HC-One Limited

Avalon Park Nursing Home

Inspection report

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Date of inspection visit:
24 November 2016
25 November 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out over two days on 24 and 25 November 2016. Our visit on 24 November 2016 was unannounced.

At the last inspection carried out in November 2015, we rated the service as 'Inadequate' which meant the service was in 'special measures.' At that inspection we identified nine regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to treating people with dignity and respect; safeguarding; safe care and treatment; meeting nutritional and hydration needs; staffing; person-centred care; premises and equipment; dealing with complaints, and good governance.

Following the inspection the provider sent us an action plan which stated the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Avalon Park Nursing Home is a 60-bedded care home registered to provide personal and nursing care to older people. Accommodation is provided over two floors and consists of 60 single rooms with en-suite facilities. At the time of our inspection the service was not providing nursing care, and there were 38 people living in the home.

The home had a manager registered with the Care Quality Commission (CQC), who was present throughout both days of inspection. A registered manager is a person who has registered with CQC 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 and associated regulations about how the service is run.

During this inspection, we found significant and major improvements had been made. As a result of the improvements the service is no longer rated "inadequate" and has moved out of special measures.

The provider had made a decision not to provide nursing care, instead focussing on the provision of personal care. A new manager had been recruited and there had been a large turnover of staff. One person who was visiting their relative at Avalon Park told us, "We've seen many changes of staff. There have been some poor and lazy managers. This new manager seems much better". We observed staff giving positive and caring support to people. However, we also identified some areas where improvements were still required. The registered manager and the assistant operational director were responsive to our feedback and had started to take actions to make some of the required changes during our inspection.

We made a recommendation regarding the deployment of staff to ensure that people are not left unsupervised for long periods.
We saw the layout of the home did not assist with close supervision of people who used the service, and that at times there was no oversight of people in lounge and communal areas for more than ten or fifteen minutes, particularly at busy times during the day, such as meal times.

People told us they felt safe at Avalon Park, and we saw that most staff had undertaken safeguarding awareness training. The staff we spoke with were able to discuss different types of abuse, and explain what they would do if they witnessed or became aware of any safeguarding concerns.

The service had good recruitment processes to ensure only suitable staff were employed. From looking at the training record and speaking with staff, we found improvements had been made to ensure staff were properly trained, particularly with regard to safer people handling. All new starters were enrolled on the Care Certificate to ensure that they were able to meet the required standards to provide care and support to people.

Care records showed that risks to people's health and well-being had been identified. These included specific risks, for example where a person's behaviour could cause a risk to themselves or other people who used the service, and we saw that appropriate actions were recorded in care plans to minimise the risk of injury and followed up by staff. Environmental hazards had been assessed and we saw records to show that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions.

There were appropriate systems in place for the safe administration of people's medicines.

We saw that arrangements were in place to assess whether people were able to consent to care and treatment, and staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken. Where people were subject to deprivation of liberty the appropriate authorisation had been sought.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. One person told us, "I've no complaints about the food – it's good!"

Staff interactions with people were caring, compassionate and respectful to people's appearance and dignity. For example, 'dignity daffodils' were displayed on doors to indicate a person required privacy. However, care staff were not always vigilant to people's needs, and we saw people could become anxious or concerned.

Care plans were written in a person centred way and reflected people's needs, wishes and how they liked their care to be delivered. We saw that there was a range of activities available.

People told us the manager was approachable and would listen and respond to any issues raised. The home regularly sought feedback, and took action to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were left unsupervised, particularly at busy times during the day, such as meal times.

Staff understood what to do to protect people from harm and people told us they felt safe.

Risks were assessed and the service had taken a balanced approach to risk taking.

There were systems in place for the safe management of medicines.

Is the service effective?

Good

The service was effective.

Care and support was delivered by well trained and knowledgeable staff who received regular supervision.

The management and staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Care was taken to ensure people's nutritional needs were met and care staff monitored what people had to eat and drink.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and showed positive regard for people who used the service. When they interacted with people who used the service staff were caring, compassionate and respectful to people's appearance and dignity.

We saw people were sometimes left unsupervised for up to fifteen minutes and became restless or anxious.

Is the service responsive?

Good

The service was responsive.

