Maison Care Ltd

Avalon

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out 5 October 2016 and 11 October 2016. It was unannounced. During our last inspection in August 2015 we found that the service needed to make improvements in its recruitment processes and quality assurance systems. During this inspection we found that improvements had been made and the service met the required standards.

Avalon is one of four homes run by a family business. It provides care and accommodation for up to four people who have a learning disability. At the time of our inspection there were four people living at the home, although one person was in hospital.

The home did not have a registered manager in post at the time of our inspection, although the manager's application to become registered was being processed. A registered manager is a person who has registered with the Care Quality Commission (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.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences. Where people had been involved in incidents because of behaviour that could have a negative effect on others, the triggers for such behaviour had been identified and action taken to reduce the occurrence of such behaviour.

There were enough skilled, qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. Staff received training to ensure that they had the necessary skills to care for and support the people who lived at the home, and were supported by way of supervisions and appraisals.

People's needs had been assessed before they moved into the home and they and their relatives had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People decided what food and drink they had and a variety of nutritious food and drink was available to them. Snacks and fruit were available to people throughout the day. People received their medicines as they had been prescribed and medicines were managed safely.

Staff were kind, caring and protected people's dignity. They treated people with respect and supported people in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to and about the services provided at the home. People were assisted to access other healthcare professionals to maintain their health and well-being. Staff worked with other healthcare professionals and people's relatives to ensure that the support provided to people best met their needs.

Staff were encouraged to attend meetings with the registered manager at which they could discuss aspects of the service and care delivery. Relatives and other healthcare professionals were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place and the provider was made aware of any required improvements that had been identified following quality audits.

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.

People's medicines were administered safely and as it had been prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink.

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People had robust care and support plans in place to meet their

individual needs.

People were supported to follow their interests and hobbies.

There was an effective complaints policy in place.

Is the service well-led?

Good

The service was well-led.

There was a manager in place who had made an application to become the registered manager. They were mentored by the provider's Organisational Manager on a weekly basis.

The manager was visible and approachable.

There was an effective quality assurance system in place. Information on the quality of the service was reported to the provider by way of reports to the Clinical Governance Committee.

Avalon

Detailed findings

Background to this inspection

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

This inspection visit took place on 5 October 2016 and telephone calls to people's relatives were made on 11 October 2016. The visit was unannounced. The inspection was carried out by one inspector .

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with two people who lived at the home, two senior care workers, the provider's Operational Manager and the manager. Following the inspection visit we spoke with a relative of one person who lived at the home.

We observed the interactions between members of staff and the people who lived at the home and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records and risk assessments for two people. We also looked at how people's medicines were managed.

We looked at two staff recruitment records and training, supervision and appraisal meeting schedules for all staff members. We reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Good

Is the service safe?

Our findings

People were unable to tell us of their experience of living at the home. However a relative we spoke with told us that people were safe living at the home. They said, "There is absolutely no doubt that [name] is kept very safe. They really do keep a close eye on people."

The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm because staff knew who had come into the home. We were told this information would also be used to ensure that everyone in the building was accounted for in the event of an emergency.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I would report any concerns to [registered manager] as the first port of call. It would also be reported to Social Services and CQC. The police may also be involved." Staff we spoke with were able to explain the types of harm that people may be exposed to.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. We saw that risk assessments had included risks associated with people using the household appliances, such as the washing machine, tumble drier and hoover. They also included risks associated with people accessing the community, taking their medicines and as a result of behaviour that had a negative effect on other people. The latter risk assessments included the various steps staff should take to de-escalate situations if they arose, such as distracting the person with another activity. One member of staff said, "We try to de-escalate situations but it depends on the individual. Distraction will only work if you know the client and they are comfortable with you."

