Avon Lea Weymouth 2015 Limited

Avon Lea Nursing 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**

Summary of findings

Overall summary

The inspection visits took place on 23, 29 and 30 March 2016. Avon Lea Nursing Home is registered to provide care nursing care for up to 40 older people in a residential area of Weymouth. At the start of our inspection there were 35 people living in the home. The majority of people living in the home had complex care needs related to the impact of their dementia.

The service had a registered manager at the time of our inspection but this manager was no longer working in the service. We had been notified of their absence in November 2015. 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. The current manager had been made deputy manager in June 2015 and had been made acting manager in January 2016. They had not applied to become registered in this role at the time of our inspection.

Avon Lea Nursing Home had been through an unsettled period due to a change in provider after entering into administration during the previous year. The current providers had owned the service since December 2015.

We found a number of areas that required improvement during our inspection. The manager and owners were aware of some of these issues and had started work on plans to improve the quality of care people experienced.

People did not always receive the support they needed to reduce the risks they faced. Reviews did not use all the appropriate information available and this meant that people were at risk of harm. People had their physical needs met by staff but there were not always staff available to meet people's emotional and social needs. The owners were recruiting to increase the availability of staff to undertake activities with people. At the time of our inspection people who were mostly cared for in their rooms were not receiving sufficient activities to meet their social care needs.

People were supported to make choices when possible by staff who understood the importance of respecting people's wishes and acting with kindness. People and their relatives were positive about the care they received from the home and told us the staff were mostly compassionate and kind. We observed kind and familiar interactions between staff and people but there were also occasions when staff spoke about people in ways that did not promote dignity.

People were not always supported to eat and drink in ways that met their needs and preferences. The meal times we observed were not organised in a way that encouraged the social aspects of eating together.

The manager and new owners were reviewing the provision of care and were focused on promoting person centred high quality care. However, some of the concerns identified during our inspection had not been

identified or acted on adequately. Policies outlining the way the home would be run did not always reflect current practice.

Most people felt safe and they were supported by staff who knew how to identify and respond to abuse. Where people needed to live in the home to be cared for safely and they did not have the mental capacity to consent to this Deprivation of Liberty Safeguards had been applied for.
A GP with regular contact with the people and staff of Avon Lea was confident that people received support for their health related needs in a timely and appropriate manner.

Relatives, people and staff told us they felt able to raise concerns and that the manager and new owners had made themselves available.
The staff had a good understanding of plans for the home and were committed to improving practice. They spoke positively about working as a team to achieve the best care for people.

There were breaches of regulation relating to how people were kept safe and how care was delivered to reflect people's personal needs and preferences. You can see the action we asked the provider to take at the back of the full report.

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. The risks people faced were not always sufficiently managed.

There were enough staff to meet peoples' physical needs but staff were not always available to meet their identified social and emotional needs.

People received their tablets as prescribed but prescribed creams and nutritional supplements were not administered safely.

People were cared for by staff who understood their role in keeping them safe.

Is the service effective?

Requires Improvement

People had varying views on the food provided at Avon Lea. Meal times were not a social event and preferences had not been incorporated into the menu.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

People were supported by staff who understood the importance of offering choice when possible.

People were cared for by staff who felt they had received the training they needed to meet the needs of people in the home and felt supported. The manager had highlighted areas of training and support that needed development and had plans in place to ensure these happened.

A GP was confident in the staff's ability to identify health concerns and seek appropriate support for these.

Is the service caring?

Requires Improvement

There was a commitment to promoting dignity and person centred care but this was not always the experience of people

living in the home.

People were supported to make some choices but there were also times when people were not communicated with effectively.

Is the service responsive?

Requires Improvement

People did not received care that was responsive to their individual social needs and access to meaningful activity was not sufficient for people who spent most of their time in their bedrooms.

People and their relatives were confident they were listened to and complaints were responded to effectively.

Is the service well-led?

Requires Improvement

The manager and owners had the confidence of people, staff, and relatives following a period of management change.

There were systems in place to monitor and improve quality, however, these had not been effective in identifying some areas that required improvement.

