K Jones and R Brown

Avalon EMI Care Home

Inspection report

24 Duke Street
Southport
Merseyside
PR8 1LW

Tel: 01704541203

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Avalon is a care home that provides personal care and support for up to twenty six people who are living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The providers [owners] are Mr K Jones and Mr R Brown.

The service was last inspected in October 2015 and was rated 'Good' at that time. This is the first time the service has been rated 'Requires Improvement'.

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 2008 and associated Regulations about how the service is run.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made. When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not always made with reference to specific key decisions.

You can see what action we told the provider to take at the back of the full version of this report.

We found the design and adaptation of the premises could be further improved with respect meeting the needs of people living with dementia.

We made a recommendation regarding this.

The manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found quality assurance systems needed further developing in line with providing further good practice for people living with dementia.

We made a recommendation regarding this.

We found medicines were being safely managed. Key staff were responsible for monitoring and administering medicines. The administration records for some medicines such as prescribed 'thickeners' for drinks (for people with swallowing difficulties) could be further improved.
We looked at how staff were recruited and the processes to ensure staff were suitable to work at Avalon EMI care Home. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people. We found there were sufficient staff on duty to meet people's care needs.

People's clinical care was assessed for any risks and organised so plans were put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training in-house. Not all of the staff we spoke with were clear about the wider issues around 'safeguarding' people and this was feedback to the registered manager to inform future training.

Arrangements were in place for checking the environment to ensure it was safe. Health and safety checks were completed on a regular basis so hazards could be identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable and safe environment. The home was clean and there were systems in place to manage the control of infection.

Staff said they were supported through induction, appraisal and the home's training programme. People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care.

We found the home supported people very well to provide effective outcomes for their health and wellbeing. We saw there was regular and effective referral and liaison with health care professionals when needed to support people. Feedback from visiting health care professionals we spoke with was positive.

People we spoke with said they were happy living at Avalon EMI Care Home. Staff interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people. We found a caring ethos throughout the service.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. We highlighted some issues, however, around the display of personal information and staff sometimes used inappropriate terms when referring to people who required assisted feeding. This was acknowledged and addressed by the registered manager.

We saw people's dietary needs were managed with reference to individual preferences and choice. Lunch time was seen to be a relaxed and sociable occasion.

People felt involved in their care and there was evidence in the care files to show how people and / or their relatives had been included in planning and reviews of their care.

Social activities were organised in the home and continued to be developed. People told us they could take part in social events which were held.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered safely. Some administration records could be better developed and this was being considered.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

The home was clean and we there were systems in place to manage the control of infection.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not always decision specific.

We found the design and adaptation of the premises could be further improved with respect to meeting the needs of people living with dementia. We made a recommendation.

Staff told us they were supported through induction, appraisal and the home's training programme.

We found the service supported people to provide effective

outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

All of the people we spoke with and their relatives told us staff were very caring in their approach to care.

Staff displayed reassuring and effective communication when interacting with people.

People told us they felt involved in their care and could have some input into the running of the home and planning of their care.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and monitoring of people's care evidenced an individual approach to care.

There were social activities planned for people living in the home and these continued to be developed.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The managers were able to evidence a range of quality assurance processes and audits carried out at the home. Some of these required further development. We made a recommendation.

There was a registered manager in post who provided an effective lead for the home and who had developed a positive

culture of care in the home. The vision and values of the service were also strongly evidenced through the leadership of the registered manager.

Avalon EMI Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 which took place over three days on 18, 20 and 25 October 2017. The inspection team consisted of two adult social care inspectors and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the home.

During the visit we were able to meet and speak with 10 of the people who were staying at the home. We spoke with seven visiting family members. We spoke with 10 of the staff working at the home including care/support staff and registered manager. We also received further information following the inspection from five visiting relatives.

We looked at the care records for three of the people staying at the home as well as medication records, four staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Good

Is the service safe?

