Elderly Care Home Limited

Avalon Nursing Home

Inspection report

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Ratings

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

Overall summary

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 37 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.

Accommodation was provided over two floors with two passenger lifts that provide level access to all parts of the home.

Our records showed there was a registered manager at the home, however this person was no longer in post at Avalon Nursing Home but worked at another home which belonged to the provider. They were in the process of deregistering as the registered manager with the Care Quality Commission (CQC) for this service. A registered manager is a person who has registered with the CQC to

Summary of findings

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. At the time of our inspection there was an acting manager in post. During the inspection the provider told us they were in the process of recruiting a new manager who would become the registered manager.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 3, 4 and 12 August 2015.

People's safety had been compromised in a number of areas. There were not enough staff on duty to safely meet people's needs. People's needs had not been taken into account when determining staffing levels.

Staff told us they understood different types of abuse. They told us what actions they would take if they believed someone was at risk. However, concerns raised were not always appropriately reported to the local safeguarding authority.

Medicines were stored safely and people received their medicines when they needed them.

Individual risk assessments to maintain people's health, safety and well-being were not in place for everyone and therefore placed people at risk.

Staff knew people well and were able to tell us about the care they required. However, care plans lacked details of how to manage and provide person specific care for their individual needs.

There was no information about how people decided where they would like to spend their day. There were a range of activities in place. However, staff did not use their knowledge of people to engage them in more meaningful activities throughout the day.

The premises were not always safe or hygienic. Cleaning products that should be locked away had been stored in an area that was accessible to people. Doors that should have been locked were open, this included a boiler room with hot water pipes. Communal bathrooms were used as storage areas and we saw linen and pillows stored next to a toilet.

Staff did not always follow the principles of the Mental Capacity Act 2005. Mental capacity assessments did include information about how decisions were made or what decisions people could make for themselves.

Mealtimes were disorganised and did not provide a pleasurable eating experience for people. Although people did receive support it was task based and not individualised. People told us staff were generally kind and caring however we observed occasions where people were not treated with respect and their dignity was not maintained.

Staff told us about the training they received however we were unable to view records to confirm what training staff had received. Supervision was not embedded into practice or valued amongst staff. Therefore not all staff received ongoing professional development through regular supervisions.

The provider had systems in place for monitoring the management and quality of the home but these were not always effective.

A complaints policy was in place. People and relatives were happy to discuss any concerns with staff. However, the provider was unable to find any records of complaints.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.<Summary here>

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Avalon nursing home was not safe.

There were not enough staff on duty to safely meet people's needs. Assessment of people's needs had not taken place to determine staffing levels.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk. However, concerns raised were not always appropriately reported to the local safeguarding authority.

Risks were not always safely managed. Individual risk assessments to maintain people's health, safety and well-being were not in place for everyone and therefore placed people at risk.

The premises were not always safe or hygienic. Cleaning products had been stored in an area that was accessible to people. Doors that should have been locked were open. Communal bathrooms were used as storage areas and we saw linen and pillows stored next to a toilet which could cause a risk of infection.

Medicines were stored safely and people received their medicines when they needed them. However, PRN guidance was not always in place.

Is the service effective?

Requires Improvement

Avalon nursing home was not consistently effective.

Staff did not always follow the principles of the Mental Capacity Act 2005. Mental capacity assessments did not include information about how decisions were made.

Not all staff received ongoing professional development through regular supervisions.

Mealtimes were disorganised and did not provide a pleasurable eating experience for people. Although people did receive support it was task based and not individualised.

People were supported to have access to see their GP when they needed to. However, people who were prone to falling had not been referred to the falls team.

Is the service caring?

Requires Improvement

Avalon nursing home was not consistently caring.

Summary of findings

We observed occasions where people were not treated with respect and their dignity was not maintained. People's preferences in relation to personal care were not always respected. The environment was cluttered and did not promote people's dignity.

Despite these concerns staff understood people's needs and preferences and we saw many occasions when staff treated people with kindness and compassion.

Is the service responsive?

Requires Improvement 

Avalon nursing home was not consistently responsive.

Care plans lacked details of how to manage and provide person specific care for their individual needs.

There was no information about how people decided where they would like to spend their day.

There were a range of activities in place. However, staff did not use their knowledge of people to engage them in more meaningful activities throughout the day.

A complaints policy was in place. People and relatives were happy to discuss any concerns with staff. However, the provider was unable to find any records of complaints.

