Avon Lodge UK Limited

Avon Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our inspection 15, 16 and 17 September 2015 we found significant shortfalls in the standard of care that was being provided to people living at Avon Lodge. Following that inspection the service was placed into special measures and enforcement action was taken by the Care Quality Commission to impose conditions upon the provider's registration. Special measures means that the Care Quality Commission keeps the service under review and it is re-inspected within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. At the inspection on 14 and 15 April 2016, we found that the provider had failed to make significant improvements to the quality of care and the service remained rated as inadequate and special measures remained in place.

This inspection took place to check if the provider had made the required improvements to ensure that they were meeting the legal requirements. This inspection took place over two days on 25 and 26 October 2016 and was unannounced. At our last inspection on 14 and 15 April 2016, we found that the provider was not meeting all the standards that we inspected. We identified breaches of regulations 9, 11, 12, 14, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment for people was not being provided safely. Risk assessments to identify and mitigate significant risks to people were not in place. Care plans failed to reflect people's preferences regarding care and treatment provided. The home did not provide activities for people to encourage communication and stimulation. There was a significant level of poor care and risks to people that used the service that were not identified or acted upon.

Avon Lodge is a residential care home that provides personal care and support for 36 people, some of whom have dementia. However, following our inspection and findings in the September 2015 inspection, the local authority placed an embargo on Avon Lodge accepting any new referrals. This means that the service was not allowed to admit any new residents. At the time of the inspection, there were 24 people using the service.

The home did not have a registered manager. However, a manager had been appointed in April 2016 and was in the process of applying for registered manager status with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessments had not been completed on subjects such as high-risk medicines or serious chronic health conditions. Diagnosis of two chronic health conditions had been included in care plans but no risks associated with these conditions had been identified. However, other risks were well documented and provided staff with guidance on how to mitigate the risks.

Staff were not receiving regular supervision. Staff had not received an annual appraisal.

The management structure of the home was confusing and the management team were unaware of what each other's roles were. There was poor communication between the management team.

One person had not received their prescribed medicines following a healthcare assessment for 21 days. This had not been identified by the service.

The service completed audits. However, there were no action plans or documentation of the outcome of these audits. The service was not ensuring that audits improved the standards of care for people using the service.

At our last inspection Mental Capacity Act (2005) assessments had not been completed for any people living at the home and in any area of decision making. At this inspection, we found that MCA assessments had been completed. However, the service had completed the same seven assessments for all people. MCA assessments completed by the home were not decision specific and contradicted healthcare professional's assessments.

Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The home had applied for Deprivation of Liberty Safeguards (DoLS) for people where appropriate. Where DoLS had been authorised, there were review dates in place.

At our last inspection there had been no activities provided for people. In the past six months the home had begun to provide entertainment and activities for people. There had been day trips to the seaside and the zoo. However, activities were not tailored to individuals. People's interests and preferences were not taken into consideration when booking activities.

Guidance for people with swallowing difficulties was now being followed. There were reviews of people's swallowing difficulties with a Speech and Language Therapist (SALT).

People had healthcare appointments that met their needs. Staff were aware of how to refer people to healthcare professionals when necessary. There were records of appointments and reviews in people's files.

At our last inspection, care plans were not person centred and did not state people likes and dislikes. Where people were unable to have input into planning their care, there were no records of best interests meetings or decisions. At this inspection, the provider had completed new care plans for all people using the service. These were person centred and documented that people were involved in planning their care. Where they were unable to be involved, there were records of best interests meetings.

There was a complaints procedure in place which people and relatives had access to.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report to if people were at risk of harm.

The service provides care and support to people living with dementia. At our last inspection, we found that staff had not received training on working with people living with dementia or behaviour that challenged. During this inspection, records confirmed that half of the staff had received training in dementia care and working with behaviour that challenges.

We observed caring interactions between staff and people. Staff knew people well and were able to tell us

about individuals likes and dislikes.

People were consulted on the food provided. Daily menus plans were in place that showed a good choice of food available, including vegetarian and halal options. People on specialist diets such as puree and fork mashable were provided with food that was at an appropriate consistency and well-presented.

The provider had redecorated areas of the home and a programme of works was in place. A new treatment room was available where people could see healthcare professionals in private.

