Elderly Care Home Limited

Avalon Nursing Home

Inspection report

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Date of inspection visit:
29 November 2016
30 November 2016

Date of publication:
02 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Avalon Nursing Home on the 29 and 30 November 2016. This was an unannounced inspection

Avalon Nursing Home provides nursing and personal care for up to 38 older people, some of whom are living with a dementia type illness. There were 28 people living at the home at the time of the inspection. In addition to living with dementia people had a range of complex health care needs which included stroke, diabetes and Parkinson's disease. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Avalon Nursing Home is owned by Elderly Care Home Limited and is situated in Hampden Park in Eastbourne, East Sussex. Accommodation for people is provided over two floors with communal areas and a garden.

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 in the Health and Social Care Act and associated regulations about how the service is run.

At a comprehensive inspection in August 2015 the overall rating for this service was Inadequate. At this time we placed the service into special measures. Seven breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. We found there were not enough staff deployed to meet people's needs. Staff had not received appropriate support or supervision. Staff did not understand their individual responsibilities in reporting safeguarding concerns. Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. The registered person had failed to notify the Care Quality Commission about any incidents that affected people who used the service. A notification is information about important events which the provider is required to tell us about by law. The premises were not always hygienic or safe to use. Care was task based rather than responsive to individual needs. People were not consistently treated with dignity and respect. The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. We issued warning notices for these breaches. The provider sent us an action plan and told us they would address these issues by February 2016.

During our inspection in May 2016, we looked to see if improvements had been made. The inspection found that improvements had been made and breaches in regulation had been met. However the improvements were not fully embedded in practice and they need further time to be fully established in to everyday care delivery.

Due to a high number of concerns raised about the safety of people, care delivery, deployment of staff and staffing levels we brought forward the scheduled inspection to the 29 and 30 November 2016, so we could ensure that people were receiving safe care from sufficient numbers of suitably qualified staff.

At this inspection, people's safety was being compromised in a number of areas. The provider had been unable to sustain the improvement made at the last inspection. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as pressure ulcers and wounds were not all up to date and did not have sufficient guidance in place for staff to deliver safe treatment or prevent a re-occurrence. The lack of appropriate deployment and suitably qualified and experienced staff impacted on the care delivery and staff were under pressure to deliver care in a timely fashion. Shortcuts in care delivery were identified. We also found the provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes and dislikes. Information in respect of people's lifestyle choices was not readily available for staff. The lack of meaningful activities impacted negatively on people's well-being.

People, staff and visitors were not always complimentary about the meal service at Avalon Nursing Home. They thought that sometimes food was not hot and one relative was concerned that their loved one was not being prompted to eat independently and losing their daily skills. Whilst another relative had had to remind staff that their loved one had been missed out when lunch and tea was served. The dining experience on the 29 November 2016 was not a social and enjoyable experience for people. People were not always supported to eat and drink enough to sustain their health and well-being.

Quality assurance systems were in place but had not identified the shortfalls in care delivery and record keeping. Incidents and accidents were recorded but there was no overview available that identified actions taken and plans to prevent a re-occurrence. We could not be assured that accidents and incidents were consistently investigated with a robust action plan to prevent a re-occurrence.

People's medicines were stored safely and in line with legal regulations. However people did not always receive their medicines as prescribed. There were missing signatures for medicines. These had not been followed up to ensure that people received their prescribed medicines. We also found poor recording of topical creams, dietary supplements and 'as required' medication.

People and visitors we spoke with were complimentary about the caring nature of some of the staff, but said that the changes to staff, use of agency staff and staff leaving had impacted on how the home was run. Some people were supported with little verbal interaction, and some spent time isolated in their rooms.

Feedback had been sought from people, relatives and staff in 2015 but had not been undertaken since changes to the running of the home were implemented and the new management had been introduced. 'Residents' and staff meetings had been held on a regular basis which provided a forum for people to raise concerns and discuss ideas. However these had lapsed in the past six months.

Staff told us they thought that communication systems needed to be improved and they required more support to deliver good care. Their comments included "We work well but need to build up the staff team, we can't do everything."

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health. However care plans did not include all the information about people's health related needs.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Avalon Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC), which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is now considering the appropriate regulatory response to resolve the problems we found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Avalon Nursing Home was not safe. Risk assessments, whilst in place were not up to date. The management of people's individual safety and skin integrity was poor and placed people at risk.