Our findings

We spoke with people about whether they felt safe living at the home. People and their visitors said they felt safe and comments included; "I feel safe, no problems at all. The staff, even if they're doing jobs, they'll stop and say 'Is everything okay?" "I'm not afraid of anything; everything's safe and they're all nice," "Yes [feels safe]; there's nothing makes me feel I'm not safe. I do feel safe; this is my home," "Yes – staff presence mainly [keeps person safe]" and "It's very safe here. [Person] has no falls now; pressure mat by the bed so [the staff] know when they are up."

We looked at how medicines were managed at the service. We found medicines were managed safely. All staff administering medicines had received training. We spoke with people and relatives who told us people always received their medicines on time.

Staff recorded the administration of external medicines such as creams and prescribed substances such as 'thickeners' for drinks; the latter used to thicken the consistency of drinks for people who had difficulty swallowing. Thickeners were recorded on fluid intake charts each time the person was given a drink. It was not clear on one fluid intake record we saw which 'stage' of thickener to use and the staff we spoke with added to the record so this was clear for staff. A person receiving thickeners in their drink also required review by the GP to confirm the prescription. During the inspection we had confirmation this had been reviewed.

We reviewed a selection of medication administration records (MARs); staff had signed to say they had administered the medicines. This helped to ensure medicines were given safely as prescribed. The service has carers dedicated to medication administration. These staff start their shift by administering medicines before they generally interact with people living at the home. The idea is that this will reduce distractions and help with safer medication routines.

The MARs contained any known allergies and a photograph for identification purposes. Sometimes we saw an incorrect code used on the MAR to record when people had refused medicines ['O' instead of 'R']; this was discussed for future reference with the staff carrying out the medicine round.

Medicines were administered from medicine trolleys. These were securely locked when not in use. We observed part of a medicine round and the staff member administered medicines safely to people.

A number of medicines were prescribed as 'when required' (PRN). A record was kept of PRN medicines and staff were following protocols for PRN medicines. For example, when to give a PRN medicine and the duration. We found not all people on PRN medication had a care / support plan in place and this was reviewed during the inspection and brought up to date. This information is important to help ensure consistent administration of PRN medicines.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The

temperature of the drug fridge was recorded. This meant the medicines stored in this fridge were safe to use.

We asked what auditing mechanisms were in place to check if medication was being administered safely. Regular audits were being carried out by the manager. We saw audits of medicines in stock carried out weekly as well as routine checks of all medicine processes including storage; a weekly check of controlled drugs (CDs) was also made. Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

The registered manager told us they were continuing to develop auditing processes in the home and would ensure the medicine audit included issues we had discussed on the inspection such as PRN support plans and monitoring of thickening agents.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at four files of staff employed and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been done. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We asked people if they thought there were enough staff on duty at all times to support everyone appropriately. Everybody asked these questions said they were satisfied with staffing levels and didn't feel they normally had to wait very long for support. Comments made included, "If anything happens there's always someone to help you" and "From what I've seen, yes [there are enough staff]." Most people said they did not have to wait long for staff if they needed them. As part of the inspection we tested a call bell and staff responded within three minutes. We saw the lounge areas were always covered by staff to observe people's safety.

Risk assessments associated with peoples clinical presentation were also in place for mobility, personal care, oral health, nutrition and hydration, the impact of the person's dementia on their living, communication, behaviour, cognition, continence, environmental control, and medication.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was stable. One staff told us, "[Registered manager] is really good and supports us well. If we need extra staff this is arranged." A recent example was the extra time arranged for staff to support one person on a one to one basis, enabling the person to be supported outside the home in the community.

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw comprehensive records of all of the routine environmental checks made in the home.