People told us the care staff responded promptly to their needs.

There was a range of activities for people.

Care records contained detailed information about people and how they liked their care to be delivered and their choices were respected.

Is the service well-led?

Good

The service was well led.

The service had a manager registered with the Care Quality Commission (CQC) who was held in high regard by staff and residents.

Systems were in place to assess and monitor the quality of service provision, and the service had developed good systems to analyse incidents and accidents.

The registered manager understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Avalon Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection was carried out over two days on the 24 and 25 November 2016. Our visit on 24 November 2016 was unannounced. The inspection team consisted of two adult social care inspectors 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 reviewed the previous Care Quality Commission (CQC) inspection report about the service and notifications of incidents that we had received from the service. We looked at the Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. This helped to inform us what areas we would focus on as part of our inspection.

We also contacted the local authority commissioners, Oldham Metropolitan Borough Council (OMBC) Health Protection Unit and Healthwatch Oldham. Healthwatch Oldham is an independent organisation working to help people have their say on local health & social care services to seek their views about the home. We did not receive any information of concern.

During our visits we spoke with the registered manager, deputy manager and assistant operations director for the provider company. We also spoke to five senior carers and three carers, one cook, three members of the domestic team, two visiting healthcare professionals, ten people living at Avalon Park and five visiting relatives.
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us.

We looked around the building including some of the bedrooms on each floor, all of the communal areas,

toilets, bathrooms, the kitchen and the garden areas.

We examined the care records for five people living at Avalon Park, medicine administration records, the recruitment and supervision records for four staff, training records and records relating to the management of the home such as the quality assurances systems.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2015, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not always treated with dignity and respect and we found derogatory comments about people in care records.

In response the service took immediate action and appointed two 'dignity champions,' whose role is to raise the profile of dignity and respect, and to ensure that people were treated well. A dignity board was put up in the entrance area with photographs of the dignity champions for reference and the service introduced a 'dignity daffodil'; a sign staff placed on closed doors to indicate that they were providing personal care so people would not enter the room whilst they were assisting people to dress, wash or toilet. Care records were reviewed and when we looked at case notes we saw there were no personalised comments. When we looked at the training matrix we saw that 38 members of staff had completed the in-house 'Dignity; the one who matters' training workshop.

When we spoke to visitors they told us that the service had turned around. One visitor said, "The way staff interact with residents has flipped. The whole atmosphere has changed." A person who used the service told us, "The staff are great. If I ask for something they will do it". Staff also told us that they believed the level of care had improved and one housekeeper told us "There's a happy atmosphere now. It used to be people just doing their own job, but if something needs to be cleaned up everyone will muck in now to get the job done".

We saw that improvements were still required, for example we saw that people were left unattended during busy times. Prior to lunch on the second day of our inspection for instance, we saw two people had been left alone for over ten minutes in one of the lounge areas as staff were assisting people to have their meals. They were clearly concerned and shouting for assistance. They had not been reassured that they would be attended to and were becoming increasingly anxious that they would miss their meal. Staff eventually responded and helped to provide reassurance. At other times we saw that people were left unattended for long periods. For example in the afternoon of the second day of our inspection people were left unattended in one downstairs lounge for fifteen minutes.

We observed that when staff interacted with people they were caring, compassionate and respectful to people's appearance and dignity. When transferring a person using a hoist, for example, we saw staff took care to ensure that they explained each step, watched and were mindful of the person's dignity treating them with courtesy and respect. On another occasion, we saw a care worker noticed that the dress of a person who used the service had puckered, and quietly and humorously assisted her to straighten her attire.

The caring attitude of staff towards people who used the service was not restricted to care workers. We saw that when a person was becoming upset, a laundry assistant went over and provided reassurance, gently stroking their hand and then finding a magazine for them to look at, thereby successfully distracting them from whatever had upset them. We overheard the person say, "You're so kind to me. Thank you."

We observed a number of occasions when staff demonstrated that they had meaningful and positive relationships with the people who used the service. For example, a care worker was giving a person with speech and swallowing difficulties a drink with food thickener in the lounge. This was done with care and patience, allowing time to cope with each spoonful. Between spoonful's the care worker read the newspaper to the person to provide stimulation and interaction. The person smiled as they told us, "I am happy here. They understand."