Is the service well-led?

Inadequate 

Avalon nursing home was not consistently well-led.

The home had not notified us of any allegations of abuse or injury to people as legally required.

People were put at risk because systems for monitoring quality were not effective.

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 3, 4 and 12 August 2015. 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. 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 seven 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 seven people who lived at the home, eight relatives, and fifteen staff members including the acting manager and deputy manager and a visiting healthcare professional. 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.

Inadequate

Is the service safe?

Our findings

One person told us, "I feel safe here," another said, "I feel absolutely safe." Visitors agreed and their comments included, "I have no concerns about safety," and "I think it's a safe place." Some people who were able to use call bells told us they were generally answered promptly. We were told, "They come quickly when I press the bell," and "If I call them on my red button they're very quick to come." Others said "You have to wait a long time sometimes when you ring." A visitor said, "Sometimes people are told they'll have to wait." Most people and visitors said there was not always sufficient staff available to look after them.

We found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Staffing numbers varied throughout the inspection between seven and nine care staff in the morning and five or six each afternoon. Due to holiday and other absences there was one nurse working each day and was responsible for people's nursing needs and the general running on the home. Care staff said, "People have to wait, we need a nurse, we can't find her, and she's so busy." Another member of staff told us there was not always enough staff therefore, "The paperwork doesn't get completed properly." The nurse told us they had been unable to complete the medicine audits over the previous two weeks due to the other demands on their time. People told us, "They could do with a few more staff," and "There is sometimes enough staff and at other times not." We were unable to talk to a nurse as they were too busy. Therefore we returned the following week to speak with the acting manager and a nurse. A visitor told us it was often "chaotic" at the weekends. Staff told us care staff would often call in sick at the weekend, in addition there was only one nurse on duty which left them short staffed.

Staff were focussed on the work they had to do in ensuring people who did not want to stay in their bedrooms were in the lounges. They had little time to spend with people or talking to them apart from when providing care. We asked staff if they were able to spend time with people and just talk with them. They said they did not. One staff member said, "That's one thing that breaks my heart, people like a chat and we don't have time."

People who had been identified at risk of falls spent time in the main lounge. Other people who were not at risk of falling and preferred a quieter environment spent time in the quieter lounge. The quiet lounge was not continually supervised and people did not have access to call bells to contact staff if they needed them. A visitor told us they often observed people calling for staff or becoming distressed because staff were not available.

The provider told us they did not use any form of dependency assessment to determine how many staff were needed to look after people. We were told staffing levels were based on discussion with the acting manager on a monthly basis, feedback from the staff meetings as to whether they are able to meet the care needs of the residents and also complaints with regards to residents care due to staffing.

We found the provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of staff deployed. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection a concern had been raised with CQC about safeguarding issues not being raised appropriately with the local authority safeguarding team. Staff were able to recognise different types of abuse and told us they would report any concerns to the acting manager or the nurse. Although they were aware of who to report to outside of the provider they were not aware of their responsibility to do so. They said they believed any concerns reported to the nurses or manager would be acted on appropriately. However, staff told us of a concern that had been reported to the acting manager, and although actions had been taken to address this it had not been referred to the local authority safeguarding team to assess if further investigation was required.

People had not been protected against the risks of abuse or improper treatment because staff did not understand their individual responsibilities in reporting concerns. Concerns that had been reported to the manager were not always treated in accordance with local safeguarding policy and procedures. This was a breach of Regulation 13 (2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not always safely managed at Avalon Nursing Home.

We found that people with specific health problems did not have sufficient guidance in their care plans for staff to

deliver safe care. This included wound care, catheter care, diabetes and support for people who were prone to seizures. Some people did not have care plans in place for their specific need. For example, one person had a pressure wound. There was no care plan in place to inform staff of the wound. There was information in a separate tissue viability folder but this documentation lacked information on the status of wound. There were photographs of the wound, one had been dated but no measurement of the wound had been recorded, another photograph included a measurement of the wound but the photograph had not been dated. Neither photo had been labelled to show the wound location or position. The tissue viability notes included a description of the wound but it had not been measured. Therefore staff could not evidence if this wound was healing. Another person had a urinary catheter. Although staff knew about this there was no care plan and no guidance about how to care for this person in relation to their catheter care.