We attended the care home's weekly fire alarm test on the second day of our inspection. The registered manager and her staff team activated the fire alarm. We found that most of the locked doors around the building had been released by the alarm. On the top floor and middle floor there were two doors that did not release. One of these doors provided the only exit during an evacuation, as the corridor led to the lift in the other direction. The doors had a manual keypad on their front and back. The registered manager explained to us that the doors were "sticking" due to having been painted; this was corrected during the

inspection. We saw the registered manager understood the importance of ensuring safe fire procedures on nights; we were shown a report of a recent unannounced site visit at night by the deputy manager where fire procedures had been reiterated with staff. In people's care plans there were detailed risk assessments including emergency evacuation risk assessments that consider the person's mental and physical ability, as well as site familiarity. We saw a Personal Evacuation Emergency Procedure (PEEP) box outside of the care home, near the activity outbuilding and 'fire assembly point'. This contained emergency items such as high visibility vests and blankets.

Overall there was good attention to ensuring safety in the home and on-going maintenance.

The staff we spoke with described the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. Their understanding of safeguarding was not always clear. One staff said, "Safeguarding means that the residents are safe, they don't hurt themselves and there are no obstacles; we keep them in the property; we alert the manager or deputy over any concerns or whistle-blow." We did not hear staff talk about wider principles of safeguarding [such as the need to reflect on care practice, empowerment or partnership, or a full mention of different types of abuse.] outside of 'protection'. This was discussed with the registered manager with reference to further and on-going training for staff.

There had been two reports of safeguarding concerns since the last inspection. The registered manager and staff had worked with the local authority safeguarding team to resolve these and learn from any of the issues involved.

When we looked round the home we found it to be clean. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we [mostly] saw they used this when providing care. All shared bathrooms/WCs were very clean and appropriately equipped for hand washing. There were cleaning schedules in place. We also saw there was additional staff employed in the laundry. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. Although we observed safe and hygienic standards we saw staff did not wear PPE during the serving of meals on day one of the inspection.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The 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 saw there was some good evidence of where people had been asked their consent and where consent around areas of clinical practice had been considered and recorded. For example, we heard carers offering support before taking any action, throughout the day, using terms that allowed people to decline if they wished. Other examples included care files showing were people or relatives had been consulted with and consented with respect to aspects of their plan of care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members].

Other key decisions regarding care and treatment were not as clear however. In particular, areas of care that may be construed as 'restrictive' such as the provision of bedrails for people [to help ensure their safety whilst in bed] and the placing of alarm sensors in peoples bedrooms lacked any reference in terms of consent. In addition the key decision to be admitted to the care home had also not been referenced on any of the [pre] admission documents. The manager explained that that staff had moved over to a new computerised recording system and some of these assessments around consent had previously been made under the old 'paper' system of recording. We were told the current computerised records would be updated.

Four of the people in the home at the time of the inspection were under a DoLS authorisation. These were being monitored by the registered manager. There were applications to the local authority for other people living in the home as per legal requirements. The supporting assessments for people prior to these applications were recorded on the new computerised system and did not always fully show that staff had a full understanding of the principals of the MCA. For example, one person on a DOLs authorisation had a mental capacity assessment completed by staff which indicated, at the first stage of the test, they had full capacity to make decisions despite clearly having a medical diagnosis indicating this should be tested.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Avalon EMI Care Home is a specialist care home for people living with dementia; the registered manager has had training in dementia care mapping [this is used to observe how people living with dementia interact

with their environment, including staff]. Our observations of the environment raised issues around appropriate and 'best' design of the building for people living with dementia.

Avalon had been refurbished and there were now six more bedrooms. We discussed with the registered manager the presence of many locked doors. These doors make the building safe, but we asked the registered manager to reflect on the need for each one of them. The corridors and various sets of stairs provide an environment that could be confusing. Together with the amount of locked doors this creates a setting that may not be straightforward for people to use and could be perceived as oppressive. One person commented, "I feel safe here but I'm not happy about the doors being locked – I'm locked in here [i.e. the landing area outside the person's own room].