Avon Lodge has continued to fail to improve standards of care to a level that meets the regulatory requirement. We found significant on-going shortfalls in the care provided to people. We identified breaches of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. As needed medicines were still sometimes unavailable at night-time. Staff that had received medicines training had not had their competency to administer medicines assessed until two months following our previous inspection when this issue had been raised by inspectors. However, following competency assessments staff members that were able to administer medicines were not always on shift at night time.

The service did not always assess all of the risks associated with people's care in order to mitigate or reduce risk to ensure people's safety. Where risk assessments had been completed, these were detailed and provided staff with adequate guidance on how to mitigate known risks.

People received their medicines on time. However, one person had waited 21 days for their medicine and staff had not followed this up.

There were sufficient staff to support people and appropriate recruitment practices were being followed.

Safe moving and handling practices were used

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive regular supervision. Staff had not received an appraisal in the past year.

The Mental Capacity Act (MCA) was not always being applied properly to assess care and treatment needs. People that required a Deprivation of Liberty Safeguard (DoLS) had one in place. However, staff were able to explain what the MCA and DoLS were and how it impacted on their work.

People had signed their care plans. Where they were unable, relatives had been involved and there were records of best interests meetings.

People received a good choice of different foods. Food was appetising and there were generous portions. The home

provided good quality food for people that required special diets.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were supported to make decisions about the care they received, where they were able.

There was a warm and friendly atmosphere between staff and people that used the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. The service has not satisfied the Care Quality Commission that improvements to the quality of care have been embedded and sustained.

People's care was person centred and planned in collaboration with them.

There were activities in place within the home.

Staff were knowledgeable about individual support needs, their interests and preferences.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager in post.

There were some audit processes in place but there were no action plans in place to identify how issues found were addressed.

Management had not ensured that regular staff support was in place, such as regular staff supervision and appraisal.

There was a confused management structure that promoted poor communication between management.

The service had not worked effectively with the local authority or the Care Quality Commission to improve standards of care to a level that met legal regulatory requirements.

There was good joint working with healthcare professionals.

Avon Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 October 2016 and was unannounced. We planned this inspection as a result of the service receiving a second rating of Inadequate and remaining in special measures at our last inspection. When a service is placed into special measures, it must be re-inspected within six months. The inspection was carried out 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 the inspection we looked at information that we had received about the service and formal notifications that the provider had sent to the CQC. We spoke with Enfield Healthwatch to get feedback regarding Avon Lodge over the past six months. We reviewed monthly reports and action plans that the provider had sent to the Care Quality commission (CQC).

We undertook general observations and used the short observational framework for inspectors (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 eight care records and risk assessments, 11 staff files, 14 people's medicines records and other paperwork related to the management of the service. We spoke with 16 people who used the service, six staff and five relatives. We also spoke with a district nurse who was visiting the home during the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at Avon Lodge and said, "Very safe. The amount of people looking after you, they are so good", "I feel safe everywhere, I'm an out-going person" and "Yes. I feel comfortable and happy." Relatives that we spoke with were generally positive about the safety of their relative and felt that the home kept people safe. However, some aspects of the service were not safe.

At our last inspection, we found that the home recorded people's weights on a monthly basis. However, there was no information or guidance on how staff should manage weight loss or fluctuating weight. At this inspection, we found that although there was guidance in place, this was not being adequately followed. For three people, weight loss had been noted on the care plan but there was no recording as to what actions had been taken. For one person there had been noted weight loss between April and May 2016 of 2.3kg. There was guidance in the person's care plan stating that, 'If weight reduces by 1.5kg any month to refer to GP'. A review had taken place on 3 October 2016 but the care plan had not been updated to reflect the outcome. For another person weight loss had been noted for a three-month period between August and October 2016. The care plan stated that the Speech and Language Therapy (SALT) team had been contacted but there was no recording of what the outcome was. On further questioning of staff, we found records that stated that a food supplement had been prescribed but this had not been received in the home and had not been chased up with a lapse of 21 days. The person had not been provided with their prescribed medicine in a timely manner. This potentially put the person at risk of further weight loss.

