HC-One Limited

Avalon Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 21 and 22 October 2014.

Accommodation for up to 40 people is provided in the home over two floors. The service is designed to meet the needs of older people.

There is a registered manager and she was available throughout the inspection. 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.

People and their relatives told us they felt safe in the home. Systems were in place for staff to identify and manage risks. People had mixed views on whether sufficient staff were on duty and we found that people did not always receive prompt care**.** A person told us that the

Summary of findings

home was clean and another person told us that staff helped them with their medicines. However, we found that staff did not follow safe medicines management and infection control procedures.

People told us that they had plenty to eat and drink. However, we saw that people were not always well supported at mealtimes. A relative told us that staff knew what they were doing but we found that staff were not always fully supported to have the knowledge and skills they needed to meet people's needs. We saw that the home involved outside professionals in people's care as appropriate, however, the requirements of the Mental Capacity Act were not fully adhered to.

People and their relatives told us that staff were kind and caring. However, we saw that staff did not always respect people's dignity and did not respond promptly to a person's distress. Relatives told us they were kept informed about their relative's care but people were not involved in their own care.

A person told us that they had not gone on any trips recently and we found that people were not supported to follow their own interests or hobbies. People and their relatives told us they knew who to complain to if they needed to and we saw that complaints had been handled appropriately by the home.

People and their relatives could raise issues at meetings, by completing questionnaires or raising them directly with staff and we saw that the registered manager responded appropriately to them. There were systems in place to monitor and improve the quality of the service provided, however, these were limited and were not always effective. The provider had not identified the concerns that we found during this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not always safe.

People were not supported safely at all times when at risk of falls. Staffing levels did not always meet the needs of people who used the service. Safe medicines management and infection control procedures were not followed.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding adults procedures. The premises were safe and staff were recruited by safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not consistently supported to ensure they had up to date information to undertake their roles and responsibilities.

People were not always well supported to eat and drink and staff knowledge of the MCA and application of its requirements were not consistent.

Staff involved other healthcare professionals if they had concerns about a person's health. However, people were not fully protected from the risk of skin damage.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were compassionate and kind and had a good knowledge of people's likes and dislikes. However, they did not always respond promptly to people's distress.

People were not always involved in making decisions about their care and the support they received, however, relatives were.

People's privacy was respected. However, staff did not always respect people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to maintain hobbies and interests.

Care plans were generally in place outlining people's care and support needs but did not always contain sufficient information to provide a personalised service.

People were listened to if they had complaints and appropriate responses were given.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Audits carried out by the provider and registered manager had not identified all the issues found during this inspection.

People and relatives were involved in the development of the service and a registered manager was in place and providing staff with clear guidance.

Requires Improvement

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

This inspection took place on 21 and 22 October 2014 and was unannounced.

The inspection team consisted of two inspectors and a specialist nursing advisor with experience of dementia care.

Before the inspection, the provider completed 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.

Before our inspection we reviewed all the information we held about the home. This information included notifications and the PIR. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service, Nottinghamshire Healthwatch and other health and social care professionals to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with seven people who used the service and six relatives and friends. We spoke with the registered manager, two care staff, a nurse, the maintenance staff, head of housekeeping, three health and social care professionals. We looked at eight care records, three recruitment files, observed care and other records relating to the management of the home.

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.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives had mixed views on whether there were enough staff to meet their needs. One person said, "Oh yes, definitely." Another person said, "Usually, although sometimes we have to wait. They are usually dealing with other people, we understand that and have to wait." Another person said, "Staff are brilliant but stretched to the limit. There are never enough staff on duty and I have to sit and wait until they can bring me downstairs." However, they told us that staff were reasonably quick to respond to the call assistance alarm which made them feel safe.

A relative told us they had visited one day and found their relative was still in their room at 10.15am despite being used to getting up at 8.30am. They told us that the manager had said that they would try and get their relative down sooner but their main challenge was having sufficient staff to make sure everyone got down to the dining room promptly in the morning. Another relative said, "Staff do look stretched sometimes, but they bring in agency staff if they need to so they seem to have enough."