We found on the top floor and outside near the activity building 'printed on doors' or 'fake shop fronts'. The doors showed a second, printed handle in addition to the physical handle. This could be confusing for residents. The member of staff showing us around the home commented on the 'fake shop fronts' that residents "Try the door handles on the shops." Although intended as a prompt for interaction, this also indicates that people may find the prints confusing. We commented on the first day of our visit on the absence of [contrasting] handrails on the top floor. This was addressed almost immediately by the provider [owner]. There was also a lack of orientation aids and signs on these corridors which, again, did not assist with people's orientation. There was a lack of aids such as 'memory boxes' outside bedrooms to promote orientation and provided a focus for conversation with reference to an individual's life.

Due to the layout of the building there was generally very limited access to people's bedrooms which were mainly upstairs and away from the day / lounge areas. This meant that during the day people spent their time in the lounge areas which, at times, presented as a very crowded environment. It also meant during activities planned by staff there was very little alternative space for people who did not want to join in.

The registered manager and staff had introduced some measures to help alleviate this; for example two sittings at meal times and regular [daily] trips out for some people which assisted to create more space. There were also plans to create more day space in the future by the addition of a conservatory to the rear of the building. Currently there was no routine auditing of the environment with the aim of identifying and developing a 'dementia friendly' living space.

Following the inspection the registered manager advised us the locked doors had been removed and some locks had been removed.

We recommend that the registered manager seeks to implement National Institute of Clinical Excellence guidelines on 'Supporting People with Dementia and their Carers in Health and Social Care'.

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. People said, "Yes, they [staff] know what they're doing," "Yes [when asked about skills and knowledge]; I get looked after properly," "They know what they're doing in the sense that they are trying to get things sorted for me." A relative told us about the actions taken by staff to encourage one person to work with them on improving their medical well-being, with positive outcomes for the person's health and mobility.

There were some elements of staff competence they needed to reflect on. We observed the strong 'caring' quality of the service meant 'professional' boundaries were not always clear. Staff appeared to mean well, but we noticed examples of 'grey areas' of affection and familiarity that could be misinterpreted. We observed how residents were greeted by kisses on cheeks and heard staff members talk in interviews about how residents were 'held' at bedtime [reference to one person who felt reassured when first going to bed

with staff presence 'holding' the covers in place]. Other examples included substances [thickeners] that should be firstly prescribed were bought directly from the pharmacist. Staff members had been trained in some extra skills, such as phlebotomy [taking bloods]; another staff was considering training around catheterisation. While this develops staff abilities and skills, processes must be cleared with health professionals and care is needed to not get in the way of good understanding around support from outside agencies.

The registered manager explained how staff were observed and given formal supervision sessions by senior staff where these issues could be discussed and clarified. We felt that some areas of staff role and competency could be better referenced however. For example, in addition to the issues stated above, medication administration competency was not formally recorded. The new computer system alerted the registered manager which supervisions were needed and meetings were recorded electronically. Staff commented that they felt very supported in their role by the registered manager. One staff said, "The manager is excellent and we are always discussing and getting updates on things." Two staff commented that communication in the home is 'excellent' and this supported them in their role. During the inspection we saw the manager leading a brief staff meeting to discuss current issues in the home.

We saw that a good percentage of staff had achieved formal qualifications at Level 2 or above NVQ or Diploma in Health and Social Care. Some senior care staff had been given extra training in medication administration. Staff members we spoke with listed a variety of e-learning courses completed, as well as some classroom based training. One staff member had certificated training and competence in 'hands-on (classroom based)' training in moving people safely and used this to train other staff.

We looked at four staff files and these included copies of training certificates covering many aspects of care including dementia awareness, dealing with challenging behaviour, safeguarding, moving and handling, medication administration and infection control. The registered manager told us that the training was cross referenced to the standards in the Care Certificate which is an identified set of standards that health and social care workers adhere to in their daily working life.

The registered manager had obtained a training / assessor qualification and stated she was in the process of moving everyone onto the Care Certificate. When we mapped learning outcomes from other sessions over the Care Certificate standards; we did not see clear reference to 'Duty of Care' or 'Fluids and Nutrition' and the registered manager was made aware of this.

