Healthcare Homes (LSC) Limited

Avon Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 31 August and 1 September 2017 and was unannounced. We carried out this inspection because we had a number of concerns shared with us. These concerns came from health and social care professionals who had visited the home. These concerns were about the care and support people were receiving in relation to the Mental Capacity Act and best interests decisions.

Avon Lodge Care Home is a care home with nursing care for up to 62 predominately older people. People have general nursing care needs and some are living with dementia. At the time of our visit there were 61 people living at the home.

There was a registered manager in post. 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 of the Health and Social Care Act 2008.

People told us they felt safe living at the home. Staff were aware of what constituted abuse and the actions they should take if they suspected abuse.

Risks associated with people's care, daily routines and activities were identified with action taken to minimise these. Care plans addressed the support people required with personal care, maintaining their health and their activities of daily living.

People were provided with safe care by adequate numbers of appropriately skilled staff being made available.

Staff recruitment procedures were safe and the employment files contained all the relevant information to help ensure only the appropriate staff were employed to work at the home.

People received their medicines when they required them and in a safe manner. Staff received training and guidance to make sure they remained competent to handle people's medicines.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received appropriate training, and had a good understanding of the Mental Capacity Act 2005 (MCA) and the DoLS. Staff had the right skills and training to support people appropriately.

People told us they felt there were enough staff available on each shift. Staff felt well supported by the manager and received regular supervision sessions and appraisals.

People told us the staff were friendly and caring and they felt safe in their presence. We observed staff caring

for people in a way that promoted their dignity in a respectful manner.

People told us they enjoyed the food in the home. They were offered a choice of meals which were appropriate for a balanced diet.

People had access to a range of healthcare professionals when they required specialist help. Care records showed advice had been sought from a range of health and social care professionals

People were actively encouraged to provide feedback. Complaints were investigated and action taken to address concerns when needed. People and their relatives told us they had no complaints.

The registered manager assessed and monitored the quality of the service provided for people. Systems were in place to check on the standards within the home. These included regular audits of care records, medicine management and health and safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Avon Lodge Care 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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 August and 1 September 2017 and was unannounced. The last inspection was carried out on 24 November 2016 and there were no breaches of legal requirements at that time.

The inspection was carried out on day one by two inspectors, a specialist advisor who had specialist knowledge of The Mental Capacity Act 2005 (MCA 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. On day two the inspection was carried out by two inspectors.

Prior to the inspection we looked at the information we had about the home. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the home is required to send us by law. We had not requested the provider to complete the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give information about the service, tells us what the service does well and the improvements they plan to make.

We contacted three health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We did not receive a response back from them.

Some people were able to talk with us about the care they received. We spoke with eight people who lived at the home. We also spoke with the relatives of eight people. We sat and carried out observations of other people who were unable to communicate.

We spoke with 13 staff, including the registered manager, deputy manager, clinical lead, regional director and nine care staff.

We looked at the care records of nine people living at the home, five staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the home. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Good

Is the service safe?

Our findings

People told us they felt safe in the home and that staff were available to help them. They told us, "Oh yes it's the security its very good", "Yes, I don't know why I feel safe I just feel safe". Another person told us, "I feel safe as the staff are around and come to check me regularly". We spoke to relatives and asked them if they felt their family member was safe. They told us, "Yes, I think she's safe every body's very good here. I tried to look after her for 6 months but I found it so hard". Another relative said, "Yes, she's safer here then she was at home".

Staff said they had received safeguarding training and knew how to report any signs of abuse. Additionally, staff were familiar with the term "whistleblowing" and said they felt confident to raise any concerns about poor practice. All of the staff said they believed that any concerns they raised would be taken seriously. One member of staff said "I am aware of how to report concerns to my manager or the local authority". Another said; "If I needed to whistle blow to report concerns, I feel this would be taken seriously".

Maintenance records were checked of the home including water supply, water temperatures, moving and handling equipment and electrical and gas system. Systems were in place to ensure the home kept up to date with annual safety checks in relation to fire safety equipment, portable electrical equipment and gas.

The home was clean and odourless. Procedures were in place to minimise the risks of infection. Staff had been trained in the prevention and control of infection. The registered manager had been identified as the infection control lead. Hand washing facilities were available for staff and visitors to the home. Hand sanitizer devices were in place around the home including the entrance hall of the home and on each floor. Suitable personal protective equipment, such as disposable aprons and gloves were available for staff. These arrangements helped minimise the risks of cross infection within the home.