A staff member told us there were normally enough staff on duty. However, another staff member said that care staff were always stretched. They felt that the home was staffed, "On the numbers of residents here, not what they need." A health and social care professional told us that the home was understaffed for the level of care people required. They said, "Care is not unsafe but people have to wait for care staff to be able to respond." The registered manager told us that there was no tool being used to assess the level of staffing required. This meant that there was a greater risk that there would not be sufficient staff on duty to keep people safe and meet their needs.

On the first day of the inspection we saw that some people received their lunch after 2pm, on the second day of inspection we saw that some people did not receive breakfast until 11am and some people had not been supported to get out of bed until after 11am. This was not due to people's choice. We also saw that staff administering medicines regularly stopped in order to serve breakfasts and to help other staff with the moving and handling of people who used the service.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not always managed safely. One person said, "I need help with my tablets. I used to get them all muddled up but staff help me to take them." However, a healthcare professional told us that the home had not managed one person's medicines effectively.

We observed that staff gave medicines to people safely. However, people's medicine administration record (MAR) charts were not fully completed to show that people received their medicines as prescribed. One person's chart did not always note whether the person was receiving food supplements as prescribed. Another person's chart had a gap on one day for a medicine used to treat blood pressure. We checked the stocks of this medicine which confirmed that this medicine had not been given. The registered manager agreed to contact the GP for advice on the effects of missing this medicine.

We saw that the treatment room door was closed but not locked. When we entered the treatment room we saw that some medicines were in a blister pack on the top of the medicines trolley. This meant that they were not stored securely and there was a risk that people who use the service could take them. We saw that the temperature of the fridge and room where the medicines were stored had not been checked on three days in the last month. While temperatures noted for the other days were within an appropriate range, temperatures should be checked every day to ensure that medicines are stored at the correct temperature so that people receive them safely.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safe infection control practices were not followed at all times which put people who used the service at risk of infection. One person said, "Everything is clean." However, we saw that a number of armchairs in the main lounge area were stained. We checked six people's bedrooms to ensure they were clean. In each room we saw an item that required cleaning. These items included stained bedside protectors, pillow cases and a commode. A shower chair in a bathroom was stained and required cleaning which the registered manager did. We saw that these issues had not been

Requires Improvement

Is the service safe?

identified or addressed following audits carried out by the provider. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The people we spoke with told us they felt safe in the home. One person said, "I feel safe knowing there are people around all the time to help." Another person said, "I feel a lot safer being somewhere I can call for help." We observed people who used the service were safely supported by staff when transferring from a chair to a wheelchair.

Staff were able to tell us how they would respond to allegations or incidents of abuse although not all staff had received safeguarding training. We saw that the safeguarding policy and procedure contained contact details for the local authority and was easily accessible for staff. We saw safeguarding information displayed on the noticeboard next to the lounge so people and their relatives knew who to contact if they had concerns.

We saw that safeguarding concerns had been responded to appropriately. We saw that body maps were completed when staff identified that people using the service had bruising and were investigated. Incident and accident forms were completed when appropriate. Forms described the circumstances of the incident or accident and actions taken in response.

We looked at the care records of a person who was at high risk of falls. They had been admitted to the home three weeks previously due to repeated falls but had fallen three times since being in the home. Two falls had resulted in admissions to hospital. The care records noted prior to the final fall that the person had been, 'wandering' and 'appears confused at times'. No falls prevention strategies had been implemented to reduce the risk of falls. This person had not been protected against avoidable harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw there were plans in place for emergency situations such as an outbreak of fire. A fire risk assessment was in place and a business continuity plan was in place in the event of emergency. We saw that a personal evacuation plan was in place for people using the service. This gave staff guidance on how to support people in the event of an emergency.