Risk assessments had identified people were at risk of pressure area damage. There was no information in place to inform staff of the correct settings for new air relieving pressure mattresses. We identified one person was using one of these mattresses. Staff told us there had been no guidance sent with the mattresses regarding settings so they were unsure how they should be set. The care plans informed staff to change people's position two hourly whilst in bed and to change their continence pads three hourly throughout the day. However, during the inspection we observed six people sitting in the communal lounges who did not have their positions altered or continence pads changed between 10am and 4pm. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage.

When care staff identified a change in a person's pressure areas for example a reddened area they completed a form which described the skin damage and where it was. The nurse decided what care or treatment the person required and this was recorded on the form. The form was completed daily by the care staff to show this care had been provided. We were told care plans were put in place if the skin damage did not improve. However we found one sore area had been present since 22 June 2015. There was no photograph or measurements of the area to demonstrate whether there was an improvement or worsening and no care plan had been implemented to provide further guidance.

Nutritional assessments were not always accurate. People's body mass index (BMI) had not always been correctly recorded. One person had been recorded as at medium risk of malnutrition whereas according to their BMI they were at high risk. For another person it was unclear how their BMI had been calculated. Therefore staff could not be sure if this person was at risk of malnutrition.

Accident and incident records were difficult to track as they were not in any order or audited. A number of unwitnessed falls had occurred. Incident forms contained information about what had happened, whether the person had sustained any injury and what actions had been taken immediately after the incident. Care plans had not been updated to inform staff of the risks and there was no information about what had been done to prevent a reoccurrence.

The personal emergency evacuation plans (PEEPs) were not in place and staff could not locate them. These are to ensure staff and emergency services are aware of people's individual needs and the assistance required in event of an emergency evacuation. The provider contacted the registered manager who no longer worked at the home and computerised copies were located. These had not been completed for a person who had recently moved into the home. This meant people were at risk of harm as essential information relating to their requirements in event of an emergency was not immediately available.

On the first floor fire emergency evacuation equipment had been stored in a cupboard but there was no signage to alert people where the equipment was stored. The provider told us, and staff confirmed, they knew where the equipment was but they would arrange for appropriate signage to be installed.

There were cleaning products stored in unlocked cupboards. Control of Substances Hazardous to Health (COSHH) is the law that requires employers to control substances that could cause harm to people's health. The provider explained these were placed in the cupboards whilst cleaning staff were on their break. However, some products had been placed in a cupboard in front of the fire

evacuation equipment, making it difficult to access in an emergency. In addition there was no risk assessment in place to identify if it was safe to leave these products unlocked even for short periods of time.

We saw COSHH products in the food cupboard near to the kitchen. The door to this area was open, and accessible to people. We saw one person had a risk assessment in place because they were likely to enter the kitchen unsupervised to obtain food. Although these products were labelled this may not be easily identifiable to someone living with dementia. Although these products were removed immediately by the provider people had been left at risk from harm because COSHH products had not been stored correctly.

A number of doors labelled to keep locked were not locked. This included a boiler cupboard where there were hot pipes and an electrical cupboard was secured with a bolt which could be accessed by people. There were three sluice rooms where, for example, commodes were cleaned and these were unlocked. In one sluice on the top floor an old carpet had been placed in front of the hand basin making it inaccessible to staff. Some COSHH products in the first floor sluice had expiry dates of 2013 and 2014 so staff could not be sure they were effective in the control of infection.

There was an unpleasant odour throughout the home and parts of the home were not tidy. Although the home was clean aspects of practice did not follow good infection control principles. In communal bathrooms we found people's toiletries including roll-on deodorant, a bar of soap and a hairbrush. These were not labelled so staff could not be sure who they belonged to. In a first floor shower room there was some bedding, including a pillow on the floor beside the toilet. The pillow was resting on the toilet seat. This is unhygienic and puts people at risk of cross infection from contaminated products.

In the main lounge, on the floor, under the television we noticed there were a number of slings which were used with hoists, footplates from wheelchairs and a pair of shoes. We heard staff discussing which slings to use for people who required hoists and it was clear from these discussions people did not have their own sling. This puts people at risk of cross infection.

Visitors to the home told us on occasions when administering medicines staff did not always take the time to make sure people had taken their medicines. However, we did not witness this practice during the inspection.

Medicine administration record (MAR) charts had been completed to show medicines had been given as prescribed. Medicines were received, disposed of, and administered safely. People took medicines 'as required' (PRN) only if they needed them, for example if they were experiencing pain. There were individual protocols in place to document why some medicines had been prescribed but not for all. We raised this with the provider and these were in place by the end of the inspection.