Avon Lea Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 23, 29 and 30 March and was unannounced. The inspection team was made up of one inspector and a specialist adviser. The specialist adviser had clinical experience and expertise.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. The provider had not been asked to complete a Provider Information Record (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather the information contained in this form during our inspection.

During our inspection we spoke with eight people living in the home, some of whom did not always communicate effectively with words due to their dementia. We also observed the care and support people received throughout our inspection. We also spoke with four visiting friends and relatives, nine members of staff and the owners. We looked at records relating to seven people's care, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring audits.

We also spoke with a social care professional and two healthcare professionals who had worked with the home or had visited people living at the home.

Requires Improvement

Is the service safe?

Our findings

Some risks people faced were managed effectively but there were also examples of insufficient risk management. One person was cared for in bed and had bed rails in place. They had a risk assessment completed for using these bed rails which was last reviewed in November 2015. We saw that they were unsettled and trying to pull themselves over the bedrails on three occasions when we visited them. Staff were checking this person every half an hour and were aware that they were sometimes distressed and agitated and that they tried to get out of bed when this happened. This knowledge had not led to a change in their risk assessment. Bed rails are not always the best option to keep people safe and the level of agitation of the person should form part of the assessment. The bed rails risk assessment had not been reviewed appropriately and this put the person at risk of harm should they fall from over the bedrails. The risks to this person had not been appropriately assessed. Another person was also cared for in their room, they were assessed as being able to use a call bell to seek assistance from staff. They did not have this available to them during our inspection as it was hung up out of reach. Another person was assessed as needing a high protein diet to reduce the risk that they developed pressure sores. The kitchen staff were not aware of this assessment and they had not been providing a high protein diet. This meant that the plans put in place to reduce the identified risks were not being followed. We discussed these examples with the manager and they told us they would review them immediately.

Monitoring information was not used effectively to review and plan to reduce the risks people faced. Two people were at high risk of developing sores on their skin and staff recorded applying preventative creams. This recording was sporadic and did not reflect the frequency of cream application that care plans indicated. One of these people had recently developed a pressure sore that had just healed. It was not possible to review whether changes needed to be made to their care plan as it was not clear whether it had been followed. Another person was assessed as being at high risk of malnutrition and dehydration. They had been prescribed a nutritional supplement in January 2016 and their fluid intake was recorded. Records did not reflect that they were getting the nutritional supplement as prescribed and their fluid intake was not always reviewed. Monitoring records were not being used to plan and reduce the risks to the person. For example on days when a low fluid intake was recorded the next day records were not tallied to monitor for improved drinking. In March the person was reviewed as being at continued high risk of malnutrition. The update stated: "(Nutritional supplement) continue. Weight continues to drop." Records suggested that they had not had the prescribed amount of nutritional supplements on 16 days in February and this information did not contribute to the review of their risk assessment.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People were given their tablets as prescribed during our inspection. Where people had pain relief tablets prescribed as and when they needed them these were available at any time day or night. Some people took medicines that needed to be kept more securely because they were covered by the Misuse of Drugs Act 1971. These medicines were stored appropriately and the records reflected the medicines held in the home. Other medicines were stored securely with the exception of some medicines which had been placed in an unlocked cupboard whilst awaiting collection by the pharmacy. These medicines were moved as soon as

this mistake was noticed. If people did not take their medicines this was recorded and this led to appropriate reviews of medicines.

There were enough staff available to meet people's physical needs and these staff had been recruited safely. People and relatives told us that staff were able to come when they needed them. We saw that staff attended quickly if people rang their bells and that there were staff available to support people at meal times. There were not always enough staff to meet people's assessed social needs. Following a member of staff leaving the service, activities were being provided by one member of staff and when they were not working no cover was arranged to ensure people who stayed in their rooms had access to meaningful activity. Three people's records indicated they had not been visited by the activities coordinator for a month. We asked the manager about this and they told us that for part of that time there was an outbreak of illness but they also acknowledged that the records reflected the experience of people during this time due to the reduced hours available to provide activities. This meant that staff had not been deployed in a way that met people's identified needs. We spoke with the owner about staffing levels and they told us that they were recruiting to fill current vacancies in the activities team.