People were placed at risk from equipment which was not suitable for their needs and we observed poor moving and handling techniques.

There was not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing deployment.

The management and administration of medicines was not always safe.

Staff had received training in how to safeguard people from abuse and staff recruitment practices were safe.

Is the service effective?

Inadequate

Avalon Nursing Home was not effective. Meal times were observed to be a solitary and inefficient service. Senior staff had no oversight of what people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy.

Staff had not all received essential training to carry out their roles effectively. Safe care delivery was not consistent throughout the service.

Not all staff received on-going professional development through regular supervisions and appraisals.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of decision specific on-going mental capacity assessments for people who had limited capacity were not in place.

Is the service caring?

Requires Improvement

Avalon Nursing Home was not consistently caring.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported.

Is the service responsive?

Inadequate

Avalon Nursing Home was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

Staff told us that people were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

Whilst a complaints policy was in place we were not assured that complaints were handled appropriately. Not all visitors felt their complaint or concern had been resolved appropriately.

Is the service well-led?

Inadequate

Avalon Nursing Home was not well led. People were put at risk because systems for monitoring quality were not effective.

Management hand not ensured that the delivery of care was person focused or ensured that people not were left for long periods of time, with no interaction or mental stimulation.

The home had a vision and values statement, however staff were not clear on the home's direction.

People spoke positively of the care staff, but commented that staffing levels and the use of agency staff had impacted on the running of the home and the care delivery. Staff and visitors had an awareness of the management team but felt communication could be improved.

Avalon 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 was an unannounced inspection on 29 and 30 November 2016. It was undertaken by two 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 our inspection we reviewed the information we held about the home, including previous inspection reports and the action plan sent to us by the provider following the last inspection. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records five staff files including staff recruitment, training and supervision records, medicine records complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at eight care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with 15 people who lived at the home, four relatives, and ten staff members. We also spoke with the provider who was present throughout the inspection.

We met with people who lived at Avalon; we observed the care which was delivered in communal areas to

get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us. We also 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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I feel safe here" and "I'm safe here, warm and cosy." A visitor told us, "There are staffing problems I think sometimes because it can be chaotic." A relative told us, "I feel they are in safe hands most of the time, but I have concerns about the fact that my relative is not moved enough." Although people told us they felt safe, we found examples of care practice which were not safe.

Peoples' risk assessments were not all accurate and some lacked sufficient guidance to keep people safe. Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at the identified risk and included a plan of action. However, some risk assessments did not include sufficient guidance for care staff to provide safe care and others were not being followed. For example, there was evidence of pressure damage for one person that was identified on the 16 November 2016 as a significant pressure sore. The documentation did not reflect what had occurred before the 16 November 2016 to prevent or mitigate the risk of skin damage. Such as taking in to consideration recent ill health, deterioration of mobility and incontinence. The lack of guidance had not prevented the development of pressure damage. The risk assessment was updated following the discovery of the wound. This had not protected the person from harm.

Good skin care involves good management of incontinence and regular change of position. There was guidance for people in bed to receive position changes, however during our inspection peoples' positions were not changed. Gaps in the daily records for hourly position changes confirmed that people were not being moved regularly. For example, one person remained in bed on their back for up to six hours. People who sat in chairs and were not independently mobile did not have change of position or toilet breaks in their care directives for staff to follow. The registered manager told us people would be moved at least six hourly however this was not documented or observed. We identified throughout the inspection, nine people had not been assisted to access the toilet or offered a change position in over seven hours from 9 am until 4 pm. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. We looked at five of these people's care plans for continence management which stated that regular checking of incontinence aids should be undertaken and barrier creams applied. These people were therefore at risk from pressure damage because staff had not followed the guidance and managed people's skin integrity safely with regular checking and movement of position.

One person living with behaviours that challenged had individual support from a care staff member from 2 pm until late but this was not reflected in the care plan. There was no rationale documented as to the behaviours that needed 1-1 care support. There was no guidance on how to staff were to recognise triggers, de-escalate or divert the person should it be required. We spoke with staff who told us that they thought it was more inappropriate behaviour but could not tell us what it was they might do. Staff also could not tell us what triggers they might see.

Incidents and accidents were recorded but not all had a record of the action taken and of preventive measures put in place to promote future safety. Analysis of accidents and incidents were sent to CQC

following the inspection.

