Tricuro Ltd

Avon View

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection was unannounced and took place on the 5 November 2015. The inspection continued on the 6 November and 9 November 2015 and was announced. It was a planned comprehensive inspection carried out by two inspectors.

The service is registered to provide accommodation and residential or nursing care for up to 81 people. During the inspection there were 80 people living at the service. The home had three floors and all the rooms were single with an en suite facility of which 25 had fixed ceiling hoists. Each room had a fixed call bell and the system also enabled people to have a mobile call bell so that they could call for assistance wherever they were in the building. Each floor provided a different type of service. The ground floor provided residential care to people living with a dementia and had access into a secure garden. The first floor provided residential care and the top floor provided nursing care to older people.

Each floor had lounges and dining room areas with self-contained kitchenettes which staff and families used for making drinks and light snacks. There was a bathroom on each floor with specialist bathing facilities. A guest room

Summary of findings

was available for visitors who needed to stay overnight. On the ground floor there was a conservatory used mainly for quiet time. There were two lifts giving access to the first and top floor, a commercial laundry and kitchen facility. The service had a security door entry system in place and provided a receptionist service seven days a week until 8pm.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the service to be safe. People told us that they felt safe living at Avon View. Staff had received safeguarding training as part of their induction and then every three years. We looked at training records that evidenced this and spoke with staff who demonstrated they understood how to protect people and keep them safe from harm. We saw safeguarding information displayed around the service which included who to contact if you had concerns.

People's risk were assessed and reviewed at least monthly. Risks included malnutrition, eating and drinking, tissue viability and mobility. Care plans were in place for any risk that had been identified and explained actions to be taken to minimise the risk and keep the person safe. One person had fallen from their recliner chair which led to their falls risk being reviewed by an occupational therapist. The person was assessed as understanding the risk to their safety and had the freedom and choice to determine what restrictions were acceptable to them.

Records for the maintenance of equipment and the premises were up to date. Staff had received fire training and fire drill evacuation practice took place six monthly. Each person had a personal fire evacuation plan in place. The service had an emergency contingency plan which contained information on how the service would keep people safe in the event of a major incident which affected the running of the service.

We observed good staffing levels. People we spoke with told us that there were enough staff. Staff files contained evidence that recruitment practices were safe. Criminal record checks had been carried out prior to employment and had been reviewed three yearly.

People's medicines were managed safely. However, the provider was in the process of making improvements to how temperatures of medicine storage areas were regulated and monitored. Refrigerators were operating within a safe range and the temperature monitoring records were being updated at the time of the inspection to allow appropriate temperature recording. A member of staff told us that some people had been getting morning medicines as late as 11am. The manager had taken actions so that senior staff supported when necessary. During our inspection people were receiving their medicines in a timely way.

New care staff completed the Care Certificate induction course, safeguarding and food hygiene training over their first days of employment. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff had completed mandatory training such as moving and handling, infection control and health and safety and certificates were on their files. Specialist training had also been completed which was specific to people living at the service. Staff received regular supervision and had an annual appraisal.

All staff, including housekeeping and catering staff had received dementia training. In July 2015 a survey was carried out with health commissioners, staff, families and people living at the service. The survey looked at people's views on how the environment, activities and staff training met the needs of people living with a dementia. The results of the survey had been used to create a 'Dementia Development Plan' with actions agreed to support improvement. The actions identified reflected people's views and preferences on receiving support with their dementia.

Nursing staff received regular clinical training and supervision. Training included wound management, syringe driver, nutrition and end of life training. The service had achieved a 'Gold Standard Framework (GSF) accreditation three years ago. The GSF is a national

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award. It is a model of care that enables good practice to be available to people nearing the end of their lives. The service was reassessed in October 2015 and received a higher level of accreditation.

People consented to their care, support and treatment. Mental capacity assessments had been carried out. Where it was assessed that the person lacked capacity to consent to the care arrangements a Deprivation of Liberty (DoLs) application had been sent to the local authority. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. The manager and staff were aware of the DoLs legislation and how to apply it to their practice.