They were also recruiting to fill vacancies in the cleaning team and had plans to restructure how cleaning was managed. At the time of our inspection there was one cleaner working and new systems had been put in place including records of cleaning undertaken. The home smelt fresh and clean but there were some areas that could not have been cleaned effectively. A shower room used by some people living in the home had linoleum coming away from the wall. This would not be possible to clean effectively. The floor in the kitchen was also not secure at the entrance and this could not been cleaned effectively. The trolley that was used to serve food was not cleaned thoroughly and dirt had built up over the wheels. This was not on the cleaning schedule for the cleaner or the kitchen staff. We were told this would be added to the kitchen cleaning schedule straight away.

People had varied experiences regarding how safe they felt. One person told us: "I've always felt safe." Another said: "Oh yes it's very safe." Two people told us they did not always feel safe. In one instance the reasons for this had been addressed with the manager and resolved but both people told us they continued to feel less safe at night. We spoke with the manager and one of the owners about this feedback. They told us that they had made changes to the way care was delivered at night and were reassured that people would experience a change in their experience. Many of the people living in the home were living with dementia and did not use words to communicate their emotions and could not tell us whether they felt safe. The majority of relatives we spoke with shared a confidence that their relative was safe. One relative told us, "I know (person's name) is safe." Staff were able to describe how they protected people from the risks of abuse by describing the signs they needed to be aware of and knowing where they would need to report any concerns they had.

Requires Improvement

Is the service effective?

Our findings

People and relatives had mixed views on the food but highlighted that there had been changes in the kitchen. One person told us," The food is nice." Whilst another told us: "It isn't terribly good." During our inspection we observed that people who ate their lunch in the lounge were not encouraged to sit together and food was brought to people by staff who did not sit down with them but stood to the edge of the room observing. This gave the meal time a functional feel and did not enhance the social aspects of eating with others. There was a choice available for the main course and people told us that they could make another choice if the meal did not suit their tastes. There was however only one choice of pudding and two people told us that they had not enjoyed it. One of these people commented to staff that they didn't like oranges. People had been asked about their suggestions and preferences about the menus at a residents meeting but this information was not available in the kitchen and it was not found during our inspection. This meant that people's preferences and suggestions for food were not being reflected in the menus. Food and drinks were offered at regular times throughout the day and people did not ask for drinks in between these times. We asked a member of staff about access to drinks and they told us "20:30 is the last drinks round" this indicated an inflexible approach to drinks that was also reflected when a member of the inspection team asked for a drink. Although people were being offered regular drinks there was a risk that people would not be encouraged to ask for drinks when they wanted them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care plans reflected the principles of the Mental Capacity Act 2005 (MCA) with consent sought appropriately in most plans we looked at and best interest decisions made where people were unable to consent to their care. Care staff were able to describe how they supported choice with people and the approaches they took when people refused care but were not able to frame their understanding within the framework of the law. We also spoke with a nurse who told us they had received training but could not describe how they used this law in their work. It is important that nurses and care staff who might make decisions on behalf of people understand the basic principles of the MCA so that peoples' human rights are protected. The manager and owners had identified gaps in MCA knowledge prior to our inspection and had a plan to meet this need.

The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made to make sure there are no other ways of supporting the person safely.

People were supported to maintain their health. We spoke with a GP who had regular contact with the home and they spoke positively about the health support people received. They told us the manager was "clinically very switched on" and good decisions were made about seeking health professional guidance. People and relatives told us that they received appropriate health support and that the staff had supported this to happen. One relative told us: "I trust (manager's name) and the nurses to know what they need." And one person told us how confident they were in the new nurses and another person described how they had been supported to improve their mobility; telling us : "(The manager) got me on my feet."

Staff told us they felt supported to do their jobs and described how guidance from colleagues ensured they were up to date with people's needs. One member of staff told us: "I feel supported and listened to." There was a system in place to ensure that staff received their training and the provider had training facilities and resources available to staff. The Care Certificate had not been introduced in the home although there were some staff who met the criteria for undertaking this training; the owner told us this would be introduced but had not yet been possible with other changes needed. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. New staff had received a comprehensive induction which covered the same competence areas as the care certificate.