We saw individual carers knew the people who used the service well and showed kindness and understanding. For example, we saw a member of staff prompted a person to recall their interest in palmistry after breakfast on the second day of our inspection which allowed for reminiscence. When a person who used the service was becoming anxious another care worker provided reassurance, speaking quietly and offering reassurance using appropriate eye contact and touch. Another person who used the service commented to us about this carer, "She is very good and is like that with everyone, not just with [person]. She takes time with everyone. I wish they were all like her."

People's personal belongings were valued and treated with respect. For example we saw one person living with dementia had an empathy doll. All staff knew this dolls name and we were told that when it went missing earlier in the month a full search was initiated until the doll was found. Empathy dolls can be nurtured by people with dementia and bring back happy memories of parenthood and of being useful and needed.

People's care records made clear what people required support with to do and what they could do independently. Care plans were written in a person centred way and instructed staff on how best to respond to the person, for example, if they challenged the care they were receiving. Staff understood the needs of people who used the service and told us the care plans were informative and helpful, for example, one care worker told us that a person who used the service can refuse personal care, depending on their mood. They told us, "If you try to mither [the person] they will get worked up." The plan indicated steps to take to support this person, leaving them for a while and try again or ask another member of staff to provide support.

Information held about people, including all care records were securely stored in unit offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessment to ensure that they were providing appropriate care and support. We noticed that all staff carried pocket notebooks to record information and observations throughout their shift. This helped to ensure that any activities or intervention could be noted and added to case records at the end of the shift.

During our inspection one person was being cared for at the end of their life. A visiting relative told us, "The care home is excellent, but I've come today to say my last goodbyes. [My relative] is now not eating or drinking and has not got long to live." We saw that appropriate steps had been taken to ensure that their care was appropriate, including provision of specialist equipment and regular monitoring, including regular positional changes to prevent skin breakdown. When we looked at care records, we saw that these had been revised to take into consideration the changes in need. A 'do not attempt resuscitation' form (DNAR) and a statement of intent had been signed by the person's GP. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). A 'statement of intent' is a form issued by a GP, which ensures that the person is reviewed by their doctor every fourteen days, and means that a Medical Certificate of Cause of Death (MCCD) can be appropriately issued without involving the coroner.

Good

Is the service effective?

Our findings

When we spoke with people who used the service and their visitors, they told us that they felt the staff were well trained and knew them well. One person told us, "They are good girls, I can't fault them. They really know us all and how to deal with us with patience and kindness." A visiting health professional told us, "[Staff] know the residents inside out; who is important in their lives, what they like to do and who the person really is".

Avalon Park had a well-equipped training room for staff to undertake e-learning, including reference materials, computers and other resources. The registered manager recognised the importance of well-trained and knowledgeable staff, telling us they believed it was important for all staff to have the skills to respond to individuals in a person centred way and encouraged staff to develop their skills and knowledge.

We saw from records that when staff first started at the home they received a full induction and were subjected to a probationary period of six months. One care worker we spoke to told us they were still completing their probationary period. This person told us "Induction has been brilliant – I have two mentors who have shown me everything." Although they had previous experience working in a care setting, their work during the first two weeks at Avalon Park was supernumerary and spent shadowing staff and being observed supporting people. For the first six months, they informed us they had a monthly meeting with team leaders or managers to chart progress and explained to us this is a two way conversation where issues can be discussed openly.

The service set clear expectations for staff and provided on-going training to ensure staff had the skills to carry out their role. From the training matrix (record), which mapped out the training staff had completed, we saw that nearly all care staff had completed some training in over 30 subjects, such as safeguarding adults, first aid, medication, food hygiene, dementia awareness and safer people handling.

New care workers were enrolled on the 'Care Certificate'. This is a nationally recognised qualification for people working in the caring sector which provides the essential knowledge that any new care workers require to ensure they have the required competence to care for people safely and effectively. When we looked at one person's training records they had recently completed the Care Certificate and had been encouraged to enrol on National Vocational Qualification (NVQ) level three training in Health and Social Care. Another care worker we spoke to told us that having completed their basic training they were on a 'stepping up' programme to become a senior. The registered manager told us that this encouraged staff to continue with their learning; they spent time with the team leaders to understand their role and undertook further training, for example in medicine administration and management. If successful they could 'act up' as senior care worker when an opportunity arose. If they did this within a six-month period they would be obliged to retake the medicine training.