One person had been noted as having 'IHD' and another person 'CKD' on their care plans. There was no explanation what these acronyms meant. When we asked the consultant that had completed the care plans and risk assessments they said that they were unaware of what the acronyms meant but had copied information from previous care plans. Ischaemic heart disease (IHD) and chronic kidney disease (CKD) are serious health conditions that can display multiple symptoms. However, these had not been identified and there were no risk assessments in place to inform staff of what could happen if people were becoming unwell and what action to take.

People's personal risks were not always assessed. For example, for one person who had a catheter in place, there was a catheter care plan. However, there was no guidance or instructions on what staff should do if the catheter got blocked or if it was accidentally removed. Another person had been prescribed a high-risk blood thinning medicine. One senior staff member that we spoke with was aware of the risks of this medicine. However, other staff were not. There was no risk assessment in place to provide guidance for staff on how to recognise and mitigate the risks associated with this medicine.

This was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where risk assessments were in place they assessed areas such as falls, pressure ulcers, moving and handling and smoking. These risk assessments provided staff with detailed guidance on how to mitigate the identified risk and were person centred and tailored to each individual. People who had had falls were

referred to the local falls clinic to be monitored and equipment such as sensors put in place if necessary. The home had risk assessed all people that were at risk of falls. There had been two falls in August 2016 and no falls in September 2016. Each person that required hoisting had written guidance for staff located on the wall in their bedroom.

Staff had access to a medicine administration policy. This had been updated within the last six months. People's medicines were recorded on Medicines Administration Record (MAR) sheets and a blister pack system was used which was provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one-month supply. People's medicines were given on time and there were no omissions in recording of administration on any of the 14 people's medicines that we checked.

At our last inspection, we found that three people were being given covert medicines without appropriate documentation being in place. Covert medicines are where the home administers medicines without the person's consent. At this inspection, we found that covert medicines had been reviewed and no people at the home were receiving covert medicines.

At our last inspection, we found that people were given 'as needed' medicines (PRN), although the arrangements in place around this were inadequate. 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. When 'as needed' medicines were given, the MAR chart was signed. However, there was no record of why this 'as needed' medicine had been given. Care plans did not state if people were receiving PRN medicines, what the medicines were, what they were used for, or in what circumstances they should be administered. At this inspection, we found that PRN protocols were available for each person where necessary and explained why the medicine had been prescribed and under what circumstances it should be administered. All PRN protocols were recorded in the medicines folder. For one care plan, there was a list of the person's medicines, with a description of what the medicines were for, including PRN, and any side effects noted with the medicine but this was not consistent for all care plans that we looked at.

At our last inspection in April 2016, we found that night care staff had not had their competency to administer medicines assessed. This resulted in some people receiving bedtime medicines early in the evening or not receiving medicines in line with their personal preferences. Between April 2016 and July 2016, people may still have not been given medicines at night as care staff working at night had not had their competency to administer medicines assessed. Rotas showed that between April and July 2016 there were days where there were no staff on duty at night that had been competency assessed and able to administer medicine if necessary. All senior care staff had their competency to administer medicines completed in July 2016. In August, September and October 2016, rotas showed that there were still nights where there were no competency assessed staff on duty. The manager told us that there was a back-up plan for the staff member in charge to call the manager or senior carers that lived locally and who had been competency assessed to come to the home and administer medicines if required during the night.

Each person had an individual section in the medicines folder. There was a cover page which had the person's personal details, a photo and any noted allergies. There were pictures of each tablet in the MAR charts, as well as directions on when to administer and what the medicine was prescribed for. A list of all staff authorised to give medicines was available on the front of the MAR folder with their signatures and initials. This allowed auditing processes to identify which staff had administered medicines and signed MAR charts.

There were authorisation documents for people who were able to self-administer creams in their own

rooms. These had been signed by the GP who agreed to the decision. We observed that some people had topical creams stored in their bedrooms.

The home had a medicines room that that was secure. Medicines trollies were securely attached to the wall and senior staff held the keys. The medicines fridge was clean and used only for the purpose to store medicines. The provider had installed a cooling system in the medicines room to ensure that medicines were stored at the correct temperature. Room temperatures and fridge temperatures were recorded on a daily basis.

Controlled drugs were checked and corresponded with the recording book. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. Controlled drugs were checked and documented by the senior carer every day when the shift changed. Eye drops and liquid medicines had recorded on the box the date of opening to remind staff of the date they should be disposed by. Medicines to be disposed of were recorded and a procedure was in place to ensure that medicines were disposed of safely.