We observed three instances where people were placed at risk of injury from poor moving and handling procedures. We saw one person being supported to move from a wheelchair to armchair with the support of hoisting equipment (electrical lifting and moving machine).The person was not in the correct position and was slipping from the sling until a third member of staff noticed and instructed the other staff to lower them back into the chair. Another incident occurred when staff were assisting a person from a stand aid (Stand Aid is a specialist piece of equipment that is designed to aid an elderly or disabled person to stand up) to an electric riser recliner armchair and the staff had not ensured that the chair was in the correct position before placing the person in the chair and they slipped to the floor. To stop the person, the staff tried to hoist the person under their arm pits which could have caused further injury. When we raised this with the registered manager, it had not been reported to them. This was to be investigated following the organisational procedures. Care staff also moved a person from an armchair to a wheelchair by means of using an underarm lift (A method of lifting people where staff place a hand or arm under the person's armpit.) Use of this lift can result in a potential injury to the person lifted, such as dislocated shoulders. There is also a potential risk of physical injury to the care staff undertaking this manoeuvre for example a back injury. People therefore were not protected from avoidable harm due to inappropriate moving and handling techniques. People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe.

Not all areas of the home were clean and hygienic. There were strong odours of urine in the building. Specific rooms were identified to the registered manager throughout the inspection and were attended to by the housekeeper. However odours were again noted on the second day of inspection. In one room there was a shredded used incontinence pad on the floor which was in full sight of people and visitors walking past to the lounge. This was not removed despite reminders to staff for four hours. This was also a health and safety risk if ingested by people.

The environment was not always safe for people who lived with dementia. We found an unlocked cupboard in a corridor (boiler) which had items that could potentially cause harm to people. Such as sharp knives with exposed blades, electric saws and adhesive sprays placed near the boiler. These were removed immediately when identified to the general manager. There was a workman repairing the boiler and this had resulted in the cupboard being left open.

Recording and giving medicines to people were not always safe. This had not ensured people received their prescribed medicines. Medication administration records (MAR) had signatory gaps which had not been identified by staff for follow up, such as a medicine used for reducing the risk of stroke and serious blood clot. Prescribed creams were not always signed for by care staff as being given to people when prescribed. Medicines given for pain relief were not always reflected in care plans as when to be given. For one person on pain relieving patches the pain care plan stated the person did not have pain. Staff when asked were not sure of the origin of the person's pain. Staff had not followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol. Records had not been completed with details of why they had been given or if the medicine was effective. Directives as to when PRN medicines should be administered, for example pain charts were not in place for everyone.

Risks associated with the use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. For example, three pressure relieving mattresses were found to be set on the wrong setting for individual people. For example one persons' weight was recorded as 57.7 kgs but the mattress was set at 90kgs. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses

being incorrect is that it could cause pressure damage.

Bed rails were in use for many people and had been used with pressure relieving mattresses. The risks associated with their use had not been assessed and did not all comply with safety guidelines as the space between the mattress and the top of the bed rails were less than that recommended by The Health and Safety Executive. People were therefore potentially at risk from falling from bed. We asked staff who checked the pressure mattress settings and were told that "I'm not sure I think the maintenance person does." We could not find the daily check list for mattress settings and the settings were not included in the care documentation of the five people we case tracked. Following the inspection we received clarification that the settings were checked by the night registered nurse. We found that metal bed rails in use were not all fixed securely which could cause injury to people and staff. We were not assured people were protected from unsafe care. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Avalon Nursing Home was divided into two units over the two floors and the staff were allocation into two staff teams to provide 24 hour care. On the first day the staffing numbers were not as detailed on the rota and they were short by two care staff. An agency care worker came in early at 12 midday to assist. The lack of staff numbers did impact negatively on the outcomes for people. For example, people did not receive the level of personal care to meet their needs. Personal care is washing, continence care, changing of clothing and oral care. Staff told us that due to the lack of staff they had not been able to give people the showers, assisted washes and continence care that they were required to have. One staff member said, "It's not right today, but we did our best with two staff down." We asked staff if they felt the staffing levels were sufficient to provide safe care. They felt staffing was a problem.