During our inspection, we sat in during a dementia training session for staff. This was part of the 'Open Hearts and Minds' training programme provided by HC-One in-house trainers. The trainer led an interactive session, using four separate exercises to highlight what it was like to have dementia. The exercises brought

together and reinforced the different aspects of online training modules previously completed. Key messages were that dementia is a disease; that each person with dementia must be treated based on individual need and with a personalised approach and that labelling was cruel and inappropriate. It also tested the truths and myths around dementia. Nine staff attended this session, including night staff, day staff and the deputy manager.

Shortly after each training session all staff had a 'learning supervision' session with a senior member of staff. This allowed staff the opportunity to discuss any learning and to explain how they had/will put lessons learnt into practice.

At our previous inspection in November 2015, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 in relation to staff supervision. This was because at that time there were no formal systems for staff to be supervised and many staff had not had a formal supervision for over a year. This related mainly to clinical supervision for nursing staff, but since that time the home was no longer providing nursing care and did not employ nursing staff. During this inspection we saw that the registered manager kept a timetable which showed that all staff received a supervision session every three months. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at three staff supervision records which showed that meetings were productive and staff used the opportunity to discuss issues of concern, identify areas for improvement and look at developing good practice. Clear records, signed by both the supervisor and the person being supervised, were kept on the staff file. Staff we spoke with told us they valued the opportunity to discuss their work with a senior member of staff and that it encouraged openness and honesty.

We saw that staff communicated well with each other and passed on information in a timely fashion. All staff attended a changeover meeting at the start and finish of each shift. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated appropriately and shared fairly.

The Mental Capacity Act (2005) (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us and we saw information to show that eleven applications to deprive people of their liberty had been authorised by the supervisory body (local authority) and we had been notified of these authorisations. A further twelve were awaiting authorisation. Where a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed and any conditions relating to the restriction. We saw that the registered manager kept an updated and colour coded list on the office wall to show when a request had been made, authorised or was due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager and allowed a quick check to determine if the deprivation made was legally permissible.

Capacity assessments had been completed to determine why people needed a DoLS authorisation. When we looked at the care records for one person we noted that staff recorded three occasions when they had spoken to the person about staying at the home and the locked doors. There was a record of the replies and a summary section stated that a DoLS application had been made. This helped to make sure that people who were not able to make decisions were protected.

We saw that where people had the capacity to make their own decisions this was noted and the decision to live at Avalon Park was recorded in case records. Care plans were signed by people who had capacity to say that they consented to care and treatment.

The care staff we spoke with were able to demonstrate a good understanding of capacity and consent issues to help ensure that people's rights were protected, including pathways to reach best interest decisions. They were able to explain DoLS and mental capacity in terms of assessment and decision-making. Staff described to us how they gave people everyday choices, such as what to wear, what food to eat and what help they required with personal care. For example, when we asked one person if they could give us an example they said, "I will put jam and marmalade on the table to help people choose which one they want, rather than just assume they want jam."

People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest. Where this was the case, information about contacting the advocate was clearly marked in care records to ensure they were consulted before any decisions were made.

At our inspection in November 2015 we found that Avalon Park was in breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had no effective system in place to meet people's hydration needs. During this inspection we saw that care was taken to ensure people had sufficient to eat and drink. We saw that orange cordial was always available in all lounges and regular supplies of hot drinks were offered. One person who used the service told us that she liked "three or four cups of tea first thing" and that this was provided. We saw that where a risk of poor nutrition or hydration had been identified, food and fluid charts recorded accurately what people had consumed. When we asked a member of staff how they recorded this, they explained that they would record the amount they had taken, not the amount provided. They told us this can sometimes be problematical as they would take a drink then move away, but they recorded the amount left in the cup to provide a more accurate reading. We observed a person who used the service being encouraged to drink a milk shake in the lounge. A care worker gave the person the drink then withdrew, keeping a discreet eye on the person. Once the drink was finished the care worker logged the fluid intake.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. One person told us, "I like the food, there is always something we can have to fill us up." Another person told us, "I've no complaints about the food – it's good!" and a third person told us, "I can have whatever I want. I love it here."