Some people had been assessed as being at a high risk of malnutrition. Staff were aware of who these people were and the actions needed to reduce the risk. Referrals had been made to health professionals to assess persons' swallowing and their risk of choking. People had safe swallowing plans and these were being followed. For main meal times there were systems in place that provided a check that people got the food and drink they needed. No processes were in place for mid-morning and afternoon drinks and snacks which led to a person not getting regular drinks. We discussed this with the manager who told us that this would be reviewed immediately.

People had a choice of meals and where they would like to eat. We saw people enjoying meals with their families. The kitchen had records from the care staff that let them know of any special dietary requirements. Staff supported people discreetly and people enjoyed their meals in a relaxed environment.

People had access to a range of healthcare services including GP's, specialist nurses, dieticians and palliative care specialists. Care files had good evidence of healthcare referrals.

We spoke with people, their relatives and professionals who visit the service who all gave us positive examples of how kind and caring they found the staff. We observed staff supporting people in a caring way. We looked at three files that contained comprehensive details of a person's life history. We found that staff had a good knowledge of people's families but in some cases a limited awareness of the person's whole life history. Staff told us they were aware it was on file and would refer to if needed.

People told us they felt involved in decisions about their care. Information about advocacy services was available around the service.

People told us that they felt their privacy and dignity were respected. Staff were able to give us examples of how they maintain a person's privacy and dignity. However two relatives we spoke with felt at times people' dignity was not maintained. We saw good examples of staff treating people with dignity and respect however some practice we observed did not. We discussed this with the manager who told us she would look at introducing a dignity audit that took place more regularly would include observations of staff practice.

People and their families felt involved in planning their care and support. People were encouraged to personalise their rooms and a leaflet had been produced with the help of people living at Avon View and given to new people moving into the service.

Care plans were written for people and clearly detailed the personalised support people had agreed. Staff had a good knowledge of people's risks and how to support them. Changes to a person's health or wellbeing was responded to quickly. People had opportunities to increase and maintain their independence. Staff were observed supporting people in a way that maximised their level of independence. Activities were available seven days a week. Each person had their own copy of the weekly activities programme which provided the information in written and picture format. People were offered a range of activities including trips into the community. Staff supported people with keeping in touch with family and friends.

People, their relatives and staff all told us that they felt they had opportunities to feedback on the service and felt able to raise a complaint. Complaints were investigated appropriately and outcomes shared with staff. We were aware that there had been a complaint about a person's experience during a short respite stay and that as a result additional checks by senior staff had been introduced. We looked at a care file for a person having respite care. They needed their catheter changed

Summary of findings

every 6-8 weeks. There was no evidence that the staff had identified and planned for the next catheter change. We spoke with a nurse who immediately addressed this. We saw minutes of meetings with people who live at the service and relative meetings. They were displayed around the service on noticeboards and in a folder in reception and included details of actions taken. Compliments were discussed at staff meetings and then displayed on the units.

We found the service was well led. Staff told us they felt happy and felt supported in their work. Staff told us that they felt able to raise questions about things they were unsure about and that this was encouraged by senior staff. We observed professional and relaxed interactions between staff and the management.

The home had an audit schedule that covered key areas of service. Feedback to staff had been provided constructively and had explained the service expectations and individual and/or team responsibilities.

The results of the quality assurance carried out in July 2015 provided positive feedback from other professionals, people who used the service and their families. However some people feedback that they felt their call bells were not being answered quick enough. A weekly audit had been introduced to monitor with a target of answering within three minutes.

People, their families, staff and other professionals were involved in developing the service. They were involved in a survey that looked at the environment, activities and staff training in relation to supporting people living with a dementia. The results had been used to create a 'Dementia Development Plan' which had been shared and was on display on notice boards.

The manager is working with a local University so that student nurses can have some of their training at Avon View. Nurses have completed a mentorship course in preparation for supporting student nurses with their training.

The manager had a good understanding of the Data Protection Act, Freedom of Information Act and her responsibilities for sharing information with CQC.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff had received safeguarding training and demonstrated that they knew how to protect people and keep them safe from harm.

People's risks were assessed and reviewed regularly. Care plans were in place that explained actions to minimise risk and keep people safe.