Peoples care records contained comprehensive risk assessments. These risk assessments covered areas important to people and aimed to protect them from harm. Risk assessments provided clear guidelines for staff on how to provide care and support. Where there were specific risks such as the risk of falls or skin breakdown, assessments were in place and reviews carried out on a regular basis. Staff spoke with us about specific risks relating to people's health and well-being and how to respond to these. These included risks associated with maintaining skin integrity, weight loss and behaviours which may challenge. People's records provided staff with detailed information about these risks and the action staff should take to reduce these.

Staff had been recruited through a recruitment process that ensured they were safe to work with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Suitable references were obtained and any gaps in recruitment history were thoroughly explored. Checks were also undertaken with the Nursing and Midwifery Council (NMC) to confirm that nurses were registered with them and were able to practice.

Staffing levels were reviewed regularly by the registered manager to ensure people were safe. The registered manager told us staffing levels were based upon the amount of support people required. Rotas confirmed sufficient staffing levels were maintained at all times. Vacant staff posts, sickness and annual leave were covered by permanent care staff and registered nurses as overtime with no shortfalls identified.

Staffing levels were sufficient to support people safely. We asked people living at the home if they felt there were enough staff on duty. We received the following comments, "Yes I think there is enough staff here", "I have no concerns about staffing and I am looked after very well. Another person told us "The staff are lovely but not enough". We spoke with people and relatives regarding if they felt their call bell was responded to promptly by staff. We received the following comment, "Yes, I've used it and they come slower at night but they're not to bad", "Yes, mum uses her call bell and they say they pop in to see her but how often I don't know. She was calling out last night but not sure for how long" and "Yes, I do and they come fairly quickly but quicker at night".

The home's calls bell system recorded each time people pressured there call bell for assistance. Reports were produced at the end of each day for the registered manager to check through. This recorded how many times people had called for assistance and the response time of staff. We found no concerns in relation to the response times of answering call bells.

Medicines were managed safely. We observed the medicine round being carried out by trained staff. The nurses administering the medicines checked people were happy to have their medicines, didn't rush them and waited until they had swallowed their tablets before signing the medicine administration record (MAR). Medicine profiles were in place for each person. These included photographs of people. Medicines were stored safely, including controlled medicines. Stock levels were checked regularly. When medicines were no longer required, they were disposed of safely by the local pharmacy. Clinical room temperatures were monitored as were fridge temperatures. This meant that staff ensured medicines were stored within recommended temperature guidelines.

Good

Is the service effective?

Our findings

People said they felt staff were professional and well trained to undertake their roles. One person told us, "I think the staff are trained well". Another person said, "They seem to have lots of knowledge and know what they are doing".

All staff had a probationary period before being employed permanently. Staff told us they felt their induction gave them the skills to be able to meet people's needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that health and social care workers should adhere to. New staff to the home received an induction which included training, shadowing experienced colleagues and being introduced to the people they would be caring for.

Staff confirmed that they received the training and support they required to meet people's needs. Staff were able to tell us what people's individual needs were and how the training they received helped them to support people in the way they preferred. Staff confirmed that they felt supported by their managers and received regular supervisions where they could discuss any issues or support they needed.

Staff undertook training in a range of areas the provider considered essential, including safeguarding, manual handling, medicines, nutrition, mental capacity act, deprivation of liberty safeguards, health and safety, falls prevention and caring for people with dementia. Staff also confirmed they could ask for additional training. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensured nurses maintained their nursing practice and kept up to date with skills training. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse. The registered manager had monitored what training staff needed, and ensured staff undertook training that was essential. This meant people were supported by staff who had the skills and experience to provide them with the individual support they needed.

People were supported to access services when needed to maintain their health. Staff told us, and healthcare professionals confirmed people had access to external health services when needed. Care plans identified what people's health needs were and how staff should support them. Staff kept contemporaneous notes regarding any health concerns and action taken. Records confirmed people were supported to access a range of health and social care professionals, an example being doctors and social workers. Any actions arising from appointments were followed up. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

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. Records showed good examples of these decisions being recorded and consent had been obtained from the relevant people. We did find some

gaps within peoples care records where people lacked mental capacity and capacity assessments were not in place. However the registered manager showed us an action plan that was in place to address this. Peoples care records were undergoing a period of transition with new care plans and systems being introduced. A deadline date of November 2017 was in place for completion. Records confirmed that people and their relatives had been involved, consulted with and had agreed with the level of care and treatment provided. Consent to care and treatment in the care records had been signed by people with the appropriate legal authority. This meant that people's rights were being protected. Any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection six applications had been authorised by the local authority for people. Records showed 55 further application forms for people were awaiting assessment by the local authority or were awaiting a decision to be made. These were submitted as some people could not freely leave the home on their own, also because people required 24 hour supervision, treatment and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

Care documentation showed people's nutritional needs were assessed and kept under review. People's care records contained information about people's nutritional intake and the support they needed to maintain good health. Records confirmed people's weight gain or loss was monitored so any health problems were identified and people's nutritional needs met. We noted where people's intake of food or fluid was being monitored; the charts were completed accurately by staff.