A choice of two hot meals was available, but if people wanted something different or required a specific diet the registered manager told us that they could meet any specific cultural or dietary requirements.

The home provided a four-week menu which was based on balanced and nutritious food. The registered manager told us that some of the meals, such as sweet and sour pork, did not appeal to many of the people who used the service, who preferred more traditional meals. With this in mind the registered manager had

arranged a meeting with the residents, their relatives and the cook to discuss alternative meal choices. We looked at five care records. All included an eating and drinking care plan and recorded that people were weighed on a monthly basis, or if there was an indication of risk of poor diet more frequently as necessary. During meals, we saw staff checked the temperature of the food prior to serving and that they logged the type and amount of food people had eaten.

We observed meals being served in three of the four dining rooms during our inspection. Meal times were cheerful and pleasurable; staff took time to speak to people and helped to create a relaxed atmosphere. The tablecloths were of red cotton cloth, offering colour, which contrasted well with the white crockery and with no pattern to cause visual confusion to people living with dementia. The food was well presented and looked appetising. Where people required assistance staff were supportive and waited for the person to acknowledge they were ready before providing assistance. One person, who had difficulty swallowing, often coughed on swallowing. Staff waited and checked the person was alright before continuing. People were asked to choose their next meal once the first meal was complete; to assist this staff had made some drawings to represent the food choices Additional portions were made in case people changed their mind from the choices made or if people wanted second helpings.

Where necessary staff encouraged people to eat more and we saw alternatives were provided when people did not like the choices on offer. When we looked at care records we saw attention to dietary needs. People were weighed regularly and Malnutrition Universal Screening Tool (MUST) scores were regularly reviewed. MUST is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity. Referrals to dieticians or speech and language therapists (SaLT) were noted and advice recorded, with attention paid to ensure food was prepared to meet diet and nutritional requirements. However, we noticed that cakes were offered as snacks during the afternoon. When we talked with the cook they were not sure who was diabetic and informed us that although they used sweeteners in cake preparation, they would sometimes add sugar. Two people required pureed meals were told by the deputy manager that all mashed potato, etc., was fortified but the cook was unclear about this. However we noticed that additional cream was put on the food trolley for staff to add to food for those that required it and we saw that smoothies were made with cream and milk for people.

We spoke to two visiting health professionals who informed us that they had developed good working relationships with the service. One person told us that care staff would make contact and seek advice when needed, follow all care plans and raise issues of concern on behalf of people who used the service. People told us they were able to access healthcare. We saw in care records, for example that one person who had complex needs required high-level care, received monthly reviews from a speech and language therapist for swallowing issues and kept regular appointments with other health professionals. We saw that staff would contact the GP's surgery if they needed advice or support. For example, we saw emails and records telling us that when staff had been unsure about how to administer or manage any medication they had contacted the persons GP by telephone or email and requested support and/or advice. It was clear that staff had developed good relationships with GP's and district nurses which they used to good effect in order to maintain the safe care and support of people who used the service. When we spoke to one person who used the service about their healthcare they informed us, "I had a virus earlier in the year and it has made me deaf in one ear. I could hear clearly before. My doctor said that my hearing loss needed to be checked, but since then my audiology referral has not come through this year." We raised this with the registered manager, who informed us that they had contacted the GP about this and they had made a referral to the audiology department in September 2016. The registered manager agreed to follow this up and informed us after our inspection that they had re-referred to the audiology department, as they had not yet been given an appointment.

This person also informed us that they received outpatient appointments for oral care, but, "My last appointment was cancelled at the last minute – I don't know why. It is so important that I attend as you can be struck off the list if you do not attend". When we raised this with the registered manager they agreed to chase up the appointment and after our inspection they told us that they had done so.

Good

Is the service caring?

Our findings

At our previous inspection in November 2015, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not always treated with dignity and respect and we found derogatory comments about people in care records.