Equipment and the premises were maintained. Staff had received fire training and each person had a personal fire evacuation plan. An emergency contingency plan was in place to keep people safe in the event of a major incident affecting the running of the service.

Recruitment practices were safe and included criminal record checks and a persons' eligibility to work in the UK. There was enough staff to meet the needs of people.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff received induction, and

on- going training which gave them the skills to support people effectively.

The service had achieved the Gold Standard Framework accreditation which is an award for a model of care that enables good practice to be available for people nearing the end of their life.

People consented to their care and treatment. The manager and staff were aware of the Deprivation of Liberty safeguards and how to apply it to their practice.

People were supported to eat and drink. Staff were aware of people who had been assessed and had a high risk of malnutrition or swallowing problems and the actions to take to reduce risk.

People had good access to other health care professionals.

Is the service caring?

Good

The service was caring. We were told by people, their families and visiting professionals and we observed staff supporting people in a caring way.

People were involved in decisions about their care and had advocacy services when needed.

People told us they felt their privacy and dignity was respected. We observed good practice the majority of the time. We highlighted to the manager some observations of poor practice when respecting a persons' dignity. We were told that a dignity audit take place more regularly and include observations of staff practice.

Is the service responsive?

Good

The service was responsive. People told us they were involved in their care and support plans and supported to maintain their independence. Staff had a good knowledge of people's risks and the actions needed to support them

Summary of findings

A range of activities were available including trips into the community. People were supported to keep in touch with friends and family.

People knew how to make a complaint and felt they had opportunities to feedback about the service. Complaints were investigated and learning shared. Regular meetings were held with people and their families and minutes and actions taken displayed for their information.

Is the service well-led?

Good

The service was well led. Staff were happy and felt supported in their work.

Audits in all key areas of the service were carried out regularly and actions identified. Feedback to staff had been provided constructively and had explained the service expectations and individual and/or team responsibilities.

People, their families, staff and other professionals were involved in continually developing the service.

The manager had a good understanding of their responsibilities for sharing information with the Care Quality Commission and other external organisations.

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Detailed findings

Background to this inspection

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

The inspection took place on the 5 November 2015 and was unannounced. The inspection continued on the 6 and 9 November 2015 and was announced. The inspection was a planned comprehensive inspection carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service. We spoke with health and social care commissioners to get information on their experience of the service.

Before the inspection we did not request a provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from the provider during the inspection.

We spoke with 10 people who live at the service, eight people who were visiting. We spoke with the Registered Manager, Deputy Manager, Deputy Nurse Manager, two nurses, 16 care staff and the Kitchen Manager. We spoke with an occupational therapist, a volunteer, a social worker from the mental health team and a district nurse who all had experience of the service.

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.

We reviewed seven peoples care files and discussed with them and care workers their accuracy. We checked health and safety records, maintenance records, medication records, management audits, staff, resident and relative meeting records and the results of quality assurance surveys. We walked around the building observing the safety and suitability of the environment and observing care practice.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Avon View. One person told us, "The staff like to keep a check on me, I'm happy, I feel safe". Staff received safeguarding training as part of their induction and then every three years. We looked at training records that evidenced this. Staff demonstrated they understood how to protect people and keep them safe from harm. Staff were able to tell us how they would recognise signs of potential abuse and what they would do if abuse was suspected. A relative told us, "Staff are very fair, sometimes people can be difficult, they don't discriminate, they carry on treating them fairly".

We saw safeguarding information displayed around the service which included who to contact if you had concerns.

People's risks were assessed prior to admission and then reviewed at least monthly. Risks included malnutrition, eating and drinking, tissue viability and mobility. Care plans were in place for any risk that had been identified and explained actions to be taken to minimise the risk and keep the person safe. One person had a risk assessment that showed a high risk of skin breakdown. A plan was in place for the person to be assisted to change position regularly and use a pressure relieving air mattress. Staff were aware of the person's needs in relation to pressure damage. We saw that the air mattress was in place and set correctly to the person's most recent weight. Charts evidenced frequent support to change position. One person had fallen from their recliner chair which led to their falls risk being reviewed by an occupational therapist. An alternative type of chair had been recommended to reduce the risk of further falls. The person was assessed as understanding the risk but decided to continue with their own recliner chair. This demonstrated that people were involved in decisions about risk to their safety and had the freedom and choice to determine what restrictions were acceptable to them.