People told us their belongings were safe in the home. A person said, "Never had a problem with clothes or anything else going missing."

Premises and equipment were managed to keep people safe. A relative said, "I reported a problem with [my relative]'s window and it was repaired the same day." Appropriate checks of the equipment and premises were taking place. These checks included legionella testing, fire alarm tests, gas safety and electrical system testing. Regular maintenance of equipment was taking place which included the lift and hoists. The minutes of the home's health and safety committee meetings noted that a range of safety issues were monitored and discussed by this group. A range of risk assessments were in place regarding the environment and other risks including the use of oxygen in people's rooms. However, we saw that six people did not have access to call bells when in their rooms. The registered manager told us they would check access to call bells as part of their daily checks.

People were recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. The files contained all relevant information and the service had carried out all appropriate checks before a staff member started work.

Requires Improvement

Is the service effective?

Our findings

A relative said, "Staff know what they are doing. New staff have to work in pairs until they can work on their own." However, staff had mixed views of whether they were supported to have the knowledge and skills they needed to carry out their roles and responsibilities. A staff member told us they received regular supervision and that they were being supported to obtain further qualifications. However, another staff member told us they didn't feel well supported and supervision was not happening as frequently as it should. They told us they didn't feel listened to. Another staff member said, "There's not enough support. It's appalling, from higher management."

Records showed that 8 of 36 staff had not received supervision in 2014 and that no staff had received an appraisal in the last performance year. Dates for supervisions and appraisals had started to be booked. Records showed that not all staff had received all relevant training including infection control and food safety which we identified as issues during this inspection. This meant that not all staff were receiving appropriate supervision, training and appraisal to support them to carry out their roles and responsibilities effectively.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed staff explained to people what they were going to do, before they provided care. A staff member told us it was important to tell people what they were about to do and to check people were happy to receive the care at that time.

Staff had a mixed understanding of the requirements of the Mental Capacity Act (MCA) 2005, an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability. A staff member had a good understanding of the principles of MCA and best interest decisions. However another staff member did not have a clear understanding. Another staff member had completed MCA and DoLS training but did not feel the training was sufficient and said, "I'm not confident about my knowledge." We saw assessments of capacity and best interests' documentation were not always in place for people who lacked capacity. One person did not have the documentation completed for the use of bedrails. Another person did not have the documentation completed for the use of covert medicine. This meant that there was a risk that people's rights were not being protected.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The registered manager told us there was no one currently living in the home who was being deprived of their liberty. We did not see any people being restricted.

We checked whether people were being supported to eat and drink enough. One person said, "I am happy here I don't really want for anything. I like the food." One person said, "We have a choice of what we can have to eat." Another person said, "There's plenty to eat and we get drinks all day." A relative said, "The food has improved recently. The menu has changed and is better." Another relative said, "My [relative] has put weight on since [they] have been here. I have had to buy [them] new clothes."

We saw that people did not always receive the food and drink that they wanted. We saw a staff member asked two people what they would like for breakfast. They both asked for a poached egg and toast. The carer told them that would be fine but then returned to tell them that there were no eggs left. We saw another person asked a staff member for a cup of tea. The staff member told them they would get them a cup of tea but then did not.

We saw that mealtimes were not on time on both days of our inspection. On the first day of inspection we saw that lunches did not start being served until 13.20 and some people did not receive them until after 2pm. We had been told that lunch was usually at 12.30 and people were waiting a long time for their meals while sitting in the dining room. On the second day of inspection we saw that some people did not receive breakfast until 11am. This was not their choice, breakfasts were served late.

People were not always appropriately supported at mealtimes. We saw that one person had been given a plate of food but then fell asleep for 15 minutes at the table. They then tried to eat using a fork for 10 minutes but could not manage this so started to eat the food with their fingers. No staff member prompted them to eat or provided support

Is the service effective?

when the person was struggling. On the second day of inspection we saw that one person had not been supported to sit up in the correct position to eat their breakfast in bed and as a result had not eaten any.