In response the service took immediate action and appointed two 'dignity champions,' whose role is to raise the profile of dignity and respect, and to ensure that people were treated well. A dignity board was put up in the entrance area with photographs of the dignity champions for reference and the service introduced a 'dignity daffodil'; a sign staff placed on closed doors to indicate that they were providing personal care so people would not enter the room whilst they were assisting people to dress, wash or toilet. Care records were reviewed and when we looked at case notes we saw there were no personalised comments. When we looked at the training matrix we saw that 38 members of staff had completed the in-house 'Dignity; the one who matters' training workshop.

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We saw that improvements were still required, for example we saw that people were left unattended during busy times. Prior to lunch on the second day of our inspection for instance, we saw two people had been left alone for over ten minutes in one of the lounge areas as staff were assisting people to have their meals. They were clearly concerned and shouting for assistance. They had not been reassured that they would be attended to and were becoming increasingly anxious that they would miss their meal. Staff eventually responded and helped to provide reassurance. At other times we saw that people were left unattended for long periods. For example in the afternoon of the second day of our inspection people were left unattended in one downstairs lounge for fifteen minutes.

We observed that when staff interacted with people they were caring, compassionate and respectful to people's appearance and dignity. When transferring a person using a hoist, for example, we saw staff took care to ensure that they explained each step, watched and were mindful of the person's dignity treating them with courtesy and respect. On another occasion, we saw a care worker noticed that the dress of a person who used the service had puckered, and quietly and humorously assisted her to straighten her attire.

The caring attitude of staff towards people who used the service was not restricted to care workers. We saw that when a person was becoming upset, a laundry assistant went over and provided reassurance, gently stroking their hand and then finding a magazine for them to look at, thereby successfully distracting them from whatever had upset them. We overheard the person say, "You're so kind to me. Thank you."

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People's care records made clear what people required support with to do and what they could do independently. Care plans were written in a person centred way and instructed staff on how best to respond to the person, for example, if they challenged the care they were receiving. Staff understood the needs of people who used the service and told us the care plans were informative and helpful, for example, one care worker told us that a person who used the service can refuse personal care, depending on their mood. They told us, "If you try to mither [the person] they will get worked up." The plan indicated steps to take to support this person, leaving them for a while and try again or ask another member of staff to provide support.

Information held about people, including all care records were securely stored in unit offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessment to ensure that they were providing appropriate care and support. We noticed that all staff carried pocket notebooks to record information and observations throughout their shift. This helped to ensure that any activities or intervention could be noted and added to case records at the end of the shift.

During our inspection one person was being cared for at the end of their life. A visiting relative told us, "The care home is excellent, but I've come today to say my last goodbyes. [My relative] is now not eating or drinking and has not got long to live." We saw that appropriate steps had been taken to ensure that their care was appropriate, including provision of specialist equipment and regular monitoring, including regular positional changes to prevent skin breakdown. When we looked at care records, we saw that these had been revised to take into consideration the changes in need. A 'do not attempt resuscitation' form (DNAR) and a statement of intent had been signed by the person's GP. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). A 'statement of intent' is a form issued by a GP, which ensures that the person is reviewed by their doctor every fourteen days, and means that a Medical Certificate of Cause of Death (MCCD) can be appropriately issued without involving the coroner.

Good

Is the service responsive?

Our findings

Before people moved in to Avalon Park a pre-admission assessment form was completed which provided a brief overview of needs, including medical history, communication, mood, behaviour, skin integrity, nutrition, oral health, elimination, personal care, mobilising, sleeping, and any equipment to be used.

The registered manager then completed an admission assessment form which provided further detail. It included information covering risk of falls, environmental considerations, symptoms shown if in distress and other details which might be relevant. For example, we looked at an admission assessment which highlighted that the person used a beaker for fluids, concerns about keeping warm and that they required encouragement to sleep in bed and not in a chair. We spoke to the relative of this person who informed me that prior to admission they had been involved in planning the person's care. They told us, "I was finding it impossible to cope with her aggression at home, but they are patient and very responsive here."

Once a person was admitted, the service competed a seven-day care plan, which provided key details about the person's needs. We saw detailed logs referring to the person's mood, type and level of support and how they were settling. Although brief, this documentation provided staff with an overview of the person and allowed to develop a consistent and person centred approach to care.