During our inspection we reviewed the care of three people living at the home. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. One person had displayed behaviour of a particularly challenging nature at previous services and was now settled at Avalon and provided with positive support and activity. We saw that all three people were subject to regular reviews of their care which involved a GP review and included a review of medication. We spoke with another visiting health care professional. They gave positive feedback regarding the care in the home and how well staff responded to any instructions or recommendations for care. We were told, "The home is particularly good at supporting [people] who have been challenging previously. I have no concerns about care here."

We sat with people at meal time .The dining room was small but bright and pleasant. Tables were simply but attractively laid before the meal. No napkins or bibs were provided, although some people were given pieces of paper towel during the meal if they asked for or seemed to need it. There was seating for only 16 people, including carers, and we were told beforehand that lunch was served in two sittings because of lack of available space. The main course looked very appetising and nutritious, served as small and appetising portions. All were served on blue plates; one person was offered a plate guard. We saw and heard staff

offering support on occasions, such as, "Do you want me to cut that up for you?" The large majority of people enjoyed their meal and comments included, "It's lovely,' [a person eating with evident enjoyment]; "The food is always very, very nice here" and "I never leave any."

Good

Is the service caring?

Our findings

We asked whether people's privacy was respected. We saw staff knocking on people's doors before entering and, as necessary, opening the door slightly to check they had permission to enter. Everybody we spoke with had no issues with privacy and dignity.

We observed staff to be pleasant and to speak kindly and courteously to people when offering or giving support, or when serving food and drinks. Relationships were evidently good between everyone living and working at the home. It was evident from the different exchanges between people and carers that staff knew people well and as individuals. We heard carers speak to people incidentally as well as specifically engaging them in conversation, using opportunities as they arose. This applied to all members of staff, not just designated carers.

During the inspection several people gave examples of a personalised approach to care. One person commented, "[They're] very good; very gentle with the older people. They've definitely got the right approach. If they see you and there's nobody around, they'll come and talk to you." Other people said, "They're all very kind; lovely. I've nothing to complain about and "They're all good; they really are nice people. I think [they know me well]."

Visitors and relatives said, "Staff are friendly, never annoyed and they know my [relative]. Nine times out of ten, when you come, there's one [carer] sat down with a resident. They get to know people's needs and how to handle them" and "What I love is they [staff] know something about everybody. They all seem to know the idiosyncrasies of everyone."

Following the inspection we received a further five individual testimonials from relatives who had received support for themselves as well as their loved ones living at Avalon. These included relatives telling us about how the staff had provided 'end of life' support to people, including support for relatives. One relative commented, "Towards the end [person] lost a lot of weight, [person] was treated with such respect and dignity right up to the end [of their life]." Another relative told us their loved one had found it difficult to settle at the home but "The persistence, the smiles, the reassuring chats, the cheerful banter between staff and residents" had eventually had a positive effect.

Other relatives commented; "Avalon is unique, [Registered Manager] and her staff understand that 'one size does not fit all'. Each and every resident in Avalon is different; each resident has their own special needs which [Avalon] is always striving to meet" and "[Staff] almost become family to the residents and because they see so much of them on a daily basis they become helpful, friendly and affectionate. Indeed many residents do not have regular visitors and the team look after them in the same way they would treat their own relatives."

People who could mobilise independently found difficulty sometimes as there was restricted space available. There was, however, always staff on hand to support and assist people so their independence was promoted.

When we spoke with staff they came across as caring and interested in their work. Staff were knowledgeable regarding the people they supported and could tell us a lot about their life history and likes and dislikes. One staff member told us that it was a person's birthday and they would like to ensure the person went out for a meal on this special occasion. This staff and the person being supported had a unique handshake to greet each other which showed some warmth and trust.