Where people were prescribed pain relief patches, the home did not record the site of application every time the patch was changed. However, senior care staff were able to tell us that the patch would be applied to a different site every time a new patch was administered.

Staff told us how they would keep people safe and understood how to report it if they thought people were at risk of harm. Staff were able to describe different types of abuse. One staff member said, "It [safeguarding] is to protect people from abuse. I would report it to my manager, the local authority or CQC". Another staff member said, "Safeguarding is to ensure the safety of a person that is at risk of physical, sexual or emotional harm. I would make sure that I report it to my manager." Staff understood what whistleblowing was and how to report concerns if necessary. Whistleblowing is where staff are able to report concerns within the organisation, often to the local authority, without fear of being victimised.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Rotas showed that there were four carers and a senior staff on duty each morning and afternoon from 07:30 until 14:00 and from 14:00 until 20:00. There were two staff and a senior staff member on duty from 20:00 until 08:00. During our inspection, staff did not appear to be rushed and were able to spend time with people. However, the home did not complete a needs assessment for people. A needs assessment looks at each individual and how much care they require and can be used to help determine staffing levels. The manager told us that if more staff were needed, then these would be booked but this was determined on a day-to-day basis.

At our last inspection, we saw that people did not have individual slings for moving and handling and we were told that slings were re-used for different people. At this inspection, we saw that slings had been purchased for people that required them. Each person had their own sling that had been clearly labelled with their name to ensure that the correct sling was used for the person when undergoing moving and handling. Slings were clean and stored appropriately. Hoists were clean and there were records of regular maintenance checks for the hoists.

We observed people being hoisted on three occasions during our inspection. Staff followed appropriate moving and handling techniques and there was good communication with the person throughout the process.

Each person had a personal evacuation plan (PEEP) in place, in case of a fire. A PEEP assesses how people should be evacuated if they have mobility issues and the best way for staff to support them. Records since February 2016 showed that the home completed three monthly fire drills and completed weekly fire alarm tests, although the last fire alarm test had been more than one month before the inspection, on 26 September 2016.

Since the last inspection the home had installed a new emergency call system that allowed staff to immediately call for help from anywhere in the home. These had been placed in all people's bedrooms, toilets and bathrooms. A staff member responded within 30 seconds when inspectors tested the system.

At our last inspection, we found that some areas of the kitchen were unclean or not maintained in a good condition. At this inspection, we found that the kitchen was clean and there were no maintenance issues. The provider had purchased new freezers and the dried food store cupboard was clean.

The home was clean and tidy on the days of inspection and we observed cleaning staff maintaining the cleanliness of the home throughout the two days. One relative commented, "It's quite clean, I can't fault that and there's no smell."

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Requires Improvement

Is the service effective?

Our findings

Staff were not receiving regular supervision. The Avon Lodge staff supervision policy stated, 'The care service is committed to providing its care staff with formal supervision at least six times a year. The minimum would be four'. Of the eleven staff files that we looked at, one had no supervision on file at all, six had not received supervision since January and February 2016 and three had supervision on file within the last three months. There were no supervisions on file prior to the three recorded. One staff member had recently resigned. However, there were no supervisions documented for this staff member at all. A supervision overview record showed that a total of eleven out of 21 staff had received supervision in August and September 2016. Further supervisions had been booked for these staff in early October 2016. However, these did not happen. The consultant who had been covering the managers leave told us, "None of these have been done. I did not have time." Three of the staff that we spoke with confirmed that they had received supervision in the past two months. One staff member said, "In one year two times [supervisions]."