There was guidance in place for people who had been prescribed covert medicines. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. The nurses had a good understanding of the medicines people were prescribed and why

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment records were not complete. One application form did not have sufficient information to identify gaps in employment. References in another staff file did not include any professional references. These issues had not been followed up during the interview. This could leave people at risk of receiving care from staff who were not of good character or suitable to work at the home. Disclosure and barring checks (DBS) were in place to identify if prospective staff were suitable to work at the home. We discussed this with the provider as an area for improvement.

At the time of the inspection the provider was having a sprinkler system installed in the home. This was being undertaken a section at a time and there were risk assessments in place to ensure this was undertaken safely. Records showed regular servicing and health and safety checks had taken place. This included gas and electrical services, emergency lighting and fire safety checks.

Requires Improvement

Is the service effective?

Our findings

People told us food at the home was good. Comments included, "The food is very good, I like it, it's my type of food," and "The food is excellent, we get a choice, three in fact." Visitors told us their relatives had enough to eat and they enjoyed their food. They told us they could see a doctor whenever they needed to. However, we found that Avalon Nursing Home did not consistently provide care that was effective.

We understood from the local authority quality monitoring team that applications for Deprivation of Liberty Safeguards (DoLS) had not been made for everybody who required one. At the time of our inspection these applications were in the process of being made and DoLS authorisations were in place for two people.

The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. There were DoLS assessments in the care plans however these were generalised and did not reflect the Supreme Court ruling (March 2014) which stated, people who are under continuous supervision and control and not free to leave are deprived of their liberty. They did not show when authorisations were required or in place. Where DoLS applications or authorisations had been made there were no care plans in place to reflect this or inform staff.

Staff did not always follow the principles of the Mental Capacity Act 2005 (MCA). The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. Staff told us most people were unable to consent to care and treatment. Although mental capacity assessments had been undertaken they were generalised, for example there was no information about how people had consented to have their photographs taken or share information. They did not identify what decisions people were able to make for themselves for example what to eat or what to wear. Some people shared bedrooms and there was no information to show what discussions had taken place or how these decisions had been made. Staff told us people had shared rooms for a number of years and discussions had taken place at that time. However, there was no evidence of any reviews to show people were still happy to share bedrooms.

Mental capacity assessments did not include information about how decisions were made or how people's freedom may be restricted. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime experience at the home. Some people chose to eat in their rooms. Others ate in one of the two lounge/dining areas. There were dining tables available in both lounges however these were not used. As a result of persistent false fire alarms during the lunchtime period, lunch took quite some time, with the result that some people had fallen asleep after the main course.

There was a chalk board in each lounge to show the menu for the day, this had not been used on the first day of the inspection. When we asked, staff were unable to find the chalk to write it up. However, the menu was displayed on the second day. There were no individual or pictorial menus for staff to use to prompt or remind people. It is important for people who are living with dementia to maintain a sense of structure and familiarity for example sitting at a dining table with other people if this is something they are used to. The lack of structure meant that lunchtime was not an enjoyable experience for people.

One of the chefs was responsible for managing the lunchtime, plating meals and ensuring that each person received the meal they had chosen. Meals were presented attractively with good portion sizes which had been adjusted for particular individuals. Meals were served to people and then staff provided people with cutlery, this was not always done immediately leaving people to wait a short time which risked them eating food that was lukewarm.

People did not sit in positions that supported them to eat independently. The individual tables were low; people frequently spilt food down their clothes and had difficulty accessing their meals. Although people were given napkins to cover their clothing these were not effective. One person became upset when their clothes were soiled by their meal.

There did not appear to be a clear plan for providing support to people who needed help to eat. Although people did receive this help it was task-based and on one

Is the service effective?

occasion passed from one member of staff to another for the same person. One member of staff stood over a person to provide the support, and did not attempt to engage with the person. Another staff member was supporting a person however another person required reassurance and encouragement and was calling to the staff member for support**.** The staff member demonstrated a good level of skill in supporting both people. She explained what she was doing and kept both people engaged throughout the mealtime. However, this did not make the mealtime a pleasurable experience for these two people.

There was not a consistent approach from staff with relation to supporting people who declined their meals. On some occasions we observed staff offering alternatives and supporting people until they found something they would like to eat. On other occasions when people refused there was no attempt to offer an alternative.