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process; this was evident through records of discussions and reviews. We asked people about their involvement in care planning and we were told, "My family might do that – I haven't seen it, no," "My [relative] has power of attorney but I take part in care plan reviews. Yes I do [have my say] and they do listen; that's why I've got that [indicating personalised timetable]" and "Yes; we've reviewed it when any medication has been changed."

We saw that people had access to advocacy support if needed. Leaflets and information was available regarding the local advocacy services. There were no people using this service at the time of the inspection although the registered manager was able to give examples of people using these in the past.

We did see and comment to the manager the importance of maintaining, at all times, confidentiality regarding people's private information. For example some personal information was on display in the entrance foyer of the home in the form of care needs summaries. Also we heard some staff using inappropriate terms when making reference to some people who required assisted feeding. The registered manager removed the information and advised us they would address the issues we raised with staff supervision and staff meetings.

Good

Is the service responsive?

Our findings

We observed overall a service that seeks to be responsive to people's needs and we saw some good 'person-centred' practice. Staff members told us in interviews about personalised approaches. This included for example the exact language used, individual to the person and based on their background, if a person was up and not settled during the night.

People told us they did not have set bedtimes nor needed to get up by a certain time. One person said, "I've overslept today and they just come and help you with getting up and that."

One person told us that they had always loved a variety of walks and that staff had supported them with different walks and outings from the care home. We discussed with the registered manager the importance of continuing to look at people's strengths and goals, to identify where residents can experience positive control over their day.

The registered manager was seeking to make care plans and records more effective and has moved to an electronic system. Care plans were stored on computers. Care staff were given time to read plans and could access them through a desktop computer in the office or laptop elsewhere in the building. Staff members were alerted if there were changes to people's care plans. Care staff commented positively on this when we spoke to them. Care files have an index that is very clear. Staff members use 'e-docs' through an app on their own phone, which is password protected.

We saw that all of the people living in the home had a care plan and these were regularly updated and evaluated. There was evidence that people and their relatives had been involved and we confirmed with some of the interviews we conducted. Care records did not always reflect the individual care given on a daily basis; sometimes staff just entered a 'check off' of tasks completed rather than give an overview of the person's day and what care outcomes were achieved. This would help support the staff team in their reflective practice, ensure care plans are based on individuals' strengths and show the impact of care on their quality of life. Some residents receive set hours of 'one to one' support by dedicated care staff. Documenting the care outcome of these hours, as well as their flexible use to meet people's needs, would be particularly useful to show how responsive the service is.

There was a detailed activities board on the lounge wall; however, this did not reflect the provision on the days of the inspection. We discussed how an actual 'today board' may be more useful. This would avoid confusion and be likely more meaningful. We were shown a 'games room' which was in the garden area and therefore could only be accessed by people accompanied by a staff member or visitor, which also applied to any area of the garden. This room provided a small-scale table tennis table plus a sweet shop, selling a range of sweets. The room also had activity boxes with various games equipment in them and we were told that staff used the contents for activities within the main building. We did not see anything in the home itself that could be used to engage or occupy a person needing distraction, comfort or stimulation such as games, dolls, or books/magazines.

People we spoke with were generally positive about the home's activities programme. One person commented, "Yes, they keep us cheerful, we have a laugh. We sit around the table and talk. In the summer when it's very warm we go out in the garden." Another person told us, "I have gone on some of the social trips and I go shopping [with support] to get food. I don't go to the games room." Visitors and relatives felt the home provided a positive environment to stimulate people's interest. One relative commented, "We filled in a questionnaire at the start, about [person's] interests. They do try to keep [person] engaged. They took [person] out for afternoon tea once and rang to check they had my permission."

For a period of time during the morning a staff member engaged a number of people in a 'sing-along', using the large TV screen with words of the songs. Those who were engaged appeared to enjoy this, sang along and at times joined hands and discussed the songs. The atmosphere was extremely lively and for those engaged, very positive. Some people did not engage actively at all and the volume of the TV made it almost impossible for them to have any conversation or potentially to engage in anything else.