One member of staff told us, "The risk assessments help us mitigate the risks. All the details we might possibly need to know are written down. For example when [name] is going out [they] have no road sense. The risk assessment gives each detail we would need to keep [them] safe." Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Actions to reduce the risks posed to people were amended when this was appropriate. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and talking about people at shift handovers. One member of staff told us, "Any change in people's behaviours is discussed at shift handovers. There is a complete handover between the seniors on the shifts when we inform each other of any changes to any risks."

The manager had carried out annual assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances.

Checks were also carried out to ensure that equipment had been serviced and portable appliances had been tested. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. Copies of these were in people's care records and in a folder by the emergency 'grab bag' that was readily accessible by staff. The 'grab bag' also contained emergency contact numbers and a copy of the service's business continuity plan. Regular fire drills were carried out. These enabled people and staff to know what to do should an emergency occur. The service had been inspected by the fire protection service in September 2016 and the fire precautions had been found to be satisfactory.

Accidents and incidents were reported to the registered manager and where appropriate reported to external bodies, such as the local authority safeguarding team and Care Quality Commission.. We saw that the registered manager kept a record of all incidents which was analysed on an individual basis. Where required, people's care plans and risk assessments had been updated. The manager reviewed the records regularly to identify any possible trends to enable appropriate action to be taken to reduce the risk of an accident or incident re-occurring. Where people had incidents of behaviour that had a negative impact on others the triggers and the times when this behaviour was observed were identified and recorded. A graph was developed to identify if these occurred at certain times of the day. The person's behaviour leading up to the incident was also recorded to enable staff to identify ways in which the recurrence of incidents may be reduced.

Relatives and staff we spoke with told us that there were enough staff on duty. One relative told us, They make sure they get the right number of staff, even when they have not been funded for it all." One member of staff said, "We have [one person] in hospital and that has meant that we have used agency staff. Staff go up to support [name] in the hospital and work alongside the staff there three times a week. There are usually five or six staff on shift in the morning and four or five in the afternoon, but it depends on what activities people are doing. We are happy to cover [shifts] for each other as much as possible. There are always two staff on at night."

We looked at the recruitment documentation for two members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

People were supported by staff with their medicines. Medicines were stored in a locked trolley within the room used by staff when 'sleeping in' at the service. This room was locked when unoccupied. Only competent care workers administered medicines and staff confirmed they had received regular training updates. We looked at the MAR charts for all of the people who lived at the home and saw that these had been completed correctly and medicines received had been recorded. There were protocols in place for medicines that had been prescribed on an 'as needed' basis and for those administered when needed, but were no longer prescribed by the GP, such as Paracetamol. Where people required creams to be applied there were body maps in place that informed staff where the application was to be made. We checked stocks of medicines held for one person which were in accordance with those recorded. There were robust processes for auditing medicines administration and temperatures inside the medicines trolley and the room in which it was stored were checked and recorded daily. We saw that a fan had been installed in the room to ensure that the temperature did not exceed that recommended by the manufacturers of the medicines. This ensured that people received medicines that had not lost their effectiveness because of damage caused by excessive heat.

Good

Is the service effective?

Our findings

A relative told us that staff had the skills that were required to care for their loved one. They said, "All the staff are very good." In a recent survey a relative stated, "Even when there are inevitable staff changes the level of care and attention is undiminished."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I had an induction booklet which had to be completed within the first three months. I did a lot of shadowing (watching experienced staff), probably for about a month. I read the care plans and policies and procedures." Another member of staff told us, "The admin lady keeps the training matrix and if we are getting close to the expiry of any training, she gives us a reminder and places it in our training folder." They went on to tell us about the physical intervention training that all staff had received. They said, "We learned various holds, but it was 95% about de-escalation techniques. We needed it as we had one person [who need more support]. It helped a lot." Another member of staff told us about mental health training that staff had received. They said, "It made me understand mental health a bit more and things to recognise that you might not think of as mental health issues. It was a very, very interesting course. We did it in two groups and I am now more confident with dealing with mental health issues."