We observed the meal time experience at lunch on both days of the inspection and found the atmosphere was pleasant and relaxed. Some people ate at the dining tables others in the lounge area and bedrooms. Staff assisted those that needed it and this was done sensitively

People told us they enjoyed the food and menu choices available to them. Comments we received included, "The food is lovely and I always enjoy my meals", "The food is alright and no I don't have a favourite meal. I never get hungry at night but if I did I would ask the staff for a sandwich". Another person said, "I do get a choice at mealtimes and find the food is nicely presented and warm".

Good

Is the service caring?

Our findings

People told us that staff were kind and considerate and were complimentary about the care they received. One person told us, "The care I receive is a very high standard. I cannot fault the home". Another person said, "The staff are lovely and really look after me. I am well cared for and have no complaints. I get lots of choices and they give me encouragement". One relative told us, "Since my mum has been here she's been well looked after. They are really good with mother".

Staff addressed people respectfully and explained to them about the support they were providing. We observed staff knelt or sat down when talking with people so they were at the same level. Staff were patient and waited for people to communicate their needs. For example, we observed how one member of staff took time to listen to one person who, as a result of their dementia, was having difficulty communicating their needs and becoming agitated. The member of staff did not leave this person until they were calm and settled. The staff and the people who lived in the home looked comfortable together. There was a lot of laughter and friendly 'banter' between them.

People appeared to look well cared for. People who needed them wore hearing aids and glasses, and they had been supported with personal grooming tasks such as shaving and hairdressing. Some people chose to spend time in their bedroom and during the inspection we noted some people chose to stay in bed. We looked at people's bedrooms which were personalised with their belongings. We observed staff had made sure they had everything they needed to hand, such as reading materials, remote controls, drinks and the nurse call alarm bell, thereby promoting their independence.

There was a relaxed, homely feel to the home. Although some people stayed in their rooms, there were communal spaces for people to socialise in and meal times were a friendly affair. Relatives told us they were welcome to visit the home at any time and staff made them feel welcome. A staff member said, "We always welcome relatives in the home and offer them a drink with their loved ones".

Staff respected people's privacy and dignity. We observed staff knocking before going into people's bedrooms. Personal care was carried out behind closed doors. Staff spoke with us about how they cared for people and we observed people being offered choices in what they wanted to wear and what they preferred to eat.

People were offered choices in line with their care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. We asked people and their relatives if they felt their privacy and dignity was respected. One relative told us, "Yes, they do respect my mother's dignity as far as I can see. If they are doing any personal care for her they won't let me into her room without asking her. If the door is shut then they always knock on her door".

Encouragement was given to people to carry out tasks themselves. An example being was people were encouraged to choose the clothing they wished to wear each day. This helped to maintain people's independence. Staff took the time to speak with people and took opportunities to interact and include them

in general chatter and discussion.

Advocacy services help people to access information and care services, support people in making decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us some people were being supported by an advocate at the time of our inspection. Information was available for people to read if they wished to make contact with advocacy services.

Good

Is the service responsive?

Our findings

People who we spoke with told us they were very happy with their care and felt well supported. Comments included, "I am happy and feel very well looked after. I am not able to do much for myself but the staff assist me" and "Yes, I would say I am well looked after and have my needs met".

People had an assessment of their needs before moving into the home and this formed the basis of their care plan. Records of people's assessments, care plan and other key information was retained in a file on each floor where people were cared for. Staff had day-to-day access to peoples care records which included information of the person's needs, interests and preferences as to how they preferred their care to be provided. Included in peoples care records were risk assessments and records required to monitor the health and well-being of the person. These care plans were retained in the individual units where people lived so staff had easy access to them.

Care plans we looked at were person centred and included details of people's preferences and choices. Care plans were informative and gave the staff the information they required to meet people's needs in a person centred way. For example, for a person who had dementia the care plan included information about the persons cognitive needs and how to reassure the person if they became agitated. Care plans had been reviewed monthly to ensure that the information was current. We noted that each person had a breathing care plan in place even though most people did not have any problems with their breathing.