We looked at another person's diet and fluid charts for the previous four days and saw that they had eaten and drunk very little. We made a safeguarding referral in relation to this person.

We spoke with health and social care professionals regarding their experience of working with staff at the home. They had mixed views. One professional told us the quality of care provided at the home was, "Variable. However there have been some improvements recently." They found the lack of continuity of nurses frustrating and felt that staff did not always follow their advice. Another professional told us that, 'My recent visits and advice have been well received and always with good engagement and fast action from the care manager and nursing team."

People did not always receive effective care to minimise the risk of damage to their skin. A relative said, "[My relative] has bed sores and is on a special mattress and staff keep checking and moving [them]." However, staff told us that people sitting in the lounge and unable to move independently would be supported to change their position at regular intervals. We did not see this taking place and there were no records to support this was taking place.

We saw that a person was not sitting on their pressure cushion as this had been left in the bathroom when they were taken down for breakfast. One person had been identified as at very high risk of pressure ulcers. Their care plan stated that there should be, 'Repositioning by two staff 2-3 hourly to prevent sores developing.' There were no position charts in place to record this was taking place. However, the registered manager confirmed that the person had no sore areas and we saw that staff were applying creams to protect the person's skin in line with their prescription.

Another person did have position charts in place. These records generally showed that staff were supporting the person to change their position every four hours; however, there was an eight hour gap in positional changes on one day.

We saw that other health and social care professionals were involved in people's care as appropriate. A person told us that a doctor had visited them to provide care. We saw a dentist visited a person during our inspection.

Requires Improvement

Is the service caring?

Our findings

People told us that staff treated them with kindness. One person said, "We all feel well looked after. We chat about how grateful we are to have help. I don't need help with much but it's nice to know they are there if I need them." Another person said, "My son brought me here to see if I liked it and I do, the staff are all really kind. Staff talk to you as friends not just people they look after."

A relative said, "Staff are polite and treat people well." Another relative said, "Staff are always very nice with [their relative] and with us." A healthcare professional said, "Carers are very good and caring."

We observed interaction between staff and people who used the service and saw people were relaxed with staff and confident to approach them throughout the day. Staff interacted positively with people, showing them kindness and compassion. However we observed a person calling out in the lounge area and becoming increasingly distressed. We saw that other people sitting near the person also became distressed and told the person to, "Shut up." Staff did not respond promptly to the person's distress and when they did respond, they offered very limited reassurance to them. This person's care plan did not contain clear guidance for staff on how to respond to the person's challenging behaviour and staff told us that they had been told to take the person to their bedroom when distressed. We observed that this did not take place promptly. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed the preferences of people who used the service with care staff. Staff had a good knowledge of people's likes and dislikes. Care records we looked at were detailed regarding people's preferences and life histories.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. For example where one person's religious requirements had been identified, they had been supported to meet these needs. This meant that people's diverse needs were being assessed and respected.

Relatives told us they felt well informed about their relative's care. A relative said, "The staff are really good at telling me how [their relative] has been." Another relative said, "If staff have anything to tell me they ring me up or wait until I visit and catch me." A guide provided for people using the service contained details of advocacy schemes available for people if they required support. Care records did not show that people were involved in their care; however, we saw some involvement of relatives in people's care.

We spoke with one person who had recently moved to the home and their relatives who were visiting. Their relative said they had spent time finding somewhere they were happy with. One of the things they had looked for was staff treating people with respect. They said they had always observed staff treating people with dignity and respect. The person agreed and also told us staff treated them courteously and with respect. Another relative told us staff, "Spoke to people properly."

We saw staff knocking and waiting before entering people's bedrooms and maintaining people's privacy when assisting them to the toilet. However, we heard staff use some terms which did not respect people's dignity. The registered manager told us that there were no dignity champions in the home. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they were supported to follow their preferred hobbies or interests. One person told us they were offered trips. They said, "I go sometimes but not always. It depends where they are going and what I feel like." Another person told us they used to like going out on trips but these had reduced since a driver had left in the summer.