On the 28 November 2016, at 12pm three people were still waiting for staff to assist with personal care. Staff had not yet been able to respond to their individual needs. For example one person had not been supported with their continence needs since 7am which had impacted negatively on their dignity and skin integrity. The staff deployment at meal times meant that people who needed assistance did not receive it. Staff began to assist people in the lounge and then left them to attend to people in their rooms. The provider had not ensured that there were sufficient suitably qualified staff deployed to meet peoples' needs and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some elements of safe care. There were systems in place to manage the storage, ordering, disposal and practical administration of medicines safely. We observed staff when they gave out medicines during the inspection. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed, and staff signed the MAR only when people had taken the medicine. Procedures were followed for the ordering and disposal of returned medicines. The clinical rooms were tidy and staff ensured that the room and fridge temperatures were checked daily. When temperatures were not at the recommended level, action was immediately taken.

People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. The staffing levels were reflected in the emergency evacuation plans.

Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' Staff told us what they would do if they suspected that abuse

was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Avalon Nursing Home and bank nurses all had registration with the Nursing Midwifery Council (NMC) which was up to date.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." However, we found staff and management at Avalon Nursing Home did not consistently provide care that was effective.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. We identified that certain decisions about where people spent their time had not been asked, considered or referred for a best interest meeting. During our inspection we noted that some people remained in their rooms and in their bed. We asked why and were told that was what was 'normal' for them. There was no evidence documented of the rationale for that decision and who made that decision for them. Staff were unable to tell us about how certain decisions were made such as, consenting to photographs of wounds and use of continence aids. One person was able to tell us clearly how they wished to spend their time but the documentation stated that they did not have the mental capacity to make that choice. Staff said, "Well, it changes very quickly." There was no consideration given for those whose mental capacity may fluctuate daily. We spent time with one person who told us that staff never asked them if they would like to get up, "I think it's for my benefit but no-one has told me why really." There was no supporting documentation that explained the reasons why the person was on bed rest and whether any other option had been considered. There were other people who remained on bed rest without any rationale documented or evidence of a best interest meeting. Documents did not detail if a best interest decision had been made or a discussion had taken place about the use of shared rooms. This told us mental capacity assessments whilst undertaken were not decision specific and were not recorded in line with legal requirements.

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. We were told that DoLS referrals had been submitted for some but it was acknowledged that not all had been referred as yet. Following the inspection we were told that DoLS referrals had been progressed. People were restricted from free movement by bed rails, tables placed in front of their chairs, positioned in recliner chairs and people remaining on bed rest without a clear rationale in place. This meant there was a lack of decision specific mental capacity assessments for people living at Avalon Nursing Home on how their freedom may be restricted or what least restrictive practice could be implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food was good. Comments included, "Tasty and always smells good," and "We get a choice and it's always delicious." However for some people the meal time experience was not always a good experience. The meal service for people was found to be variable over the two days of inspection.

On the 29 November 2016 only three people ate in the communal dining room at a table whilst other people sat in the lounge area and used a small table or received their meals in their bedrooms. The people who sat at the table did not receive the support or prompting required from staff. There was no overview of the meal service from senior staff. One person sat with their meal in front of them and did not eat unless reminded. An activity person returned periodically and said to the person, "Come on, eat up before it gets cold." which meant without continued prompting the person ate very little. The persons' relative identified this as an on-going problem and said, "If someone doesn't remind my relative they forget to eat and forget how to use the cutlery, it really worries me." Two people in the lounge area who required assistance were given one spoonful of food and then staff left them to assist people in their rooms. No-one returned to assist. Both people fell asleep. Following intervention from an inspector one activity co-ordinator re-heated one persons' meal in the microwave and attempted to encourage the person to eat, but the person had lost interest and ate very little. The other person when approached by the other activity co-ordinator refused to eat their meal. Not all people got the nutrition required to maintain their health.

Food and fluid charts were not consistently completed. We saw a lot of food was returned to the kitchen uneaten. The staff when asked had various ideas of why, which included, "Some people ate their breakfast late so were not hungry at lunch," "It got cold and then people don't want it, but they will eat their pudding," and "They didn't want it." We noted that whilst alternatives were available from the kitchen, staff did not offer people a different meal to see if that prompted their appetite.
Food returned uneaten or partially eaten was not always monitored or recorded accurately. Staff said they would notice if a pattern was occurring, however due to the lack of senior staff overview of the meal service and of poorly completed charts it would be difficult for staff to assess whether people were receiving adequate nutrition to maintain their health.