The Avon Lodge staff appraisal policy stated that, 'The care services policy on staff appraisal establishes that each member of staff will have an annual appraisal'. Of the 11 staff files that we looked at none of them had received an appraisal in the past year. We spoke with the manger about this who confirmed that no staff working at the home had received an appraisal in the past year.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received training which the service considered to be mandatory, such as manual handling, safeguarding, Mental Capacity Act 2005 and health and safety. However, out of 18 staff, nine staff had not received training in 'Dignity in care' and 'Challenging behaviour' and eight staff needed to complete or refresh their dementia care training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met. Records showed that the home had applied for Deprivation of Liberty Safeguards (DoLS) for people and had documented when these had been authorised and when they needed to be reviewed. The home had completed independent MCA assessments and best interest decisions for each person in the following areas; daily personal care, administering

medication, assisting with daily nutritional needs, supporting incontinence needs, establishing ability to decide on activities to take part in, assessing and managing personal safety and arranging health professional visits. People's mental capacity had been assessed but consideration had not been given to previous MCA assessments completed by external healthcare professionals as part of the DoLS authorisation. Where the home had assessed people to have capacity for the seven specific decisions, this was contradicted by the DoLS assessments and authorisation which deemed people to lack capacity.

The same areas were assessed for each person. MCA assessments were not person centred and decision specific. Blanket assessments had been completed covering the same seven areas as listed above for each person living at the home. Where MCA assessments had been completed, the assessor had explored different ways of ensuring that the process had been explained to the person and whether they understood the need for the assessment and the decision that needed to be made. All MCA assessments had been completed in August and September 2016.

Records showed that staff had received training in the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA) in the past eleven months. At our last inspection we found that, despite training, some staff did not have an understanding of MCA or DoLS. At this inspection, we found that staff understanding was greatly improved. One staff member told us, "As human being and human right, we have a right to choose what to eat and drink. If people can't make a decision, you would make a decision for them in their best interest" and "It is a law that protects vulnerable people. To check if they understand what is being said to them and if they are able to make decisions. If they cannot then they lack capacity and we would need a best interests [meeting]." All staff that we spoke with were able to explain what MCA and DoLS were and how it impacted on the care that they provided to people. There were posters around the home to remind staff and people what the key principles of the MCA were.

People, where they were able, or their relatives had signed the care plans agreeing to the contents of the care plan. Consent forms had also been signed by people or their relatives in areas such as photograph consent, consent to being regularly weighed and consent for the flu vaccine. Where people were unable to give consent, a best interests meeting had been conducted.

The home did not currently have any people with pressure ulcers. Where people had been noted to be at risk of developing a pressure ulcer, they had been provided with pressure relieving equipment such as air flow mattresses and cushions. Where people needed to be repositioned whilst in bed to help prevent pressure ulcers, there were turning charts in place. However, there were inconsistencies in the recording on the care plan and the turning chart about how often a person was to be turned during the night. Three turning charts had these noted inconsistencies. For example, one care plan stated the person needed to be turned every three hours but the turning chart stated every four hours.

The home employed two chefs. The kitchen was clean and food was stored appropriately. We found that the service catered for people with differing faiths and the chef showed inspectors separate storage facilities for halal meat which was kept separately in accordance with guidance around storing halal products. There was a menu board on display in the main lounge that showed what options were available for breakfast, lunch and dinner. Vegetarian options were also available.

There were lists in the kitchen of people who required specialist diets, such as mashed, pureed or vegetarian food. One person had a severe allergy. The chef was aware of this allergy and there was guidance noted on the kitchen wall around what foods needed to be avoided. There was also information in the kitchen regarding a person that was diabetic. We spoke with the chef who was knowledgeable about what types of foods could and could not be given to someone that was diabetic.

We observed lunch on the first day of our inspection and saw that people were served in a timely manner. The food looked and smelled appetising. Where people required support to eat, staff were patient and communicative whilst supporting them.

One person was served a meat curry. We observed that the person did not have any teeth. We raised this with the manager who told us he was unaware that the person did not have their dentures in. We also spoke with the chef who told us that he did not know that the person did not have teeth but that they always cut their food up anyway. The person was not noted to have swallowing difficulties. Care staff told us that they always fed the person with small mouthfuls of food and did not rush them whilst they were eating.

People that we spoke with were generally positive about the food and said, "You get breakfast and rosie lee [tea]", "You can ask for food anytime, it's very good. The chef will make you something if you want it" and "Yeah, the foods okay. I like a light lunch so I get sandwiches that I ask for and dinner in the evening." People also told us that the chef asked people what they wanted to eat. On day one of the inspection we observed the chef asking people which meal they would like. Records confirmed that people were asked each morning what they wanted to eat.