We saw no evidence of people being supported to follow their preferred hobbies or interests during our inspection. We observed that most people sat in the lounge staring into space. The registered manager told us that the activities coordinator had been off sick for three weeks. We were told that some people did go out in the minibus but this had not happened while the activities coordinator was off. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had understanding of people's individual needs and some care records contained good information regarding people's individual needs and how to meet them. However, other care records were disorganised and did not contain information to meet people's personalised needs. Care plans were reviewed regularly and care plans were generally in place for recorded needs. However we saw that one person had been assessed as at high risk of skin damage and no care plan had been in put in place to address this need. We saw that a person's care records included information on how to identify whether their health was deteriorating as a result of their diabetes. We also saw that a person's religious needs had been identified and met.

We asked three people who they would speak to if they had any concerns. Two people said they would speak to the manager. One person said they weren't sure.

A relative told us that they thought things had improved and if they had any issues they raised them to make sure they were resolved. They told us that the manager listened and acted upon the issues they raised. Another relative said, "If I was unhappy I wouldn't hesitate to raise it and I am confident something would get done." A staff member said, "If anyone is unhappy about anything we tell them to speak to one of the seniors or the manager."

The complaints policy was stored in a folder near the front door and was also included in the guide provided for people who used the service. We looked at the complaints records and saw there was a clear procedure for staff to follow should a concern be raised. We looked at recent complaints and saw that they had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not fully effective. We saw that audits were completed by the registered manager and also representatives of the provider not directly working at the home. We saw that care plan audits had identified issues and set actions to address these issues. While completed dates were not noted next to some of these actions we checked two care plans and the actions identified had been completed. The registered manager carried out an enhancing mealtimes audit which assessed a range of areas regarding the mealtime experience; however, it did not look at the time of mealtimes which was the main issue we identified during our inspection. We saw that a medicines audit had taken place in October 2014 and an action plan was in place, however, this did not include all the issues that had been identified.

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed and actions were identified and taken. We saw that safeguarding concerns were also responded to appropriately and appropriate notifications were made to us where required by law. We saw that the provider monitored levels of incidents, accidents and safeguarding at each service to identify patterns of concerns. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this. However, we identified a number of shortcomings during this inspection which had not been identified or addressed following audits carried out by the provider. These included the areas of care, infection control, medicines and supporting staff. These shortcomings constituted breaches of a number of regulations. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives were involved in the development of the service. We saw that there were separate comments books in the main reception for people using the service, relatives and for comments regarding meals. We saw the minutes from the most recent meeting of people who use the services and saw that issues raised had been addressed. Surveys had been completed by relatives and by staff.

A Whistleblowing policy was in place and contained appropriate details. One member of staff told us they would raise any concerns with a senior carer and if nothing happened they would take it higher or report concerns outside the home. We saw that the provider's set of values were displayed in the main reception area. These values referred to kindness, respect, integrity, listening, privacy, dignity and choice, complaints, feedback and zero tolerance to abuse. These values were also in the guide provided for people who used the service which we saw in each bedroom.

A relative said, "I speak to the manager about anything I am unhappy with and they listen." A staff member told us they felt well supported by the registered manager. A registered manager was in post and she clearly explained her responsibilities and how she worked with the staff to deliver good care in the home. We saw that all conditions of registration with the CQC were being met and the registered manager had sent notifications to us where required.

We saw that a staff meeting had taken place in October 2014 and the manager had clearly set out their expectations of staff. The registered manager told us that there was a weekly staff meeting with the heads of department. They also had a daily handover with the nurse in charge.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have an effective system in place to regularly assess and monitor the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks associated with the unsafe and use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that staff were appropriately supervised, appraised and trained to deliver safe care and support to people.**