The manager told us that most on-going training was completed by way of a recognised on-line training system, which was also used to monitor that staff had updated their training when this was due. However, they said some training was delivered face to face, such as the physical interventions and mental health training.

Staff told us that they had regular supervision meetings. One member of staff said "We have supervisions every four to six weeks. We talk about how we're feeling, working relationships with other members of staff, any issues with the [people who live at the home], how things have been since the last supervision and what we want to achieve by the next." Another member of staff said, "During supervision we talk about ways to improve practice, any training I would like, how training is going, how home life may be affecting work life. It is a very open process." The manager was mentored by the provider's Operational Manager and had weekly supervision meetings with them.

Staff told us that they also had recently had an appraisal. One member of staff said, "I had a formal appraisal with [manager]. This was more focussed on where we want to be going than a supervision. Both [manager] and I filled in paperwork beforehand and we swapped and discussed them at the meeting. We looked at them together."

People's capacity to make and understand the implication of decisions about their care had been assessed prior to their admission to the service and documented within their care records. One member of staff told us, "Everyone here has mental capacity and can decide for themselves, but we still look at it." The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make

their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. There were DoLS in place for two people as they were supported on a one to one basis at all times. One person had a paid advocate appointed to act on their behalf.

Staff told us that people made their own decisions as much as possible. One member of staff said, "Everyone has the right to make choices. Whether it is the wrong choice is not for me to say. If I thought it was the wrong choice I would look up the pros and cons and explain these to the service user. I would still let them do it unless what they wanted to do would endanger their life. We have a duty of care and would have to make a decision that was in their best interests." We saw that staff asked for permission before they supported people with various tasks throughout our inspection and staff told us that they always gained consent from people. Another member of staff told us, "They all have choice boards. They have loads of pictures [to tell us what they want] and are offered alternatives such as to go for a walk or a drive."

People had a good variety of quality and nutritious food and drink. A relative told us, "The diet is very good, better than when [name] is at home. It is really good as they don't buy or give people any processed foods. They get the [people] involved in the cooking. For example if they are having home-made pizza the [people] will grate the cheese and add their own toppings. The repertoire of what [name] will eat is much wider. The other day they had a home-made curry. I did not know [name] likes curry so it will give us a wider choice when [name] comes home." A member of staff told us, "We are encouraging healthy eating but without dieting. There is always a fruit tub in the kitchen for people to help themselves. We have a three weekly menu and there is always two choices. We use picture menus as it is easier for them to understand."

Records showed that people were supported to attend appointments with other healthcare professionals, such as GP's, mental health professionals, dentists and opticians to maintain their health and well-being. One member of staff told us, "We get a lot of support from the doctors. We are working alongside staff at the [name] hospital at their request to look at if there is anything they could do to improve the care for [name] whilst [they are] there and vice versa. We try to come up with strategies that may help in supporting them."

Good

Is the service caring?

Our findings

People were unable to tell us of their experience of living at the home. However a relative told us, "However challenging [name] is they are so lovely to [them.] It has such a homely atmosphere." In a recent survey a relative stated, "Staff, without exception, are all friendly and so kind to [name]."

We observed that staff knew the people well and people knew the staff who supported them. One member of staff told us, "[Name] can use Makaton, [another person] can read so everything is written for them although they do understand what we say to them . [Third person] can be verbal but we do use pictures of reference with them." Staff were aware of people's life histories and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives. This had helped them to support people to set goals for the future.

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff spoke appropriately with people and people enjoyed interacting with the staff.

Staff told us of ways in which they promoted people's dignity and maintained confidentiality. In a recent survey a relative stated, "[Name] is always clean and smelling lovely, shaved, etc." One member of staff told us, "I take their thoughts into consideration. I make sure I knock on doors and close doors. If I am providing personal care I put the sign up to tell others not to come in." They went on to say, "I treat them as I would want to be treated in their place. I tell staff that this is their home, we only work here." A comment received from a health care professional in a recent survey described staff as, "Very respectful of the people they support."