We found that the service was responsive to people's individual needs and the care plans were person centred. There were very detailed descriptions about peoples care needs, and how staff should support those needs. They contained a one-page profile detailing what people enjoyed; what help they required and a dated photo. This information helped staff to quickly understand their needs. However, when we looked at the care plan for a person on the end of life pathway the plan did not reflect the changing needs and wishes of the person.

Each care plan we looked at outlined what was important to the person who used the service and reflected their wishes and preferences. This information helped staff who were caring for them to know more about the person and to generate topics of conversation. We saw that the care plans had been reviewed to ensure that people were receiving the care they needed. Each day the service would have a 'resident of the day'. This system allowed a co-ordinated approach to reviewing needs, so for the named person, the kitchen staff would review dietary and nutritional needs; housekeeping would complete a deep clean of the person's room and check equipment was in working order and there would be a thorough review and evaluation of care plans and risk assessments completed by the care staff. This included, for example, weight, medicine checks, and review of visitors and other forms of stimulation. This system allowed the named person to have a converging review of their needs on a monthly basis and meant that there was a co-ordinated approach across the service to meeting their needs. We saw evidence that people and their families were involved in care reviews and records were kept of any local authority reviews of care for people who were funded by their local authority.

Separate records were kept and completed on a daily basis for every person who used the service to ensure that all hygiene needs met, or to note if the person had refused. These were detailed and indicated if the

person had been bathed, washed (upper and lower) showered, teeth or dentures cleaned, self-image, hair nails etc. This also prompted staff to check and sign that they had checked any equipment, such as walking frames, hoists, slings and chairs, changed bedding and dressed in clean clothes. The registered manager informed us that all staff were required to ensure that they had assisted at least one person to bathe on each shift.

We saw that the home was well equipped with suitable aids and adaptations, for example walking aids and a through lift. There were other suitable aids such as grab rails and assisted hoists so that people who used the service were able to access all areas with or without support dependant on their needs and abilities.

We asked people who used the service how they spent their day and saw that a range of activities were available. People told us it was their choice whether they joined in or not. One person told us, "There is always something to do, or people to talk to. They keep us amused." Another person spoke fondly of the activity co-ordinator, saying, "[Name of activities co-ordinator] is a lovely girl. Do you know we had a singer who came and she also danced? She was a lady in red and she mesmerised me – I loved it!'' This person also told us that before she moved in to Avalon Park she had a dog and was happy that the dog could still visit her.

We saw staff interacting with people who used the service, not only in quiet conversation but, for example, playing memory games, encouraging people to join in (two staff and five people who used the service), or, in a separate lounge, staff interacting with people, listening, discussing and singing along to music from the 1940's to encourage reminiscence.

We saw that monthly church services had been organised and the activity co-ordinator informed us that she was planning to take some people to church in the home's bus on some Sundays.

We saw an activities noticeboard displayed a range of planned activities and we saw a programme which included one-to-one activities for people who spent time in their rooms. The home had a minibus and trips out were being arranged. The activity co-ordinator informed us that there had been some intergenerational work going on with a local primary school. For example, the school choir came to sing and talk to people who used the service and they had invited people back to the school for the school Christmas play. The Alzheimer's Society encourages this type of activity, as it helps to remove the stigma of dementia in society and achieve better community support and engagement; it provides children and young people with confidence and insight into a widespread issue affecting their lives and communities and it provides interaction and enrichment between people with dementia and children/young people.

Visitors mentioned that they could raise concerns about care. One visiting relative told us, "I feel that I can approach this manager with my concerns and [these have] been addressed nicely. There are always drawbacks around inconsistencies amongst the staff, but I feel I can raise issues if I need to."

We asked people who used the service if they wanted to complain about something what would they do. One person said they would tell the staff and they felt sure their concerns would be dealt with. We saw that effective systems were in place to deal with any complaints raised and that any complaints had been responded to in accordance with the service policy. There was an easy read complaints policy to ensure that people who used the service knew how to make a complaint and a touch screen in the foyer to allow people to feedback any issues about the care and support provided at Avalon Park.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager was present throughout our inspection. They had been registered with CQC since October 2016 but had been employed as manager of Avalon Park since last December. They had previously managed other care homes in the North West and had over twenty years' experience working in care.

Before our inspection we checked our records to see if any accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant that we were able to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager reported incidents to us and gave us information about actions taken to respond to the issue.