Nutritional assessments in people's care plans did not always inform staff they needed to complete a food or fluid chart. Food and fluid charts were incomplete and not reviewed, and therefore were not an effective way of monitoring people's health. One person's care plan stated the person was on a pureed diet and to follow guidance from the speech and language therapist (SALT). However, no guidance was available. Where people had lost weight there was not always evidence that any action had been taken to prevent further loss.

The provider had not ensured that the nutritional and hydration needs of people supported their well-being. This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food was freshly cooked each day following people's meal choice in the morning. The chefs and staff had a good understanding of people's dietary needs in relation to specialised diets for example diabetic or pureed. They knew about people's individual food choices, preferences and portion sizes. Although we saw examples of poor staff interactions at mealtimes we also observed staff supporting people appropriately. Spending time to find out what they would like to eat, engaging with them throughout the mealtime and encouraging and prompting them to eat their food. We raised our concerns with the provider and when we returned on 12 August 2015 we saw a number of people were sitting at the meal tables to eat their lunch.

There was a supervision programme in place but this was not embedded into practice. Staff told us they received regular supervision and could talk to the acting manager or deputy manager whenever they wished. However, staff told us they could opt to receive supervision three or six monthly. One staff member told us, "Supervision is a waste of time, if we have a problem we talk to someone." This meant the provider could not identify the learning and development needs of staff because there was less opportunity for individual support and the process was not valued by staff.

Staff had not received appropriate support, supervision and appraisal to ensure their competence was maintained. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular training and this included safeguarding, infection control and moving and handling and the training they received enabled them to provide appropriate support to people. We observed them supporting people appropriately throughout the inspection. We saw certificates in staff files which confirmed staff had received training. A number of care staff had undertaken health and social care diploma training and some had recently completed a distance learning course in dementia care. Staff told us they had enjoyed the dementia training as this had helped them understand how to provide care for people. One member of the care staff said, "We're told to think outside the box, but dementia training made me look at what I'm doing and realise that's what helps people." The nurses told us they received training updates in relation to their clinical skills. This included would care and catheter care. Nurses had received training about medicines management and had also had regular competency checks to ensure that their knowledge and practice was of a suitable standard. The policy stated competency checks were to take place six monthly however no competency checks had taken place since September 2014. However, the provider was unable to show us an overview of the training all staff had received. They told us they would send us a copy following the inspection. We had not received this at the time of writing this report.

The design and adaptation of the home did not always meet the needs or promote the independence of people living with dementia. The home was divided into two areas although these were not clearly distinguishable. Both areas

Requires Improvement

Is the service effective?

had their own bedroom numbers, for example there was a bedroom one in both areas. It was possible to get lost in corridors; there was no signage to guide people for example to the lounges or bedrooms. Some bedrooms did not have numbers (or names) on the door and there was nothing in place to support people to identify their own bedroom. There was no use of pictures for example to show people where the toilet was.

People said that there was no problem in getting to see a doctor if needed and that staff would arrange this for them.

Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP's, tissue viability nurses, optician and chiropodist. We spoke with one healthcare professional who told us staff contacted them appropriately when they required support. Visitors we spoke with told us if there was any change in their relative's health the appropriate healthcare professionals were contacted.

Requires Improvement

Is the service caring?

Our findings

People said that the majority of staff at Avalon were kind and caring, although they noted that there were some individual exceptions. One person told us, "Staff are definitely kind, maybe one or two who are a bit abrupt." Another person said, "Some are very pleasant, with others it's you'll do as I say." Visitors told us most staff were, "Genuinely caring and loving." Other visitors said, "99% of the staff are kind and caring, you might get the odd one who's a bit off," and "The carers are really good, I've had one or two issues with a couple of them but spoke to matron and sorted it out."

Although we observed staff engaging with people in a kind and caring way people were not always treated with the respect and dignity they deserved. At mealtimes people were not assisted to sit in a position where they could eat their meals in a dignified way. We observed another person whose clothes were soiled after their meal was not asked if they wanted to change.

Dining tables were cluttered with dirty cups and staff paperwork and were not inviting for people to use. People ate at individual tables which were brought to the armchair they were sitting in. These were not well presented, for example they were not laid with cutlery or condiments. Some people had spilt food on the floor this had not been cleaned away. A visitor told us, "I do feel some of the residents should be cleaned up after their meals." Where people required support at meal time's staff did not always engage with the person and the support on occasions was passed to another member of staff.