Staff supervision had not been kept up to date due to management changes in the home. The manager was aware of this and had a plan in place to ensure this was addressed. Staff had a strong sense of their own strengths and we saw that the manager supported staff in individual ways.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives described the service as caring. One person told us: "I love it here". Another person said: "They are very kind. Anything you ask of them, if they can do it, they will."

Staff told us they promoted people's dignity and privacy by undertaking personal care and offering support discretely. There was also a strong commitment to promoting person centred care and dignity amongst the management team and whilst we heard about and saw examples of this in practice it was not consistently the experience of people living in the home and this was an area for improvement.

We saw staff take time with people asking permission before they offered care and support and ensuring privacy. We also saw staff taking time to talk with people and to make a connection as they went about their tasks. For example, a member of staff joked with a person when arriving to support them with personal care. One relative acknowledged this telling us: "They work hard but they have time to talk." This personalised approach had a visibly calming and mood enhancing effect on people. However, two people told us that not all staff were as kind and caring and some made them feel rushed. We observed that at times staff were working in a task focussed way and at these times the personalised approach slipped and this had an impact on people's dignity. For example staff discussing whether anyone needed support with their lunch referred to a group of people as "the pureeds" in a communal area in front of other people who lived in the home, another member of staff was asked by a colleague: "Did you do (person's name)?" again in a communal area.

Staff told us about the importance of kindness and doing things the way people like but also acknowledged they did not always feel able to give people the time they needed. One member of staff described how important this was to them when they reflected on their professional motivation telling is it was: "To make people smile – I know I've done my best". We saw examples of attention paid to personal detail for example one person always had a soft toy with them that was of great significance to them. The way that some individual's dementia affected them meant that they were sometimes fearful and sought reassurance. One of these people was visibly calmed by the presence of staff but staff did not always stay with them when they were distressed. We spoke with staff about this and they told us they checked the person every half an hour but sometimes left them in an unsettled state. One member of staff told us: "I hold their hand for a bit – it is the time element." This meant that people were sometimes not experiencing a caring response to their distress.

There were some inconsistencies in how well people were supported to communicate their wishes. People were supported to make some choices throughout the day such as what they wore, where they sat, what they ate and whether they joined in activities. One person told us that staff did not all take the time to use their communication aids and this meant they were not able to communicate. We spoke with the manager about this and saw that on our return visits the person had their aid with them. They told us it was now being used more.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed and recorded alongside plans to meet these needs in their records. These plans were reviewed regularly, with people and relatives as appropriate, although staffing changes had meant that some plans had not been reviewed since November 2015. Complete care plans were in people's rooms when we started our inspection; this decision had been made to support staff's understanding of people's histories, needs and preferences as a support for person centred care approaches. We explored this understanding amongst the staff team in relation to people who could not communicate this information themselves with words. Whilst staff understood people's care needs they did not understand their life stories if these weren't obvious through photos or visitors. For example staff were aware of important relationships when these people visited regularly and people's working histories when visitors discussed them or photos acted as a visual prompt. They did not know about the important detail of people's lives when these prompts were not available. It was important that staff were able to assimilate this information so that they could use it to ensure the care and support provided was personalised appropriately and sensitively. They had not been able to do this and this meant that people's experience did not always reflect their preferences. For example one person's care plan described how they liked classical music and preferred to listen to Radio Three. A staff member told us they liked Radio Two and this was what was played in their room. They would be unable to communicate if this was contributing to any distress they experienced and had no other stimulation available to them in their bedroom. We spoke with the manager about the care plans being kept insecurely in people's rooms as records should be kept securely to protect people's privacy. The manager acted to ensure these records were kept securely.

Following recent staff changes activities were planned for groups and individuals by one activity coordinator. We reviewed the activities for two people identified by the manager as at the biggest risk of social isolation in the home. These people had not been visited by the activities coordinator in over a month. We spoke with the manager and owner about this and they highlighted that an outbreak of illness had meant that room visits had been suspended during this time. Care plans related to these people's social care needs did not indicate that they needed to stay in their rooms. One person's care plan said they should get up on alternate days and go to a communal lounge for a short while and the other person's said they should sit in the lounge two to three times per week. Paperwork related to the outbreak of illness indicated that this accounted for about half of the time these people had not been visited but no additional plans had been made to meet people's social needs.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People's views were captured during residents meetings and by asking themed questions. This was not always effective in ensuring their views were used to improve the quality of care at Avon Lea. There had been a plan to review people's preferences and needs with reference to meaningful activity in January 2016. This included asking people and relatives about their preferences. We asked the manager and an owner to locate this work but they were not able to and told us it may not have been carried out. The owner highlighted that they were currently advertising to add to the activities provision in the home. They told us that they now had

a "golden opportunity to review what people want".