The care plans directed staff to monitor people's fluid intake when it had been identified the person was at risk from dehydration. Some records were incomplete and not added up to provide the total amount of fluid taken. Therefore the records would not be an effective way of monitoring how much they had eaten or drunk. There was also no guide amount for staff to aim for individual people, such as against the person's body weight. We identified three people on the nursing unit whose records indicated a fluid intake of less than 250 mls in 24 hours on three consecutive days. Staff had not recorded if a refusal had been followed up or whether it had been identified to the registered nurse (RN). One RN was not aware that two specific people had not been drinking well. This placed people at risk of dehydration. We were told water jugs were refilled by night staff at midnight and this ensured that people were offered and had access to drinks but this had not happened on the 29 November 2016. For example, at 9:30 am one person had only a quarter of jug of water and no glass in their room. We checked again at intervals throughout the day and it was not changed until the afternoon. As the persons fluid record had not been completed for the previous day (28 November 2016) as well as the 29 November 2016 we were not assured that the person was protected from the risk of dehydration. This was not an isolated incident. It was confirmed by the general manager that water jugs had not been refilled as per the organisational policy.

We saw both good and poor assistance given by staff to people. Two people were assisted to eat in bed by staff still in a semi reclined position which meant that they were at risk from choking. One care staff member was assisting a person lying in bed with their meal, by leaning over the raised bed rails. There no verbal interaction or eye contact and the person ate very little. We also saw good practice from a senior care staff member who had lowered the bed and bed rails and sat by the persons' side to assist them in a professional way.

Discussion with the cook told us that they had a list of people dietary needs and preferences. This list was kept in the main kitchen at the sister home. Dietary and fluid requirements updates were included on the

handovers but not all staff we spoke with had received a handover sheet that day. This meant that staff could not be sure of people's up to date dietary and fluid requirements. We asked how often the printed handover sheet was updated with people's identified fluid and food intake requirements and received no definitive answer. We were therefore not assured that people's nutritional needs were known and met on a day to day basis. The provider had ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health and was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed various training to make sure they had the skills and knowledge to provide the support individuals needed. Some staff told us they were behind in some areas and this was already known to the organisation. Whilst some training was available it was not effective in all cases. We observed poor practices in moving people, assisting people with their food and in delivering person centred care. There was also a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting them and not managing some behaviours effectively.

Training records indicated that fundamental training was not up to date for all staff. For example, fire training, food hygiene, Control of Substances Hazardous to Health, (COSHH), health and safety. It was a specific concern that nurses and senior care staff had not all completed training in safeguarding and the MCA. Service specific training, such as end of life care, dementia, wound care and nutrition had not been undertaken or updated to ensure best practice was followed by all staff

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which would be supported if necessary by additional training. Staff said, "Supervision is a bit hit and miss but it has now been organised." Staff records of supervision confirmed that staff supervision had fallen behind by nine months, but recommenced in October 2016. Staff told us they had felt unsupported due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed. This meant the provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The menu demonstrated a wide range of nutritious meals. The chef had a good understanding of people's dietary needs and preferences. There was information displayed in the kitchen which informed staff who was at risk, the type of diet and what support they required at mealtimes. On the second day of the inspection, thought and planning ensured that people were given the attention and support they required.

People received effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician. Visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the tissue viability nurse (TVN) and speech and language therapist as required.

Requires Improvement

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, and therefore there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact who were given very little time and attention throughout the day. People spoke positively of some care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived at Avalon Nursing Home. Comments included, "I visit every day and sometimes I feel it's too busy and not everyone is given attention," and "I see staff busy, too busy and they are too busy to help people when they call out, I worry that people might not get the care they need." We were also told "Very nice staff, they are kind, and "The care staff are really good."

People were not always treated with dignity and respect. People's preferences for personal care were recorded for each person but not always followed due to staff being rushed or staff shortages. Documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in over a week. We noted that some peoples' nails were grubby which indicated that staff had not checked their nails whilst undertaking personal care. We noted that some people's clothing was stained with food and there was no offer of a change of clothing. Continence care was not being offered regularly. There were strong odours of urine in certain rooms which staff confirmed that were due to heavy incontinence. One staff member said, "There hasn't been time to wash and change them, they were got up by the night staff at 6:30 am." It was identified that it had been six hours since the person was supported with their continence needs. This impacted negatively on the persons' dignity. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes and personal care check lists we looked at were not consistently completed. Visitors shared concerns that baths and showers were not being offered. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. Not all people's personal hygiene needs were being met.