Staff told us because there was not always enough staff people's choices in relation to personal hygiene were not always respected. One staff member said, "When we are busy we don't have time to bath or shower people, we wash them in bed." Another staff member told us when people were put to bed at night they were often wet and their continence pads appeared not to have been changed for some time. Although records showed people received oral hygiene each day we saw toothbrushes in some people's en-suite bathrooms were dry and had not been recently used.

We were told people who were most at risk of falls spent their time in the main lounge as there was always a member of staff present. However, people were not asked if they were happy with this arrangement, or for example would they like to sit somewhere quieter. We observed six people who needed support with their mobility spent up to six hours sitting in the lounge without a change of position or being asked if they wanted to sit elsewhere.

Staff did not always provide a dignified environment for people to live in. The main lounge was cluttered. We saw people's toiletries including a hairbrush remained in a communal bathroom these were not named and it was unclear who they belonged to. In one communal bathroom there was an open packet of continence pads, these pads should be stored in a dry environment as they could absorb moisture from the atmosphere which would reduce their effectiveness when used. We observed one person in bed in a shared bedroom. The second bed had been stripped as the other person was in the lounge. There were three bags of soiled continence pads left on the floor. This did not show any respect to the person who remained in the room. During the inspection a training session was held for staff in the quieter lounge. Three people who lived at Avalon Nursing Home were sitting in the lounge were left to sit there whilst the training went on around them. Staff were unable to tell us whether people had been offered the choice to move to another room.

People were not consistently treated with dignity and respect in ensuring their personal care needs and individual choices were met. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we saw many other occasions when staff treated people with kindness and compassion. We saw staff comforting and reassuring people who were distressed for example when they were being moved with the hoist. Staff spoke with people discreetly, giving them eye contact and listening to what they said.

Although people were not always given choices it was clear staff knew people well. They were able to tell us about people's care needs, likes, dislikes and individual preferences. They told us, and we observed, how they communicated with people who were less able to express themselves verbally. This included observing how people responded to questions and gestures. Some people preferred to spend time in their bedrooms and staff respected this. People who were able to moved freely around the home.

Requires Improvement

Is the service caring?

Staff spoke with people using their preferred name. People's privacy was maintained, staff knocked at bedroom doors before they entered and introduced themselves as they went in. Some people shared bedrooms; we observed screens were available to ensure people had the privacy they required. We observed staff speaking quietly and discreetly with people in communal areas.

Requires Improvement

Is the service responsive?

Our findings

Care plans lacked details of how to manage and provide person specific care for individual needs. Reviews took place regularly however information from the reviews was not used to update people's care plans. There was limited evidence to show how people or their representatives had been involved in reviews of care plans. We saw the care plan for one person stated the person required support to manage their continence. The care plan informed staff the person was able to ask to use the toilet. There was also information about symptoms the person may display if they needed the toilet. A care plan review in July 2015 stated this person now had a catheter in place. However, the care plan had not been updated to reflect this new need. Although staff knew about the care this person required there was no care plan in place to inform them about the care and support this person required. Daily notes did not reflect the care people received. There was no guidance how to communicate with people who were less able. People who lived at Avalon nursing home had complex nursing needs. Although staff could tell us how they looked after people there was a risk because new staff or staff who had not met people previously would not be able to refer to the records and there was no guidance to ensure consistency.

Where people were prescribed topical medicines such as creams the MAR charts were completed to demonstrate the medicine had been applied. There were no care plans or body maps to inform staff where this medicine needed to be applied. Staff told us they were informed in handover who needed what cream. This was then applied and the nurse informed to sign the MAR chart. There was no guidance in place to ensure consistency.

We were told about a specific mouth care regime which one person required. There was no guidance in the care plan, no risk assessment in place and information in the oral care assessment did not identify any concerns. Staff told us about how they supported this person but there was no evidence specific guidelines were followed. This did not ensure consistency or demonstrate evidence that people's needs were met.

Although staff knew about people's individual waking and bedtime routines or what people liked to do during the day there was no information in care plans in relation to personal care were not detailed, they did not include information about how much people could do for themselves, whether they needed full support or were able to maintain some independence through prompting, reminding and encouragement.

There was not an accurate, complete and contemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some information about people's past interests and hobbies however activity plans did not contain guidance for staff about how they could support people to continue with these interests. One person was who was distressed on occasions was telling us about their spiritual needs. Although staff treated this person with kindness there was no guidance to provide specific or appropriate support and comfort to this person.