The management team had a positive attitude to complaints and mistakes. Staff, people and relatives told us they would be comfortable to raise any concerns they had with the managers. One relative told us that they had been more than satisfied with the manager's response to a concern they raised. They told us they felt comfortable raising this concern and would do so again if necessary. One person told us: "Oh I'd tell them if there was a problem." Complaints were recorded alongside their outcomes in line with the complaints policy of the home.

Requires Improvement

Is the service well-led?

Our findings

Avon Lea Nursing Home had been through a period of unstable management including a period of time in administration during the year prior to our inspection. Staff acknowledged that it had been a difficult time but identified that they felt confident in the new owners and current manager's commitment and capabilities. One member of staff told us that the new owners were quite "open" about changes and that the manager was "very good". At the time of our inspection the previous registered manager was still registered with the Care Quality Commission however the administrative resolution of this had been started. People recognised the manager, spoke highly of them and were comfortable in their presence. We saw residents, staff and relatives talking with them throughout or inspection. One person said "They really know what is going on." People, relatives and staff were being kept informed by the new owners and managers and we saw that meetings had already taken place to set out their ethos and plans and that further meetings were scheduled.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved but we found areas of concern highlighted during our inspection had not been identified and adequately addressed and this was an area that required improvement. For example, the issues noted regarding the monitoring and reviewing of records related to risk management had not been picked up as part of the quality assurance processes because charts were not being reviewed. Where concerns had been identified by the management team about specific staff engagement with changes and performance this had not always resulted in additional scrutiny of practice to ensure no impact was experience by people living in the home. This lack of oversight had led to people's feedback about aspects of their care not being used to improve the service. The manager and owner were also not aware that some people had not been visited by activities staff for a month. There was also evidence of monitoring undertaken by the manager which had identified areas for improvement and led to changes for example a medicines audit had led to clarification of responsibilities in relation to the pharmacy resulting in a safer and better service for people.

One of the new owners had clinical experience and they had undertaken a review of the care provided. They told us they had started to address areas where they saw the need for changes in working practice. For example they had identifies the need to improve infection control and we saw that cleaning schedules had been implemented, the auditing and training related to infection control had been reviewed and updated and recruitment was underway to bolster the cleaning staff team. Whilst this work was evident the areas of the home that were not clean identified during our inspection had not been addressed. They had also implemented intentional rounding after our first inspection visit. Intentional rounding is a nursing method that ensures nurses assess people on a regular and planned basis. At Avon Lea this was being implemented with an additional recording system related to managing risks of people developing pressure sores.

Policies had been put in place at Avon Lea by the new owners but these did not always reflect current information, procedures in place and occasionally referred to another home that the owner who was the nominated individual for Avon Lea Nursing Home was the registered manager for. For example the safe to leave policy referred to staff achieving the care certificate within six months but this was not in place in the

home. The incident policy did not reflect a change in how reportable incidents should be reported although it was dated after this change was made.

The owners, manager and staff described a change in working practices and ethos since the new owners had taken over and this was reflected on positively. One member of staff reflected on the impact of this saying: "All the staff have come together." The management team were responsive and proactive in their work with other professionals. A GP commented on their confidence in the manager with regard to people's nursing needs and the owners described their involvement with commissioners in terms of ensuring that they were planning to meet need within the locality.

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 RA Regulations 2014 Person-centred care People's care was not planned for and delivered in a way that reflected their preferences and ensured their social needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks people faced were not adequately assessed. Where risks were identified these were not sufficiently monitored and reviewed to ensure that people were at a reduced risk of harm. Prescribed nutritional supplements and creams were not administered in a way that reduced risks to people.