory or practice in relation to providing care to people. Management were unable to explain how they ensured that training provided was understood and implemented by staff. The service provides care and support to people living with dementia. However, staff had not received training in working with people living with dementia of behaviour that challenged.

Following our last inspection the home had been holding meetings with friends and families. Records showed that friends and families discussed updates on the care that was being provided to people, care plans, activities, relative involvement in people's care staff training and food. There was another meeting booked for 21 April 2016. However, although activities and relatives involvement had been discussed at these meetings, the home could not provide evidence that this had been happening.

Surveys around people and relatives opinions of the service had been recently sent out and results were being collated. We looked at feedback from the surveys. Comments were mostly positive around the care and support provided. The area manager told us that results of the survey would be shared with relatives and people that used the service.

There were monthly staff meetings. Agendas included discussions around job descriptions, the CQC report, meal times, personal hygiene, residents, food and fluid charts and care plans. Staff told us that they had an opportunity to raise concerns and felt management listened to them.

We found breaches of regulations 9, 11, 12, 14, 16 and 17 the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This means that the home is not complying with all of the regulations we inspect against. The breaches that were identified at this inspection were the same breaches that had been identified at the last inspection. The home's systems to monitor and have oversight of the service were not effective. These were not reviewed regularly or not in place at all. The shortfalls we found in areas such as ensuring that people were involved in planning their care, the service they received and audits of care plans and risk assessments had not been recognised by the provider.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to act on complaints received and document thorough investigations and outcomes. Regulation 16(1)