We had also received a detailed provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

At our previous inspection in November 2015, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not using quality assurance systems in place to record issues and monitor the quality of service that people received, resulting in a number of beaches of regulations. During this inspection we saw that the home had undergone a number of significant changes since we last visited. For example, the home no longer employed nursing staff and was not providing nursing care. A high proportion of staff previously employed were no longer working at Avalon Park, with a significant number of newer recruits joining the team. This reduced the risk of providing unsafe clinical care and allowed the management team to focus on improvements to provision of personal care and support.

The registered manager had worked hard to meet the breaches in regulations that were found at the last inspection. For example, full and regular audits of care plans show evidence of follow up action; staff training had improved and included training for all staff on dignity and respect and safer people handling; there were meaningful activities available to people with a new activities co-ordinator appointed and diet and fluid intake charts were completed.

We saw that systems to monitor the service were fully implemented and used to ensure the safe care and treatment of people. Audits of people's care had been carried out on a monthly basis. These gathered information about how care was delivered, medicines, mealtimes, people's choice and involvement and the experiences of people who used the service. In addition the local authority was working closely with Avalon Park and the registered manager had developed an action plan following the last CQC inspection to bring about improvements to the service. This demonstrated the commitment of this service to improving and

developing the service.

The registered manager had introduced daily 'flash meetings' with team leaders, catering, housekeeping and maintenance staff to discuss any issues and co-ordinate work schedules to aid improvement and communication amongst different areas of the home. They conducted daily 'walkabouts' where they would speak to people who used the service, visiting relatives, and staff. Any concerns or issues were noted for action. We observed that the manager was visible in different areas of the home at different times of the day.

We saw that regular audits were undertaken by either the registered manager or more senior staff from the parent company, HC-One. We looked at audits of health and safety, falls, infection control and care plans. Home visit were unannounced and we saw that these were conducted at least on a monthly basis and reports of the visit included action points with clear targets set and showed signs of continuous development. Where actions were required, points were noted, timescales set and actions signed off once completed. We noted that most of these target dates had been met, but a Health and safety audit noted that, "A lot of the maintenance checks were not being completed in the timescales set." When we asked why this was, we were informed that the home had difficulty recruiting a maintenance officer, but we saw one had started recently. When we spoke with this person they informed us, "I think this work here is going to suit me well. There's a lot to do, but staff are helpful and can give me a good steer if needed."

The people we spoke with agreed that the home was well led and that staff enjoyed their work. Staff, residents and visitors commented on how they felt the service had improved. For example, a visiting relative told us, "We've seen many changes of staff. There have been some poor and lazy managers. This new manager seems much better. I have been involved in some care planning for [my relative], particularly in terms of their likes and dislikes, which has improved the quality of their care. The cleanliness, food and staff are much better now too."

One of the housekeepers commented, "The care and cleaning routines are all better now." A care worker told us that the changes had been positive; all staff were correctly completing paperwork and team leaders had been introduced to provide greater accountability. They told us that the registered manager operated an open door policy which meant that they were available to discuss any issues of concern, "even if it's to discuss a personal issue; it's good to know there is someone who will listen."

In addition to the manager and team leaders the home had also appointed 'champions' for dignity, infection control, health and safety and falls. The falls champion told us that the number of incidents of falls had reduced and that they had developed good links with the CCG Falls team. We also spoke to a visiting health professional who informed us that there had been a 40% reduction in the use of antipsychotic drugs in the home over the past year.

People who used the service and their relatives also told us that they believed they had a say in how the home was managed. One visiting relative told us, "There are now resident's meetings every two months where we can make suggestions. The home has been cleaner and brighter since this new manager. I made a suggestion and the lights are now kept on at all times and this has helped [my relative] a lot."

The home had also sought feedback from people who used the service and their relatives in June 2016 and we were shown an analysis of the results. Respondents were asked to rate aspects of the service, and the analysis showed that the majority of people believed the service was 'good' or 'outstanding'.

Prior to our inspection we contacted the local authority commissioner and safeguarding teams. They did not raise any concerns with us about Avalon Park.

We found the registered manager to be open and helpful during the inspection. They were realistic in their assessment of the current situation and transparent in the way they shared information with the inspection team.