Records for the maintenance of equipment and the premises, including fire equipment, were up to date. Staff attended fire drill evacuation practice six monthly. Each person had a personal fire evacuation plan in place. The service had an emergency contingency plan which contained information on how the service would keep people safe in the event of a major incident which affected the running of the service.

People told us that there were enough staff. One relative said, "Can always find somebody to talk to. Always enough staff". A care worker told us, "Can't fault staffing". We observed good staffing levels. Staff were able to respond quickly to people who needed support. Staff were observed regularly checking people who were alone in their rooms. The manager showed us a tool that was completed each week that calculates the staffing hours needed to support people living at Avon View. The staff rota showed 200 more care hours than the tool recommended. Staff files contained evidence that recruitment practices were safe. Criminal record checks had been carried out prior to employment and had been reviewed three yearly. There was evidence that staff were eligible to work in the UK. We spoke with a volunteer who told us, "I've had my DBS (criminal record check) and other checks, just the same as the staff".

People's medicines were managed safely. However, the provider was in the process of making improvements to how temperatures of medicine storage areas were regulated and monitored. The provider had responded to a recent external pharmacy audit which had indicated that temperatures in medicine storage areas were, on occasion, in excess of what they should be. Fans had been installed and the storage had been upgraded to address this issue, however this had not removed the problem entirely and the registered manager told us that this had been escalated to their maintenance department. The system for monitoring the temperature of pharmacy refrigerators was in the process of being improved as actual temperatures of the refrigerators were not always being recorded daily. However, refrigerators were operating within a safe range and the temperature monitoring records were being updated at the time of the inspection to allow for appropriate temperature recording.

People's Medicine Administration Records (MAR) were maintained and where these were handwritten two signatures were present to confirm the accuracy of the entry. A code was used to indicate the reason why a medicine was not given. MAR were signed and medicines were absent from the monitored dosage system indicating that people had received their prescribed medicines. Medicines were not used past the expiry date and the date of opening liquid medicines was recorded on the medicines on most occasions to ensure that they were not used past the effective date. Staff told us some people were getting their breakfast medicines as late as 11am due to the

Good

Is the service safe?

time it took to complete the medicines round. The impact was that lunch time medicines needed to be delayed. The manager told us that actions had been taken. Senior staff now supported when necessary so that people had their morning medicines no later than 10am and people who had lunch medicines had their morning medicines first. During our inspection people were receiving their medicines in a timely way.

Good

Is the service effective?

Our findings

New care staff completed the Care Certificate induction course, safeguarding and food hygiene training over their first seven days of employment. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff files contained certificates of completed training. Records were kept for each member of staff detailing the training they had taken and how often it needed to be renewed. Training staff had taken included moving and handling, health and safety, infection control, nutritional care and first aid. More specialist training had also been completed which was specific to people and included person centred care, introduction to Parkinson's disease, understanding and managing behaviours that challenge and skin care. Training records showed us that staff had been given the skills to carry out their roles effectively. One member of staff told us, "The manager is always working to improve the quality of staff". Staff told us that they receive regular supervision and we evidenced monthly supervision records. Staff had received their annual appraisal setting out personal development objectives for the forthcoming year.

All staff, including housekeeping and catering staff, had received dementia training. We were told by one care worker, "Feel enough knowledge to do my job. Be good for a refresher as some time ago". In July 2015 a survey was carried out with health commissioners, staff, families and people living at the service. The survey looked at people's views on how the environment, activities and staff training met the needs of people living with a dementia. The results of the survey went into a 'Dementia Development Plan' with actions agreed to support improvement. The actions identified reflected people's views and preferences on receiving effective support with their dementia. The plan included all new staff completing a basic first training book on dementia and person centred care. A new member of staff told us they had, "just been given a booklet for dementia training. It explains different types of dementia. It's good to understand, to have an explanation for what you see. It's constant learning". The 'Dementia Development Plan' had been shared with staff and was displayed on notice boards.