Staff were confident when talking about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. One member of staff told us they always covered the lower part of a person if they were washing the top. Another member of staff told us they felt it was important to "tell people what you're doing". Whilst acknowledging staff's knowledge, not all practices encouraged people's dignity. A member of staff adjusted a persons' clothing in the lounge without asking or telling them the reason why. They did not ask the person if they wanted to go somewhere more private. Another relative told us their family member's dignity was maintained on a wider sense but compromised at times by wearing clothes that weren't theirs.

Staff did not always respond to people appropriately and in a caring manner. Staff talked between themselves and not always to people. One member of the care team had a lengthy conversation about their home life to another member of staff. They "talked over" people and did not include them in the conversation. The same member of staff called loudly across the room, to gain the attention of other staff.

One of the staff responded and sat behind a person. They started talking to them but as they were out of the person's field of vision, the person began to look from side to side to determine where the voice was coming from. The member of staff acknowledged we were observing interactions within the lounge. They then moved their chair appropriately to the side of the person and continued to talk to them. The person relaxed when they saw the member of staff and responded to them in a positive manner. Another person was assisted to move from their chair to a wheelchair using the hoist. Staff talked between themselves, whilst intermittently telling the person "going up" or "going down". They did not give focused attention or reassurance. There was a problem with the persons' position but instead of explaining the problem they kept trying to move the persons arm into the correct position. No reassurance was given during this time. During the morning some people were assisted to the lounge after personal care. A member of staff supporting people asked another member of staff "Where do you want me to sit them?" The response was "Over there." Staff did not consult with people to find out where they wanted to sit. This did not promote dignity or respect.

Some staff spoke about people, whilst in the vicinity of them and others. One member of staff told another "X is not themselves today." Another staff member called out to another "I'm off to do X now." This was in relation to supporting a person with their personal care. The comment did not show a personalised approach.

People's independence was not always promoted. For example, there were people who could request attention, but had no access to a call bell to summon assistance. We asked one person how they called for staff, they said, "I wait till I see someone, then call out." For another person we were told that they were able to weight bear and use a commode until very recently, but were now immobile and incontinent. The family member said, "I have asked them to help my relative to the commode but have been told they are " wearing a pad and doesn't need a commode." The care plan for this person had no care plan in place for continence promotion or for using incontinence aids. The family also said "There has been no attempt to encourage them to stand just for a few minutes to keep a little bit of independence." People were not consistently treated with dignity and respect and they were not encouraged to independent or to live a life of their choice. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, other interactions were more positive. One member of staff supported a person who said they were not very well. They leant down towards the person, spoke softly and offered solutions that might make them feel better. Another person was showing signs of being disorientated and agitated. Staff offered ways to help them feel more settled. This included offering a drink and giving reassurance by explaining what they could do to help them. A member of staff supported and offered reassurance to another person who was mobilising with their walking frame. They told the person "when you've had enough, just tell me, the wheelchair is behind you" and "if you want to sit down, the chair is here". The person walked the length of the corridor and then sat down. The member of staff congratulated the person on their achievement.

People and their relatives gave positive feedback about the staff. They described staff as "Friendly", "Very nice" and "caring." Other comments were "Staff work hard and are caring," "When I need help and support it is forthcoming" and "Everyone is most helpful." One person told a member of staff "You're very kind," as they gave them a drink. Another person said "It's a nice place here." A relative told us "The staff are all ok but some are lovely. X is fantastic, very caring." Another relative told us they were pleased with the staff and the care their family member received. The relative told us staff had taken time to get to know their family member and had created a file, which included their personal preferences. Relatives told us staff kept them informed of any ill health, consultations, incidents or accidents. They said they were able to visit at any time

and were made to feel welcome.

Inadequate

Is the service responsive?

Our findings

Whilst some people and visitors told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to peoples' individual needs.

Care plans and daily records were not always clear and sometimes included conflicting information. In addition, staff were not always knowledgeable about the actual care people required. Pain assessments were not undertaken on a day to day basis or at times of symptoms, such as agitation, which could indicate pain. Records showed some people were identified as having pain but this was not defined and there was no information about the areas affected. We were told that one person spent alternate days on bed rest but that was not clearly documented in their care plan.