People were encouraged to be as independent as possible. One member of staff said, "I encourage people to be as independent as possible, like making choices and learning general life skills. If they want a sandwich I would show them in pictures how to do it, such as washing their hands, getting the bread, spreading the butter." Staff told us that one person has an electronic organiser that shows their daily routine using photographs of the individual performing daily living tasks. This gave the person information about their next task or activity for each day of the week. The person was more able to identify with the task as the photograph showed them performing it.

A relative we spoke with told us that they were able to visit whenever they wanted to. They said, "It is a very open atmosphere. I can just pop round to see [name] at any time. It really gives me confidence." They went on to say, "They give me any information I need. They tell me things that they do that get good results so I can try them when [name] comes [to visit at] home. I can literally pop in, pick up the phone or e-mail them about anything. There is really open communication." We saw that information, such as how to make a complaint, was available for people in easy read format.

Good

Is the service responsive?

Our findings

A relative told us that they were involved in deciding what support their relative needed and how this was to be provided. They told us, When [name] first went to Avalon they talked to me then the support plans were drafted and e-mailed to me so I could add or correct anything." Before people joined the service the manager had visited them to assess their needs and to determine whether the service was able to fully meet them.

The care plans followed a standard template which included information on people's personal history, their individual preferences and their interests. The care records included the names of the people involved in the multi-disciplinary team that supported the individual and had been involved in their care and decision making. Each support plan was individualised to reflect people's needs and included clear instructions for staff on how best to support people with their specific needs and tasks associated with these. One record included plans that covered the individuals' preparation of a hot drink for themselves. This included guidance for each step of the process, including reminding them that they only need a little milk for a cup of coffee. Support plans were in place for people's independent living and physical and emotional well-being needs. In a recent survey of health care professionals one comment received was, "One of the more 'person centred' services I have worked with, great staff with a real passion to support well and ensure that the needs of the individual are met at all times."

People and their relatives were involved in the regular review of their support needs. A relative told us, "We have regular meetings and if any changes are needed to [name]'s support plans they talk with me about these." Each person who used the service had been allocated a key worker who completed a monthly review with the individual and produced a monthly report. During these monthly reviews the key worker looked at the support plans and if changes to these were required, these were updated after they discussed with the manager.

People were supported to maintain their interests and hobbies. Each person had a weekly schedule of activities. However a relative told us, "They adapt the routine to suit [name]'s moods. They are really reactive to the mood [name] is in. Sometimes [name] needs somewhere quiet." The scheduled activities included shopping trips, cooking, going for a drive, swimming and attendance at a local club. For one person this was on their electronic diary as well as the pictorial 'Now and Next' boards that each person used. This showed the activity that they were currently involved in and the one they would do next. A member of staff told us that these were a useful way of limiting the amount of drinks for some of the people who would otherwise drink excessively. One person had a vehicle provided under the Motability scheme which was used to take them for drives and other outings. Their relative told us, "[name] is due a new vehicle in December. [Registered manager] deals with things related to this." In a recent survey a relative stated, "[Name] has a better social life than anyone I know."

We saw that one person was particularly interested in watching videos on a smartphone which they carried with them throughout the time of our inspection. They shared their experience with members of staff as well as our inspector. Staff engaged people with various activities and games. One member of staff spent time on

the floor with one person whilst they played an interactive game together. Staff told us of other activities that people were regularly involved with. One person was able to make regular trips to a local zoo as they had acquired a gold card that enabled them to visit as many times as they wished during the year. A senior support worker also had a gold card so was able to support the person when they wanted to go. People also had membership of the National Trust. The registered manager had introduced evaluation records that staff completed for each activity so that activities that people liked could be pursued whilst those that people did not engage with well could be replaced. One member of staff told us, "We have an activity sheet which we fill in daily as to whether the activity was beneficial to the person or not. People get personal money and activity money from Head Office."