Nursing staff received regular clinical training and supervision which enabled them to provide effective clinical care to people. Training included wound management, syringe driver, nutrition, taking bloods and end of life training. We were told by one nurse, "Good support, training, calm atmosphere to work in. Staffing very good, which is also a factor, good team of nurses who have been here a long time".

We observed staff asking people for consent before providing support. Care files contained written evidence that people had signed consenting to their care, treatment and support. Mental capacity assessments had been carried out and where it was assessed that the person lacked capacity to consent to their care arrangements a Deprivation of Liberty (DoLs) application had been sent to the local authority. One person had been assessed as needing bed rails and bumpers. A mental capacity assessment had been carried out and it had been decided it would be in the persons' best interest to have the bed rails and bumper fitted. We saw these in place and staff were aware of the need for them to reduce the persons' risk of falling. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The manager and staff were aware of DoLs legislation and how to apply it to their practice.

Some people had been assessed as having a high risk of malnutrition. Staff were aware of who these people were and the actions needed to reduce the risk. People at risk were being weighed regularly and food charts were being completed. The charts were checked nightly and any issues and actions highlighted. We saw that a referral had been made to a persons' GP about their weight loss. Referrals had been made to health professionals to assess persons' swallowing and risk of choking. One person had a safe swallowing plan and needed to have fluids thickened and a fork mashable diet. Staff were aware of the swallowing plan and the support the person needed. One person had lost weight and three days before our visit their care plan had been reviewed and changes put into the plan to support the person in a different way to prevent further weight loss. We spoke with the care worker supporting this person and they had a full understanding of the changes to how they needed to be supported with eating and drinking.

One relative told us, "I arrive unannounced; mum is slow at taking drinks. There will be somebody sitting helping her. It can take an hour". However we spoke with one person who spends all their time in their room. They told us that they

Good

Is the service effective?

regularly do not get offered mid-morning or mid-afternoon drinks. This person needed staff support with food and drinks. We discussed this with the staff supporting this person. They were not able to tell us how they could ensure everybody received drinks and snacks between meals. For main meal times there were systems in place that provided a check that people got the food and drink they needed. There were no systems in place for drinks and snacks between meals which resulted in this person not getting regular drinks. We discussed this with the Manager who told us that this would be reviewed immediately.

Each dining room had menus displayed offering three choices at lunchtime and alternative options. The menu was in writing and picture form to enable more people to make choices. People could choose to have their meals in the dining room or their own rooms. We saw people enjoying meals with their family. People told us the food was good and if you wanted something different to the menu it had never been a problem. Each dining room had a comment book to record any messages for the kitchen. The Cook Manager who told us they were going to the next resident meeting to get face to face feedback. The kitchen had records from the care staff that let them know of any special dietary requirements. We observed meal times and the food looked and smelled appetising. There were enough staff to support people discreetly and in an unhurried way. Catering staff served the meals in each of the dining rooms. We were told “I usually serve meals in the same dining room each day. It’s good because I know the people and what they like”. Every morning the kitchen cooked two people a full english breakfast. One told us “They organise a big breakfast each day, keeps me going”.

People had access to a range of healthcare services including GP’s, specialist nurses, dieticians and palliative care specialists. A district nurse told us, “They always call us to just even discuss a concern. Never leave anything at all. Can’t ask for any more”. Care files had good evidence of healthcare referrals.

Good

Is the service caring?

Our findings

We spoke with people, their relatives and professionals who visit the service who all gave us positive examples of how kind and caring they found the staff. One person told us "Care excellent". A relative told us "There have been times when I have been able to have a holiday because I feel he is being well cared for". A visiting social worker told us "Every person I have reviewed here has improved. One person would not let anybody care for her or engage in conversation. They have done an amazing job. Now going out, wouldn't do that before. It's down to love and care and a person centred approach". Another relative told us "My wife gets upset when I visit and wants to come home with me. I find this really hard to cope with but staff distract her and this helps". A family member had written a letter to the home which included "We could not have found a more loving and caring home".