On the second day of the inspection, inspectors tasted samples of the lunchtime menu. This included testing the consistency and flavour of both puree and mashed food given to people that had swallowing difficulties. What was on the menu was what was being served to people on the day of inspection. Food that was tasted included soup, salmon fillets, halal beef curry, mashed potato, a mousse and a homemade fruit crumble. Food was flavoursome and cooked well. Mashed and pureed foods were presented well with each part of the meal being separate on the plate. The consistencies were appropriate for puree and mashed diets. The chef tried to ensure that people on special diets received a meal that looked appetising. However, at lunchtime, we observed a staff member assisting a person who was on a puree diet. The staff member mixed the persons food all together whilst encouraging them to eat. This meant that the person would be unable to distinguish between different foods and tastes as it was all mixed together.

The home had recently completed construction of a treatment room. This was a space that people could see visiting healthcare professionals in private. The room was equipped with an examination couch, sink and chairs. Staff told us that this was where the GP and district nurses saw patients.

People's personal files had details of healthcare visits, appointments and reviews. Records showed that people had access to healthcare such as podiatry, opticians, and dentists. Staff had signed to say that these visits had been attended by people. Staff were knowledgeable about people's healthcare needs and knew how to refer people for further healthcare assessment if necessary. A district nurse that was visiting during our inspection told us, "Communication with the home is good. Staff always refer [people] when it is needed. The notes [people's care files] are brilliant because everything is in there. Very comprehensive."

Good

Is the service caring?

Our findings

We asked people and relatives if they thought the service treated them or their relative with dignity and respect. People told us, "This place is lovely. You hear a lot of laughter", "The staff are mostly kind and treat me well" and "I'm happy in here. Everybody's friendly." Relatives generally felt that people were treated with dignity and respect by the staff.

One staff member told us, "We have to work with dignity and show people respect. We have people who need personal care. I make sure I close the door and curtain. We have to obey their choices. Everyone is able to make their own choice and we need to ask people before we give care." Another staff member gave us an example of how they ensured people's cultural needs were met. The staff member said that she often provided care to a person who followed the Islamic faith. Following bathing, she ensured she helped the person say a traditional prayer, which in Islam means that the person is clean and gives thanks. Staff were positive about working with gay, lesbian or bisexual people and had a good understanding of equality and diversity. One staff member said, "It does not make any difference, all people need care, not judgement."

The home had a priest that visited on a regular basis to hold services and communion. Dates of each visit were clearly displayed in the hallway of the home. People told us, "I get Sunday communion but I think it's from a Protestant church" and "I'm Catholic and take communion." Where people were noted as having differing faiths, the manager told us that they had offered for these people to go to a place of worship but people had declined the offer.

During the inspection, we observed warm and friendly interactions between staff and people. Staff appeared to know people well. One staff member was discussing books with a person and we later found out that the person had a passion for reading. Staff knew how to encourage people to talk about things that interested them. During lunchtime on the first day of the inspection, we observed a person becoming quite distressed. When the person became distressed they would use certain physical movements that indicated their levels of anxiety. Staff explained to inspectors that when the person did this they would step back and approach them a short time later to check the person's welfare and encourage them to eat. Another person became unwell during lunch, staff dealt with this in a way that preserved the person dignity and did not embarrass them. The person was calmly encouraged to leave the dining room by two staff.

People's waking and sleeping preferences were noted on their care plans. One staff member told us, "If I'm giving personal care in the morning, I have to knock on their door and wait for them to answer and say it's okay to go in. I greet the person and ask how they are. I ask if they want a cup of tea before having personal care. It's nice on cold mornings, especially if they have a lie in."

Staff told us that relatives could visit whenever they wanted. One relative told us, "I visit one or two times a week. It's never a problem."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that care plans were not person centred and failed to include important information about people. People were not involved in planning their care. Where people were not able to have input, there were no records of best interests meetings or decisions. A best interests decision is when a person is unable to have input into their care and healthcare professionals and relatives are consulted on the best way to care for that person. Care plans that we looked at had not been signed by people, their relatives or healthcare professionals. At this inspection we found that the provider had addressed this issue.