We looked at documentation of people who had developed pressure damage (ulcer). There was a lack of preventative measures recorded. There was no evidence recorded of any action taken by staff on noticing skin changes or of physical health changes that may affect their skin, such as enforced bed rest due to chest infection. Care plans for pressure ulcers for one person started on the day that a grade 2/3 pressure ulcer was discovered. The risk assessment for tissue viability stated no update until two days following this. This person had contributing factors that had not been recorded or responded to, such as incontinence, chest infection and immobility.

One person's care plan had been mislaid for seven days and no replacement care plan had been put in to place. Not all staff spoken with knew this person and were unaware that they needed regular continence care or prompting with their meals or that they could not weight bear. Emergency contact details were also not This meant the person was place at risk from potentially inappropriate care and treatment.

Care was not always person centred. This was particularly apparent in relation to assisting people to manage their continence. Assistance to use the bathroom was not given on an individual, needs led basis. Staff did not ask people before or after lunch if they wanted to use the bathroom.

Staff were not always aware of people's needs. When asked about specific aspects such as whether a person had a fluid chart in place, many responses from staff were "I'm not sure. I don't usually work on this side." We asked a number of staff members about the reasons why one person was now staying on bed rest and were told different things. We were told 'Their health has deteriorated so they stay in bed now,' another staff member said, "They do get out of bed."

Another person had a chart in place to monitor their pressure care, as they required frequent repositioning to prevent pressure ulcers. The chart identified that the person's position had not been changed all day which contradicted the care instructions. This placed the person at risk of harm. Staff could not explain why the person was not moved as they should have been.

There were designated staff to arrange social activities for people. The activities were undertaken in the

communal areas of the home and people from the different units were supported to attend if they wanted to. Staff told us in addition to group activities, "one to one" chats were undertaken with people who were unable or did not wish to participate in group activities. Staff told us this was done to try to help prevent people from becoming socially isolated. However on both days the activity co-ordinators spent all their time in the communal lounge. It People in their rooms received very little interaction apart from 'tasks' such as meal service. During the inspection, there were musical sessions and seated exercises, which people enjoyed.

On both days the main activity appeared to be a musical session, which only a few people took notice of. We were told that a craft session of making Christmas cards was to happen, however the activity co-ordinator sat alone at the table making the cards without asking people to participate. Whilst some people enjoyed the music, those who were frailer or living with more advanced stages of their dementia, were not involved and received limited stimulation. Some people spent the majority of their time in the lounge or in their room, either sleeping or unoccupied, looking ahead but not engaging. One person held a sensory item but no other such equipment was seen. One member of staff told us social activities for everyone was an area they felt the home could improve upon. Another member of staff told us they would like to see more sensory items for people. One member of staff told us trips out for people was needed. They said these were people who were independent and could acknowledge "what's around them." The member of staff told us not everyone was offered the opportunity to go out, which they did not feel was fair.

Staff told us there was always a member of staff allocated to a lounge, to monitor people and minimise incidents. This was not always the case, we found on two occasions during the morning that people were left unattended. We also noted when there was a member of staff in the lounge, they sat next to people but did not engage with them. They had limited conversation with people and did not undertake any activity to promote involvement. This was a missed opportunity, as the time available could have been spent undertaking meaningful activity or interaction with people. The evidence above demonstrates that delivery of care in Avalon Nursing Home at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format such as large print or pictorial. We received differing views on the complaint response, which were discussed with the provider. One visitor told us "I have been to the office but I'm not sure I have been taken seriously." Another visitor said, "I am confident that I can raise any concerns or grumble and the team ensure its dealt with." We received information from visitors that they had raised a number of complaints but the provider told us that as they had been referred to the local authority the home had not recorded them as a complaint and there was no record of action taken to resolve the complaint. The providers' complaint procedure was not fully established and did not operate effectively.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated. One person told us that staff had provided them with a special light so that they can continue to do their hobby, "I like my curtains drawn because I stay in bed and the sun affects my vision, staff got me this light, it's really helpful."

Quality assurance (QA) is carried out quarterly and the last QA summary had been carried out at the end of August 2016. Surveys had also been sent out on 7 November 2016, which were due to be analysed in December. Quality assurance surveys for visitors is also provided at the entrance of the home and a feedback box is also available for any feedback or concerns. One visitor said, "I have been asked to complete a survey but I think it was last year, but I give feedback all the time."

Inadequate

Is the service well-led?