In the early afternoon, the activities staff member invited a small group of people to go out with them on the home minibus, for a visit in the local area; this was a very regular activity for some people.

People had access to a complaints procedure and this was available to people within the home. A person said, "I'd go and tell the one in charge; or I'd tell staff; I wouldn't hide it if I had something to say." Other comments were, "If you've got any complaints, you see them so you can tell them; they do sort it out, yes" and "You'd have to speak to [name]. There are two people here [who you could speak to]. I'm confident it would be sorted if you did." We did not see the complaints procedure displayed in the home and the registered manager said this would be actioned.

A system was in place to record and monitor complaints. There had been two complaints since the last inspection and both had been responded to positively.

Requires Improvement

Is the service well-led?

Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety, infection control [cleanliness audit], accidents and falls, and routine checks for health and safety regarding the environment such as fire safety. Some external audits were also seen as the registered manager actively promoted feedback from outside the home. For example, we saw an environmental audit from August 2016 by an external consultant and recommendations had been actioned.

The issues we highlighted on this inspection and also recommendations made, particularly the need for further development of a dementia friendly environment, including use of available day space, had not been identified or examined in any of the homes auditing systems. The computerised care recording system needed developing to include clearer reference to issues around the Mental Capacity Act 2005 and daily reflections by care staff. Although the registered manager had completed some higher level training in dementia care there had been no audits carried out using this background knowledge to further inform development of the service.

We would recommend that the development of good practice of care for people living with dementia is reflected in the development of the homes auditing and quality assurance systems.

The manager at Avalon EMI Care Home has been registered for a number of years with the Care Quality Commission [CQC] and has been a consistent lead providing continuity and building a positive culture within the home.

The feedback from all of the people we spoke with as well as staff was that the registered manager was providing positive leadership as well as good clinical skills and a solid knowledge base. They were described as supportive, open and consistent. They demonstrated a willingness to develop standards in the home and we saw they could reflect positively on the feedback we gave throughout the inspection.

People we spoke with commented, "On the whole we all get on very well – a nice atmosphere and "I'm happy here – I give it ten out of ten." A relative told us, "Management is fine [gave name of manager], although not around as often as they used to be; and I know I can phone them any time to speak to them. I get questionnaires emailed to me and I know there's a newsletter."

Staff were equally positive and cited the registered manager as strong lead and very accessible and supportive.

There was a clear management structure for the service from the providers, who were present in the home during the inspection and were a daily presence, to the registered manager and deputy manager. We saw some of the home's philosophy was related in the literature provided; for example the 'Statement of Purpose' and 'Service User Guide'. These documents were, however, rather formal and difficult to negotiate which meant they were not very user friendly. There were no more accessible documents available for

people living with dementia [for example] to access. We discussed with the registered manager the possibility of redesigning these to better suit the home and people living there.

There had been an updated 'shorter' version of the SOP developed in May 2017 and this stated, 'The views of service users are sought regularly and given full consideration throughout their time in Avalon EMI/DE Care Home, together with the views of relatives or agents'. We found strong examples of this philosophy. The registered manager advised us that regular one to one meetings with people and their relatives elicited the best feedback. We saw examples of notes from these interviews. 'Satisfaction' surveys were also sent out but these had had a poor response. For example a survey sent out in July 2017 had had a nil return and similarly in 2016 only four respondents. We discussed the layout and content of the survey, which was long and not very accessible or easy to fill in and the manager said they would devise a shorter more user friendly version. Those returned had been analysed however and we saw some action points, such as the renewal of the home's mini bus, had resulted from comments made. Other feedback such as the lack of space in the lounge areas still needed consideration.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Avalon EMI Care Home was displayed for people to see. The rating was not being clearly displayed on the care home's website. The registered manager informed us that the website was currently being 'rebuilt' and the rating would be displayed accordingly.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not always decision specific.