A one-page profile was available for each person at the front of their care plan that was detailed and very person centred. It contained sections called, 'What things are important to me', 'How to best work with me', 'Daily routine', 'Things I like to do', 'Food and drink preferences' and 'Things that I don't like.' Where people had been unable to be involved, these were written in conjunction with family members and from observations by care staff. For example, for one person there was an entry that stated, "[Person's] family informed us that [person] likes most foods. Is said to enjoy roast beef, chicken, sausages, fresh fruit, and fish and chips. [Person's] favourite meal is said to be ham, egg and chips. Prefers tea to coffee and likes fruit juice." Each person's likes and dislikes were clearly documented. Staff were aware of each individuals, preferences and were able to tell inspectors during the inspection.

A needs assessment had been completed for each person. This corresponded and fed into the care plans. The needs assessment looked at hearing, sight, speech, comprehension, orientation, memory, mood/emotion, relationships, response to care intervention, mobility and walking, potential to fall, dexterity, nutritional risk, food preferences, drinking and eating, swallowing, oral care and washing. Where areas had been identified as a specific issue for people these were covered in detail in the care plan. The needs assessment allowed staff to appropriately identify individuals' needs and produce a person centred care plan. However, the home had also completed a further care and support plan which was a duplicate, but in a different format, of the original care plan. We raised this with the manager who told us that he would look at this.

Each person had a folder kept in their room which contained the person's one page profile and a copy of their care and support plan. The file also contained, topical cream charts, the person's PEEP and turn charts where applicable. This was a new initiative that had been put in place following our last inspection.

People were involved in planning their care, where they were able to. Where people were unable, there were records of invites from Avon Lodge to relatives to have input into their relatives care and best interests meetings documented. Records showed that family members' opinions and views on care had been documented within the care plans.

At our last inspection, we found that there were very few activities provided for people. People told us that they were often bored and we had observed people wandering around the home with very little staff interaction. The home did not have an activities coordinator. At this inspection, we found that the home had begun providing activities on a regular basis within the home. This included gardening, a weekly musician,

arts and crafts and visits from an interactive theatre company. The home had begun photographing these activities so that they could put together a memory aid for people. There was a weekly pictorial activities plan in the lounge area which noted indoor activities, and a tour of the garden. Since our last inspection, there had been day trips to the zoo and the seaside. One person told us, "I enjoyed the two trips out that we did and I'd like to do more of that" and "I like to paint in the afternoon and I'm good at quizzes." However, people also told us that there had not been any external activities in the last few months. There was an activities file in place which documented activities that had taken place, but this had not been updated since May 2016. All activities within the home were group activities, people were not provided with individualised activities that reflected their wishes and preferences. For example, three people said that they would like to go out together for lunch. We raised this at the previous inspection but this had not been actioned by the manager.

Other feedback from people and relatives was not as positive regarding activities. Relatives told us, "There needs to be more activities. [A relative] used to love his football. He doesn't do anything. Trips out would be good. There are people with Alzheimer's and they can't go out by themselves. Trips on a weekly basis would be good. We've mentioned it a few times. I think they must feel like they're in prison and there's nothing to look forward to" and "I would say that they take care of basic needs and [people] are well looked-after but they need more stimulation and I would like to see [relative] go out. They [the home] had promised day trips at the beginning."

The home had recently completed a fully equipped hairdressing room. A hairdresser visited the home twice a week and people were able to make appointments.

At our last inspection, we found that the home was failing to act on complaints and did not document investigations and outcomes of complaints received. At this inspection, we found that the home had addressed this issue. There had been two complaints logged since the last inspection. Both had been dealt with appropriately with records of the actions taken to resolve the issue. The complaints procedure was displayed by the front door. This was in a larger font which made it easier for people to read. A pictorial, large font copy of how to complain was in the service user handbook. A copy of the complaints policy was also included. A complaints and compliments box was by the front door for people and relatives to use.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager. The registered manager had left in February 2016. At the time of our inspection a new manager had been in post since the end of May 2016. The new manager had applied for registered manager status with the Care Quality Commission (CQC).

The management roles and responsibilities within the service were not clear. Following the last inspection in April 2016, the provider had hired three management consultants. The provider explained that one of the consultants had provided care plan templates and an action plan to help address the concerns found at the last inspection. One had been brought in to look at medicines, provide training and review policies and procedures. A third consultant was brought in to complete care plans and Mental Capacity Act (MCA) assessments. The consultants and the manager were unsure of each other's roles and responsibilities. Staff that we spoke with were not always clear on the role of the manager and consultants. There was a lack of communication between the consultants, the manager and the provider.