We observed staff supporting people in a caring way. One person was anxious and upset and a staff member reassured her, asked her if she was cold, helped her with a cardigan and stayed quietly talking until she was visibly relaxed and smiling. Another person had received e-mails from friends and a member of staff was sitting helping access them. They read them to the person and shared a conversation about the messages. One person was watching a wildlife programme and a member of staff was sitting with them and they were laughing and enjoying it together.

We looked at three files that contained comprehensive details of a person's life history. We found that staff had a good knowledge of people's families but in some cases a limited awareness of the person's whole life history. One member of staff told us they were aware it was on the file and would refer to if needed.

People told us they felt involved in decisions about their care. We observed a nurse asking a person if they would like more pain relief. Relatives told us staff kept them informed of changes. Care files contained evidence of discussions involving people in decisions about how they would like to receive care such as times they liked to get up or go to bed. At the time of our visit nobody was using an advocacy service. Details of the advocacy service were on display on noticeboards around the service.

People told us that they felt their privacy and dignity were respected. One person said about the staff, "Don't come in unless invited". Staff gave us examples of how they maintain a person's privacy and dignity. They included using the 'Do not Disturb' signs on bedroom doors, minimising the number of people in the room when providing personal care, giving people time when using the toilet. Some staff were dignity champions and there photographs were displayed on the noticeboards. One told us they had attended a day workshop.

Residents had completed an annual dignity audit. There had been 16 returned and the feedback was positive on dignity, privacy and staff politeness. However we spoke with two relatives who felt people's dignity was not always respected. One relative said "Feel care is safe. It's the silly little things". An example had been not cleaning a person's mouth properly, another was food left on clothing after a meal. We observed good examples of staff treating people with dignity and respect. Staff discreetly offering people support, not rushing people when supporting them, walking at the person's pace, knocking on doors before entering and asking people if they can assist them before providing support. However some practice we observed did not respect a person's dignity. One person had started to eat her lunch. A care worker without seeking the persons' agreement put a tabard on them saying "I know you don't like it but you need to wear it". The person looked taken aback. We saw a care worker not using people's preferred names but calling them sweetheart and darling. A bathroom that people used for bathing was full of wheelchairs. We discussed this with the manager who told us she would look at introducing a more regular dignity audit that would include observations of staff practice.

Good

Is the service responsive?

Our findings

People and their families were involved in discussing and planning their care and support needs prior to admission. A relative told us, "Staff visited mum at home. Asked us to make her room familiar. We could bring anything we felt would help mum settle in. On day she was admitted she was introduced to everybody, they gave us an information pack. They sat us down and went through all mum's risk assessments. Mum and myself felt listened to."

The staff had noticed that some people seemed apprehensive about personalising their rooms. A leaflet called 'Personalising Your Room' had been produced with the help of people living at Avon View and was given to people before they moved to the service. The leaflet contained quotes from people such as "Bits and bobs make you think of home and remember the past and can be conversation starters".

People told us that if their care needs or health change staff respond quickly and ensure they get the support they need. A relative told us "There quick at noticing change and calling GP. They keep me informed". Care plans were written for people and clearly detailed the personalised support people had agreed. We spoke with four staff and they had a good knowledge of people's risks and how to support them. We were told "Handover is good. Also there is a communication book and the person in charge records actions passed on in handover and they are followed up". Staff told us that they have time to read the care plans.

People had opportunities to maintain their independence. Three people were early risers and had asked if they could make their own breakfasts. They were being supported by the occupational therapist to make tea and breakfast in the kitchenette. A relative told us "They tried to maintain his independence with walking for as long as possible". We observed a person with a specialist drinking beaker. The staff gently placed his hands on the handles and guided the beaker with him. With this support they were able to continue their drink independently.