There were three activity co-ordinators employed at the home and all activities were undertaken by/with them. There was one or two on duty each day. One would spend time supervising people in the busier lounge to ensure they were not left unattended. However, these people required individual or small group activities and there were periods of time when people were sat doing nothing or dozing but enjoyed interaction when approached by staff. A visitor said, "There's not enough activities, the care staff don't really do enough with them." People told us they would like to go outside for a walk or to the nearby park. One visitor said, "My relative would love to go for a walk." Another visitor told us, "None of the residents ever gets taken into the garden." When activity co-ordinators were not at work care staff did not take advantage of opportunities to engage people in meaningful activity. One person said about the staff, "I don't think they have the time to get to know you."

The activities co-ordinators gave us examples of activities that had taken place which had been specifically adapted to meet people's needs. For example one activity co-ordinator told us about a quiz that had taken place for three people. Activity notes recorded how people had participated and whether they had enjoyed themselves. For people who were less able to engage with activities or liked to remain in their bedrooms we were told, "We see people in their rooms (for activities) at least once a week." There was no clear plan or guidance in place to demonstrate how these people's social needs were met.

Requires Improvement

Is the service responsive?

The priority was to ensure people in the busy lounge were not left unattended but people in the quieter lounge sat for long periods of time without staff supervision or anything to do. People in the lounge had no access to call bells to summon assistance. One person was able to express themselves and asked to watch the television however other people were not asked if they were happy to watch the program this person had chosen. We were told about two people in the quieter lounge who would often call out and we observed one of these people required constant reassurance and responded happily when staff engaged with them. One visitor told us there was always a member of staff in the main lounge but the quieter lounge was unsupervised. The visitor said, "People here still need supervision, staff do come in but they don't know when people want help." There was no information about how people decided where they would like to spend their day. For some people we were told this was based on their likelihood of falling rather than individual choices.

Care at this time was 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 is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their visitors said that they would be happy to make a complaint if needed and some had done so. One person told us, "I would be happy to tell someone about a complaint, I think I'd tell the acting manager." Another person said, "If I had a complaint I'd go and see the manager." Visitors told us they were happy to discuss any concerns with the acting manager. They told us the acting manager was approachable and they could talk to her easily. One visitor told us when they had previously raised concerns, "The manager had got them sorted out."

There was a complaints policy in place and this was available to people at the home. The provider told us how any complaints received were handled. We looked at the complaints folder and found this did not contain any complaints. The provider was unsure where these had been stored. This is an area that needs to be improved.

Inadequate

Is the service well-led?

Our findings

Our records showed there was a registered manager at the home; however we were told this person no longer worked at Avalon Nursing Home but at another home which belonged to the provider. We were told they were in the process of deregistering as the registered manager with the CQC for this service. A registered manager is a person who has registered with the CQC 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. At the time of our inspection there had been an acting manager in post since May 2015. This person had worked at the home for a number of years prior to taking this role. During the inspection the provider told us they were in the process of recruiting a new manager who would become the registered manager. The provider told us in view of the concerns we had identified during the inspection they would be working at the home to support staff until the registered manager had been appointed.

There were systems in place for monitoring the management and quality of the home but these were not always effective. Care plan audits had not identified that care plans and risk assessments did not contain sufficient information for care to be provided safely, effectively and in a person centred manner. They had not identified that people's specific health needs were not accurately reflected in their care plans.

The provider had not identified people's safety was potentially at risk from inadequate staffing levels. Staff told us that agency staff were not used at the home because, "It took too long to explain what needed to be done." This meant the lack of information in the care plans was affecting the day to day running of the home which impacted on care delivery.

There was no analysis of falls to identify themes and trends across the home, or that people's nutritional needs were not being managed effectively. Systems had not identified the environment was not always clean and for people who lived with dementia was not suitable to support them appropriately or safely.

Whilst staff were happy to provide us with any information we required during the inspection this was not always readily available for example the PEEPs. People's care records were not always stored securely, the trolley was in the hallway and this was not always locked which meant anybody could access people's care plans. Although we were told staff received regular training there was no available overview of what training staff had received or what they may require.

The provider and acting manager told us they were working at the home each day until a registered manager had been appointed. It had not been identified what areas each of them would be responsible for or how this arrangement would work. During our inspection the acting manager was working on the floor providing care to people whilst the provider identified a format for re-writing care plans. There was a lack of leadership at the home. In the absence of a registered manager it was not clear who was taking overall responsibility for the day to day running of the home, who staff should report to or who was responsible for decision making.