The management team were following three action plans: one devised by the local authorities, who were working with Avon Lodge; one from an external consultant; and, one that they provided to the Care Quality Commission (CQC). However, there appeared to be some confusion around how to make the required improvements identified during the last two CQC inspections. We asked one of the consultants how the provider monitored the action plans and were informed, "He phones and asks how things are going." There was no documentation to show how the action plans were being monitored and how the provider was ensuring that issues raised at the previous inspections were being addressed. On the second day, the provider attended the inspection and told us that he had hired the consultants to help support the manager.

On the first day of the inspection we asked if there was a deputy manager in place within the home and we were told that there was not by the manager. However, on the second day of inspection we were told by the provider that there was a deputy manager in place who had been working as the deputy manager for over six months. We discussed this with the two management consultants and the manager. The manager, who had been in post for six months, and the consultant, who had covered the manager for six weeks when the manager was off recently, confirmed that they were unaware that this person was the deputy manager. We were unable to speak with the deputy manager as she was on leave.

Staff confirmed and records showed that staff supervision was not regularly carried out. Staff had not received an appraisal. There were no regular records of how staff performance and progress was monitored by the manager.

At our inspection in April 2016, night staff had not been signed off as competent to administer medicines. This meant that people were not always receiving their medicines as needed or in line with their preferences. This issue had not been fully addressed. Competencies were assessed over two months following the last inspection and the home still had night shifts where there were no staff members on duty and competent to administer medicines. Staff on duty would need to call another staff member who lived

locally to come to the home during the night if necessary so that medicines could be administered. This had not been identified as an issue that needed to be addressed with any urgency despite it being raised at the last inspection.

The provider had conditions imposed upon their registration as part of our enforcement action following the inspection in September 2015. A part of these conditions required the provider to send the CQC a monthly report on progress of care plans, risk assessments and mental capacity assessments. At our inspection in April 2016 care plans, risk assessments and MCA assessments were still inadequate. The provider had sent monthly reports to say that they were completing these. However, during this inspection we found that care plans had only been correctly completed in late August and September 2016, up to 12 months after our first inspection. At this inspection, we found that some issues around risk assessments that we raised had not been identified despite monthly audits. The management team did not fully understand how to apply the MCA effectively to the care and support that they were providing to people living at Avon Lodge.

A number of audits were being carried out. The manager and consultant completed monthly audits of residents ('Residents monthly audits'). This was information that the manager gathered about each person's number of falls. A bi-annual fire safety audit had been completed on 1 August 2016. A health and safety audit had been completed on 8 September 2016. However, no outcomes or action plans had been devised after these audits had been completed to address any issues that were identified. These audits were not used by the manager to improve the quality of care provided to people.

Accidents and incidents were documented. However, for one accident which occurred on 17 September 2016 where a person was transferred to a wheelchair and injured themselves on the footrest, there was no further information or follow up.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held approximately every two months. Staff meeting agendas included discussions around job descriptions, the CQC report, meal times, residents, food and fluid charts, care plans, issues within the team and the changes within the home. Staff told us that they had an opportunity to raise concerns and felt management listened to them. Night staff that we spoke with said that minutes were available for them to read so that they were aware of what was discussed.

Whilst many of the issues identified at previous inspections had been addressed, some of the issues that had been identified at the last inspection in April 2016 had still not been fully addressed. The service has relied upon several consultants to provide support. There have been two groups of consultants employed by Avon Lodge, one in January 2016 and August 2016. Despite the use of consultants, the service has been slow to improve and it is still not meeting the regulatory requirements.

Despite the confused management structure, the care staff appeared to work well together and there was a warm and friendly atmosphere throughout the two days of inspection. Staff were positive about working at Avon Lodge and said, "I feel it's very good here. I'm happy and satisfied in my job. We work like a team. The manager is well mannered and he is supportive" and "The manager is good. If anything goes wrong, he will take action immediately. Anything about the residents he will always take action." Staff told us that they generally felt supported by the manager. One relative that we spoke with felt that they were more able to bring up issues in the past six months and had confidence that they would be dealt with.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure proper and safe management of medicines relating to one person that had not received their prescribed medicines. 12(2)(g)