Activities staff worked seven days a week. Each person had a weekly activities timetable in their room which contained words and pictures of planned activities. We were told "Things the activity team organise is brilliant". Another person said "Care has been brilliant from the social side". During our visit we observed a number of activities including musical recorder practice, quizzes and art work. People told us that they could choose if they wanted to join in. One person had always wanted to have chickens. Staff had sourced a chicken coup and chickens were arriving the following week. On the ground floor corridor residents had created through their art work a woodland walk. Newspapers of people's choice had been delivered to their rooms. The service had the use of a mini bus once a week which they used to organise trips into the community. We were told about a community event where eight people went and enjoyed a fish and chip supper. Some people had joined a choir and were having weekly practice for a planned christmas carol concert.

People, their relatives and staff all told us that they felt they had opportunities to feedback on the service and felt able to raise a complaint. We saw that complaints were investigated appropriately and outcomes shared with staff. Complaints were investigated and actions taken as a result. A senior care worker told us, "Now a senior carer has to make a check on a person who is having a respite stay three times a day. We check food and fluid, see if they are they making friends and try to identify if there are any issues". We checked the file of a person on a respite stay. They needed to have their catheter changed every 6-8 weeks. The catheter had last been changed on the 27 September prior to admission. There was no record that staff had identified and planned for the next catheter change. We spoke with a nurse who immediately addressed this. One person told us, "I did complain once. I wasn't happy with how they were doing something. I put my foot down. They must have listened because they rectified it". Another person told us they had made a complaint. They said "It's being dealt with. Felt listened to. Been told I'll be getting an apology later".

We saw minutes of meetings with people who live at the service and relative meetings. They were displayed around the service on noticeboards and in a folder in reception and included details of actions taken. Compliments were discussed at staff meetings and then displayed on the units.

Good

Is the service well-led?

Our findings

We found that the service was well-led. Staff told us they were happy in their work and they felt supported. One care worker said, "The manager is very good at being at meetings and supporting with any issues on the unit". Staff told us that they felt able to raise questions about things they were unsure about and that this was encouraged by senior staff. We observed professional and relaxed interactions between staff and the management. A person said, "I talk to the manager a lot, we get on well. She listens and will put things right". Another person told us, "A lot of good people who put in a lot of effort – it's well driven. Staff work as a team". A visitor told us, "They sustain staff, some been here for years. That's really good, not like some places always advertising".

The home had an audit schedule which covered key areas of service. As part of the Manager's supervision the organisation carried out a monthly audit of the service which included walking around and talking to people and staff. The manager and deputy carried out audits including care plan and medicine audits, activities, dignity, mealtimes and infection control. Feedback was provided constructively to staff that enabled them to understand the service expectations and their responsibilities.

The results of the quality assurance carried out in July 2015 provided positive feedback from other professionals, people who use the service and their families. It had highlighted that some people felt that their call bells were not being answered quick enough. In response an audit was carried out where the call bell response times were randomly checked three times a week. The results from the quality assurance feedback were displayed on noticeboards and included issues identified and the actions taken.

The manager talked to us about including people who use the service, their relatives, staff and other professionals when developing the service. We saw evidence of this in the dementia development plan that was displayed around the service. A survey had been carried out with the Clinical Commissioning Group, residents and their families and staff. They had looked at the environment and activities and staff training. The results had been put into an action plan that was shared with all staff, families and residents. We spoke with people and staff who knew about the action plan. They told us that people wanted to have more cushions and throws around the lounges to make them more homely. We found people motivated and engaged with the action plan.

The manager told us that they had been working with the local university in preparation for student nurses to complete aspects of their training at Avon View. The service had been putting actions in place so that they can support student nurses. One nurse told us that he had just successfully completed a mentorship qualification and was looking forward to having students working at the service.

The service had achieved a 'Gold Standard Framework' (GSF) accreditation three years ago. The GSF is a national award. It is a model of care that enables good practice to be available to people nearing the end of their lives. It provides a framework for a planned system of care in consultation with the person and their family. The framework promotes forward planning with the GP to ensure medicines are available when needed. The service was reassessed in October 2015 and received a higher level of accreditation. We spoke with a care worker who told us, "End of life care really good. With GSF we had training and we and families know what to expect".

We saw evidence that the manager had a good understanding of the Data Protection Act and the Freedom of Information Act. The Manager had a good understanding of her responsibilities for sharing information with CQC and our records told us this was done in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.