Comprehensive daily notes were kept for each person so that staff could monitor peoples wellbeing. We found peoples daily notes were detailed however they were task orientated. The registered manager told us the paperwork was due to be changed once the new care plan documentation had been introduced. We were told the staff would receive training beforehand.

There was a member of staff employed to support people with their hobbies and interests, referred to as an activity co-ordinator. Various activities were regularly offered taking into consideration people's interests and hobbies and to promote their physical, emotional and spiritual wellbeing. Activities included music, trips into Bristol town shopping, creative minds and a tea club. The home had its own cinema room which had comfortable chairs, tables and a large TV. Regular cinema sessions were planned as activities for people. For people who were cared for in bed we saw time had been allocated to them for one to one activity time with staff. Peoples birthdays were celebrated with presents, cards and a birthday cake. Whilst people were waiting for lunch they used the opportunity for a social time. We observed that people looked like they were enjoying the interaction with each other. We spoke with people and relatives about the activities provided and we received the following comments, "Yes, we had the activities coordinator doing flash cards of film stars", "The activities lady is very good and she gets mum involved in the singing" and "Yes, I do and we have a new activities lady now and she's quite good".

The home had an effective complaints process in place which gave people information on how to raise any concerns they might have about the home. We looked at how the registered manager responded if people or their relatives wanted to make a complaint. There was information about how to do this in the home's

complaint's procedure which enable them to make complaints if they should need to. There had been three complaints raised within the last twelve months which had been investigated by the home. Staff knew how to respond to complaints if they arose. People and their relatives told us they were confident to raise concerns or complaints to senior staff or the registered manager. We asked people and their relatives if they had felt the need to complain before and what they would do if they were unhappy. We received the following comments, "No none she was in a place before not very good, it's nice here bright and always warm and the foods good and I've eaten here", No never and if we did it would be to X the manager". Another person told us, "I have no complaints or concerns to raise. I feel extremely well looked after".

Good

Is the service well-led?

Our findings

There was a registered manager in post who was well liked and respected by staff, people who lived in the home and relatives. 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 home is run.

People told us the registered manager had a very visible presence in the home and was very approachable. Comments included, "Yes, and she is doing a good job" and "Yes, we have spoken to the manager and she is doing a good job. Considering she was here as deputy manager she has made a lot of changes here".

Staff told us they enjoyed their jobs and said they were well supported through staff meetings, regular supervision, and through informal support on a daily basis. Handover sessions were held regularly during the day ensure staff received updates on each person's health, personal care needs and any changes. Staff told us they felt supported by the registered manager. Comments included, "The registered manager is supportive of me and we have a really nice team of staff here" and "If I have any questions to ask I can always go and ask the manager of the home or the deputy". Staff told us the registered manager had an 'open door' management style and was always available for advice or guidance.

Regular quality audits were undertaken by senior management and the clinical lead. The registered manager told us they felt supported by the provider and that the senior managers visited the home once a month and that the clinical lead visited regularly. They were also available by phone when needed if the registered manager had any concerns, suggestions or queries.

Systems were in place to monitor any accidents and incidents within the home. Accidents and incidents at the home were recorded appropriately and reported to the registered manager. Any injuries to people were recorded. Accident and incident records were reviewed and analysed by the registered manager to help identify any trends and potential situations which could result in further harm to people. Body maps were also used to monitor and review any injurys to people. Accidents and incidents were also monitored by senior managers. This meant people were protected against receiving inappropriate and unsafe care and support.

The registered manager showed us checks they completed to maintain the quality of the home and to identify any areas where improvement was required. Checks were completed of the environment of the home that included maintenance of equipment, infection control, health and safety, fire safety and call bell response times. Other monthly checks had been completed to audit the management of people's medicines, care plans and records associated with people's health and wellbeing. Where audits identified any areas for improvement, these were added to an action plan for review and completion.

Quality assurance systems were in place to drive improvements within the home. For example, surveys were due to be sent out to obtain feedback from people and relatives about the care they received. The registered

manager said surveys were due to be sent out to people and their relatives within the next few months. We were told surveys would be analysed by the registered manager with the necessary action taken to address any shortfalls.

The registered manager appropriately notified the CQC of incidents and events which occurred within the home which they were legally obliged to inform us about. This showed us the registered manager had an understanding of their role and responsibilities. This enabled us to decide if the home had acted appropriately to ensure people were protected against the risk of inappropriate and unsafe care.