There was an up to date complaints policy in place and the manager listened to people's concerns. Information about the complaints system was available in a format that people could understand. A relative told us that they were aware of the complaints policy but had not had to use it. They said, "If there was a problem I would just pick up the phone. I have never had to make a complaint. They have been just fantastic." The manager showed us the complaints records. These showed that the only complaint received had been from a neighbour about the noise people made when they were in the garden during late evenings in the summer. The manager had met with the neighbour to discuss their concerns and had asked staff to dissuade people from going out in the garden after 10pm. This showed that the manager listened and acted upon complaints. A relative told us "They do listen to me."

The manager kept a log of compliments received by the home. Five compliments had been received in two months praising staff for their professionalism and support for people. These had been shared with all the staff at the home. This showed that relatives and other healthcare professionals appreciated that people were supported by trained, professional and caring staff.

Good

Is the service well-led?

Our findings

Relatives and staff had confidence in the manager. They found them to be open and approachable. A relative told us, "[Manager] is excellent. We talk a lot." A member of staff said of the manager, "[They] are very accommodating and approachable." Another member of staff said, "[Manager] is approachable and very supportive. [They] are extremely supportive to staff and if there are any problems you don't feel that you can't go to [them]. [They] have an open door policy. The service has tremendously improved since [they] became manager." The manager told us that they were seeking accreditation for the service with the National Autistic Society and had established relationships with local businesses and communities.

Relatives and staff told us that people and staff interacted as a family. A relative said, "There is such a homely atmosphere." A member of staff told us, "It can be tough and stressful at times but we have a really good team and talk to each other. You can tell people are happy from the atmosphere here." Relatives and other health care professionals were asked for their opinion of the service that was provided and for ways in which this could be improved. We saw that no suggestions for improvements had been received and nearly all the responses received rated the level of satisfaction with service as excellent.

Staff were able to contribute to the development of the service during supervisions and staff meetings. One member of staff told us, "[Manager] is coming up with good ideas on how to reduce errors and improve recording. If [they] want to introduce anything they will discuss it and ask for suggestions for ways it could be improved." Staff attended regular meetings with the manager at which they could discuss any ideas they had for ways in which the service could be improved. Minutes of the last meeting held showed that staff had discussed training needs and they had requested training in Makaton and other more specialised training that would improve their skills to support people. The manager had agreed to look into this. They were also to source training on how to support people who had eating disorders. This would assist staff to support an individual who currently lived at the home. This showed that people were supported by staff who were committed to continuous improvement of their skills and the service provided.

The manager attended monthly manager's meetings with the managers of the other services owned by the provider. This allowed them to share concerns and areas of good practice. These meetings were also attended by the provider's Operational Manager who discussed with the managers good practice and areas of improvements they had identified from published CQC reports.

Staff told us that they were supported by regular reviews of their competency. They were knowledgeable about their roles and what was expected of them and were able to tell us of the values and vision of the service. One member of staff told us, "We give [people] as much independence as possible. We teach them living skills as far as they physically and mentally can reach. We give them the best life and the choices in life possible." Another member of staff said, "We promote [people's] independence and encourage all of them to reach their full potential, emotionally, physically and spiritually." The manager told us, "I have a vision of where I want us to go. I want to keep [people] safe and well. I want to stretch them, teach them and educate them. I want to push them to achieve their goals and reach their maximum potential."

There was an effective quality assurance system in place. Quality audits completed by the manager covered a range of areas, including audits of support plans, medicines and the environment. Improvement plans had been developed where shortfalls had been identified and the actions were signed off when they had been completed. The manager produced a monthly service provision report for the provider. In addition, the provider's Operational Manager conducted quarterly audits of the service and action plans arising from these were completed. The reports and action plans were seen by the provider's Clinical Governance Committee and the provider.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.