It did not appear that staff were supported or encouraged to identify shortfalls or areas for improvement. Staff appeared to be reliant on having things pointed out to them and being told what to do. For example the provider told us they had previously identified concerns related to the lunchtime experience for people. As a result they had carried out a number of lunchtime observations which had all been positive therefore the observations had stopped. However, we identified this was now an area for improvement.

An audit in April 2015 had identified one person who required a diet care plan. Although this was addressed a further provider audit in June 2015 identified another person required a diet care plan. Staff had not applied any learning from the previous audit where a shortfall had been identified and apply to other care plans.

The lack of supervision meant the provider had not identified whether staff needed further training or support to meet people's needs. Or whether they were aware of the requirements and responsibilities of managing a nursing home. Staff did not appear to fully understand what was required of them in relation to accurate record keeping. One staff member who was responsible for reviewing care plans told us, "Care plans are never rewritten, new information is put into the review section." Other staff assured us people received the care but, "It wasn't always written down."

Inadequate

Is the service well-led?

The culture at the home was not always open. People, visitors and staff told us the acting manager and the deputy manager were approachable. Staff told us the provider was often at the home and they could talk to her at any time. Whilst staff told us they were able to discuss any concerns related to people who lived at the home they told us they were not confident that all information shared would be treated as confidential. Staff told us if they had concerns about a colleagues practice or behaviour they did not have confidence they would be listened to or taken seriously. One staff member said, "Sometimes the team dynamics don't work." Another staff member said, "Not all staff are treated equally, some have more privileges than others." For example staff explained a number of staff smoked and they often, "Popped out for a cigarette" which left other staff to do the work. We saw this concern had been discussed in a staff meeting however no action had been taken to address this.

People and visitors spoke to us about issues related to staffing regarding sickness and staff conflicts. This was information people could only have acquired from staff which indicated to us the culture of the home was affecting people who lived there.

The provider did not have a system in place to assess and monitor the service that responded to people's changing needs. People had not been protected against unsafe treatment by the quality assurance systems in place. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered person (provider or manager) must send notifications about incidents that affect people who use services to the Care Quality Commission without delay. We were aware of allegations of abuse however the provider had not submitted any statutory notifications or notified us of any allegations of abuse or injury to people who lived at the home. This meant that we did not have the opportunity to assess if the events affecting people who used the service needed CQC to take further action if required. This is a breach of Regulation 18 of The Care Quality Commission (Registration) regulations 2009.

Staff, resident and relatives meetings took place regularly and a recent meeting had informed people about the installation of a sprinkler system. People and relatives raised concerns for example the safekeeping of their belongings whilst works were taking place. The provider had introduced secure storage for people, other measures included maintenance staff accompanying the builders whilst they were in the home.

Quarterly surveys had been sent to staff, people, relatives and professionals. The latest survey from staff highlighted the lack of storage and the provider told us there was being addressed by converting a bathroom and there was an action plan in place to demonstrate this was planned. A new survey format for professionals and relatives had not been a success and the provider told us this would be reviewed prior to the next survey. There was an annual development plan in place from February 2015 and amended in June 2015 this highlighted the need for involving people and families in care plan reviews.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found the registered provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of staff deployed.** **Staff had not received appropriate support or supervision.** **Regulation 18(1)(2)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider had not protected people against the risks of abuse or improper treatment because staff did not understand their individual responsibilities in reporting concerns.** **Regulation 13(2)(3).**

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.** **Regulation 11.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered person had failed to notify the Care Quality Commission about any incidents that affected people who used the service. Regulation 18(1)(2)(a)(e).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 Care was task based rather than responsive to individual needs. The provider had not ensured that the nutritional and hydration needs of people supported their well-being. Regulation 9(1)(a)(b)(c)(3)(a)(b)(i)

The enforcement action we took:
Warning notice

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 People were not consistently treated with dignity and respect in ensuring their personal care needs and individual choices were met. Regulation 10(1)(2)(a)(b)

The enforcement action we took:
Warning notice

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 Care and treatment had not been provided in a safe way. The premises were not always hygienic or safe to use. Regulation 12 (2)(a)(b)(d)(g)(h

The enforcement action we took:
Warning notice

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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.

Regulation 17(1)(2)(a)(b)(c)(d)(f).

The enforcement action we took:
Warning notice