Our findings

Feedback from people, staff and visitors about the leadership in the home was varied. Comments from visitors included, "It seems a little unsteady here at times," and "I feel the use of agency staff has really affected the atmosphere, the care and my fear is however nice they are, the staff don't always know the residents well enough." Staff told us, "Changes have happened in the past six months, staff not reliable all a bit tough," and "Not everyone listens."

Organisational quality assurance systems were in place, however they were not all fully completed and had not identified all the shortfalls we found. The newly formed management team consisting of a registered manager, general manager and deputy manger told us that the audits had identified that there was a lot of work to do. The improvements seen in May 2016 to the Breaches of Regulation found in August 2015 had not been sustained and embedded in to everyday care delivery

The provider's systems for audit had not identified a wide range of areas. These included people's safety being potentially at risk as some care plans were lacking in specific information, which had the potential to cause harm to the individual. Also some care plans we looked at, had not been updated since July 2016. We are aware of the difficulties experienced in finding a care plan system that was suitable. There were currently two different care plan formats in place which has caused confusion. A new computerised care plan was just being introduced, which the management team believed would improve care delivery and record keeping. Essential training for all staff was not in place and staff had not received regular supervision or yearly appraisals. This meant staff were not being appropriately supported to undertake their role and improve care practices. This was confirmed by the unsafe care practices observed during the inspection process.

The website for Avalon Nursing home was not up to date and referred to the previous registered manager and contained edit suggestions not removed.

We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink. The provider's care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of wound care, dementia and continence. People's records were not always accurate and placed people at risk from inappropriate care. The weight records for people were updated weekly, two weekly or monthly depending on the level of risk identified. However the records did not identify if there was weight loss or weight gain from the previous weight recorded. As the weights had not been put in to peoples care plans, staff were not informed if there was a risk. Strategies to manage weight loss were not commenced in a timely way. People had not been protected against unsafe treatment by the quality assurance systems in place and this was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. The philosophy

statement states "Avalon Nursing & dementia Home is committed to meeting the needs of our residents by providing them with the highest level of person centred care in a home from home environment" It also stated that "Both Registered Nurses and care staff regularly undergo supervision sessions from the Matron to ensure the highest levels of care for each resident are always achieved. These had not been achieved at this time. Staff told us that they felt unsupported had not received regular supervision and that the management team were not always approachable and supportive.

Staff we spoke with did not yet have an understanding of the vision of the home, which was to 'treat people as an individual and give them the opportunity to be fully involved with their care, and be encouraged to lead as active a lifestyle as they choose'. From observing staff interactions with people it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff. This told us that the culture of the home had still to change to ensure person centred and safe care was delivered. The management team confirmed that staffing over the past six months had been a challenge.

Communication and leadership needed to be improved within the home. People and visitors had an awareness of the management team but felt that staff turnover and use of agency had unsettled the running of the home. Due to staff deployment and the use of agency staff we saw that poor practice was accepted by staff. We saw shortcuts in care delivery such as not moving people in a safe way and not supporting them with adequately with meals and drinks. These shortcuts were noted to be due to time constraints and staff deployment. People therefore did not always receive the care they wanted and required. One visitor said, "Sometimes I worry that the information I get is not accurate, I'm not sure that my concerns are taken seriously enough."

We spoke with staff about how information was shared. They told us they were given updates but felt they "Were too quick and didn't really tell them much." They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, handover sheets and supervision. However feedback from staff said this was not consistent.

During the inspection we raised concerns that the management overview of the service was not up to date or accurate. We found that the management were not fully aware of people's wounds, of the poor documentation and of people's weight loss. The lack of training was acknowledged and a schedule of training booked after the inspection has been provided to CQC.

The general manager told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were held regularly and surveys were conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views.

Staff meetings had not been held regularly over the past six months, and we were assured that regular meetings would be held whilst changes to the home and documentation continued. The general manager said, "There is a lot to change, such as the culture, but I have confidence that we will get there. There is a strong organisational team that are working with us to improve the service."

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

Records showed equipment such as the passenger lift, mobile hoists, nurse call bell system, fire alarms and

emergency lighting were regularly serviced by external contractors. This ensured they were effective and in good working order. There were systems to monitor the safety of the hot water and regular checks to minimise Legionella. Staff checked and documented the temperature of the water whilst assisting a person to have a bath or shower, to minimise the risk of scalding.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place and had not maintained accurate, complete and contemporaneous records in respect of each service user

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision.