Camelot Care (Somerset) Limited

Avalon Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23, 24 February and 1 March 2016. The inspection was unannounced. This was the first inspection since the service registered with the Care Quality Commission in May 2015.

Avalon Nursing Home specialises in providing nursing care to people who have dementia and other mental health needs. The home is registered to provide support for up to 55 people. There were 34 people living at the home when we carried out the inspection. At the time of the inspection the home was being managed by the provider until a new registered manager was appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was supported by a deputy manager, and was appropriately qualified and experienced to manage the home in the absence of a manager.

People's care was not planned and delivered in a way that always met their needs, for example. People were at risk of unsafe care because effective and consistent monitoring systems were not in place.

Staff did not receive regular, planned supervision sessions to support them in their role. The provider explained the supervision process had not been fully established as they were still in the process of developing the staff team at Avalon. Supervisions are an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

Staff had received a variety of training including manual handling and infection control. Induction training was available which prepares staff for their roles and provides evidence of competency within roles and responsibilities. However some staff said they had not completed their induction training including manual handling training. People were put at risk due to unsafe manual handling procedures, including moving people without the aid of a hoist or slide sheets. Further risks were identified in relation to infection control and hygiene procedures. We discussed our concerns with the provider.

Speech and Language Therapist assessments (SALT) had been completed prior to admission. Malnutrition Universal Screening Tool (MUST) had been completed for people with weight loss risk on admission. The people identified as being at risk following the assessments were not being monitored on an on going basis therefore the risk remained.

Care plans did not reflect how a person living with dementia should be supported. The provider informed us the care plans were still being developed. Personal information was not always stored securely to protect confidentiality, for example daily records and behaviour charts were stored on a table in one of the main lounges, staff were not always present in this area.

Wound care plans gave guidance when wound dressing needed to be changed. Systems were not in place to assess and monitor procedures were carried within the correct time scales This meant people were at risk of not having their care needs met. A number of people remained in their rooms who did not receive very much stimulation apart from meals being brought to the room. One person who was in bed told us they were lonely sometimes. Staff told us they did not have time to sit and just talk to people, This meant people received care which was task focused rather than person centred.

A recruitment procedure was in place to ensure people were supported by staff with the appropriate experience and character. Staff files showed the appropriate checks had been carried out before staff members were able to support people. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. However they did not always consider these rights when restricting someone's liberty or movement around the home.

The service employed two activity coordinators who implemented a variety of activities throughout the week. Activity schedules could be seen on display around the home showing pictures of activities planned and photos of activities that had already taken place.

People's day to day health needs were met, Staff knew people well and were able to monitor and support people to access healthcare services. Nurses informed us they had good links with local GP surgeries. Care plans held details of relevant health professionals involved in people's care and support dates of visits and recommended treatments.

People were supported to eat a balanced diet. Catering staff told us "People defiantly get enough to eat and drink". Snack boxes were used to encourage additional nutrition for people who are losing weight. We observed fresh fruit available in the dining areas and saw that people were offered a variety of biscuits with their drinks during the morning.

People and their representatives told us they would know how to raise a complaint and would feel comfortable doing so. The provider had a complaints policy that gave clear guidance on their complaints process.

The home was well maintained, clean, warm and comfortable. There was a large main lounge area that linked two corridors leading to other areas such as large dining room, sensory room, and private lounges for people to have private meetings with visitors or time alone. During one of the inspection day's people were seen in the main lounge enjoying musical entertainment.

The provider had a range of monitoring systems in place to ensure the home ran smoothly and to identify where improvements were needed. However the quality assurance system were not as effective as they had failed to identify the issues found at this inspection.

We found 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.

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 safe.

People did not always receive care and treatment in a safe way. People were unable to summon for help and support when required.

Risks to people's health and safety were not managed effectively.

People were not protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not effective.

People were not supported by staff who had received regular supervision or appraisal to monitor their practice or identify areas where further training or guidance may be necessary.

People's capacity to make decisions about their lives had not been considered in regards restrictions of movement.

People received a diet in line with their nutritional needs; staff were aware of these guidelines and followed them.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care which was tasked focused rather than person centred that took into account their preferences and wishes

When staff supported people, they did so in a caring and respectful manner.

Staff understood the importance of providing care in a manner which protected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always give staff sufficient or up to date information about each person's needs.

People's social needs were met. People were supported to receive a range of activities suited to their individual needs and preferences. However some people were not encouraged to be involved.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider did not always have an open and positive culture which did not provide a happy and relaxed atmosphere.

The providers quality assurance systems failed to monitor practice and plan improvements which meant they had failed to ensure all aspects of the service were 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 inspection took place on 23, 24 February and 1 March 2016 and was unannounced. It was carried out by two adult social care inspectors on the first two days of the inspection and an adult social care inspector and a specialist advisor (a registered nurse) on the third day of the inspection.

Before the inspection we reviewed the information we held about the service. This included statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider.

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 looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

We 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. People were seen to be supported to eat their meals in an unhurried respectful manner. People's nutritional needs were assessed to provide a diet in line with their needs. The chef understood the importance of choice and worked towards providing for people's individual dietary needs.

During the inspection we spoke with 17 people and 6 visitors about their views on the quality of the care and support being provided. We also spoke with three health professionals, the provider, director and 27 staff including the chef, the maintenance person and activity coordinator.

Some people were unable to tell us about their experiences of living at the home due to different health reasons or because they were unable to verbally communicate their thoughts. We spent time observing the

way staff interacted with people and looked at the records relating to care and decision making for four people. We looked at records about the management of the service, 12 care plans, and 10 staffing files.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who supported them. However there were risks that people may not receive safe care. For example, some people were at risk because they were unable to use a call bell for support if they required it. They did not receive regular checks from staff. A member of staff said "We are supposed to do hourly checks with people who remain in bed, if we have a full staff team we do, if not, we do them when we can". There were no records to show when people had been seen by staff, and care plans did not reflect how often people in their rooms should be checked. This meant people were at risk of unsafe care because there was no effective or consistent monitoring systems of regularly checking people who were at risk. We discussed this with a senior member of staff who informed us there were two teams which worked down each corridor in the home, each team were meant to take responsibility for their own side.

Staff rotas showed on occasions staff worked long hours over consecutive days. The provider informed us rotas were amended when staff rang in sick or staff swapped shifts to cover the rota. However this meant, staff were often working long shifts with many days without breaks. The provider tried to accommodate staff preference for both the length of their shifts and timing of their shifts.

Staff and visitors raised concerns regarding people being at risk because of low staffing levels. One member of staff informed us "I think people here are at risk due to the staffing levels". Another member of staff told us " There are high dependency needs, some people need two to three members of staff to support with personal care, there are times when depending on staff when we can answer the bells". One family member told us "The staff are lovely but busy there are a lots of staff around today, you do not normally see that". During the inspection we observed one person distressed and calling out for staff on numerous occasions. We asked a member of staff why this person was calling for support, they explained the person was poorly and liked staff to sit with them, but they did not have time. When the staff member sat with the person and comforted them they became less distressed.

Staffing changes were made during the days of the inspection because staff rang in sick, additional staff were made available from one of the providers other homes. Staff commented on a number of occasions how it was unusual to have so many staff on duty. One staff members informed us "This is a show for you, they [the provider] have brought staff in because you are here" The provider confirmed staff had been brought in from another home due to the inspection taking place They said "I don't know why but staff are more anxious when an inspection is happening, to support them to do their jobs well today I have brought in additional staff from another of our homes." They informed us they aimed for a 5:1 ratio. Staffing levels were based on dependency needs, the provider said they had established their senior team and planned to implement lead roles to all senior members of staff, they were currently recruiting more staff to ensure safe staffing levels. Agency staff were not being used at the home, as when needed additional staff were provided from one of the providers other homes.

At the time of the inspection six people were funded to receive varying levels of one to one supported hours. The allocation of this support was noted on the rota and also on a separate sheet. Staff who were allocated

to provide the one to one care were identified by red bands. The provider informed us these staff members were "ring fenced" which meant they were only to provide support to the person they were assigned to, other members of staff were aware these staff were unable to help with other tasks.

We saw staff members who should have been providing one to one support helping with other tasks around the home. For example on one of the days of the inspection we saw a staff member wearing a red arm band helping with the tea trolley, we asked why they were supporting this task and not providing the one to one support, the staff member informed us "they were just helping other staff out". A health professional visiting the home informed us the person they were supporting should be receiving a specific amount of individual hours per day. During the inspection a person was seen wondering alone staff informed us the person had not received their one to one support yet, but they were hoping the person would be able to have the support later. We observed this person to be upset and agitated, resulting in a potential risk to theirs and other people's safety.

Some people were at risk due to unsafe manual handling procedures. For example, a person was witnessed being repositioned in bed by staff, using a drag lift with the aid of the sheet they were lying on, this was seen to cause the person discomfort due to pressure areas. When questioned why they were moving the person in this way staff said they did not have any option as they did not have the necessary equipment supplied. We raised these issues with the provider who confirmed all staff received manual handling training as part of their induction training and knew how to move people safely, they informed us there had been slide sheets in every room when the home opened but they had gone missing. We spoke with the provider after the inspection they informed us they had purchased slide sheets for every room and had marked each one with the room number to ensure if they were moved or lost they could be instantly identified and returned to the correct room.

Infection control measures were in place, however, people were at risk of infection due to procedures that had the potential to cause risk of cross contamination. Clinical waste bags were transferred on trolleys which staff moved from room to room whilst supporting people with personal care. Staff informed us and we observed the bags were not always sealed when being moved from room to room. This placed people at risk of cross infection. The provider informed us they would review this practice and ensure the bags were sealed before being moved.

The issue of staffing, the lack of monitoring people and the poor infection control and manual handling processes are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Records were not up to date where people were identified at risk of losing weight. Malnutrition Universal Screening Tool (MUST) had been completed alongside SALT assessments for people when they were admitted to the home, which identified if they were at risk of weight loss. Weight charts for people at risk were not up to date and care plans did not reflect the individual support people required. One family member visiting the home informed us they were concerned their relative had lost a lot of weight since moving to the home, they told us " [person's name], has problem with textures, they will not eat if they don't like the food, I am concerned so try to be around at mealtimes". Puree diets and nutritional supplements were available for people assessed with swallowing difficulties. Another relative informed us "It looks like [person's name] has lost weight. I am having a meeting to discuss my concerns". This placed people at risk of staff not monitoring weight loss in a timely way or ensuring measures were in place to maintain people's weights.

Waterlow scores were not up to date. One person who needed additional care and support regrading

pressure areas had no records of when cream had last been applied. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sores.

Repositioning charts, were not up to date, staff told us they were aware of the risks and the importance of monitoring and maintaining records. We addressed our concerns with the provider who acknowledged and admitted that there was a problem with some record keeping and agreed to address the concern as soon as possible. A senior member of staff informed us "There is still a lot to do, in regards documentation they need updating. We need to consult more with each other" They explained they were supporting lots of complex needs which meant lots of challenges for the staff team. They felt the provider was passionate about the home and wanted "things" done the right way but they did not have time to do things the way the provider wanted.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

Two bottles of medicines did not have a date recorded when they had been opened. The bottles clearly stated that the date must be recorded once opened as the medicines had to be disposed of within 12 weeks. We informed a registered nurse of this issue they were unaware why dates had not been recorded, They informed us they would dispose of the medicines and have more reissued.

The home used a blister pack system with printed medication administration records. (MAR) records showed medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration The drug trolley was locked when unattended. Medicines were administered in a kind and sensitive way.

Recruitment procedures helped to protect people against the risk of abuse. Staff underwent pre-employment checks before starting work. Staff had a clear understanding of what might constitute abuse and how to report it. Personnel files contained signatures that safeguarding and whistleblowing policy and procedures had been read and understood. New staff were employed on a six month probation period, the provider informed us this gave staff members a period of time to demonstrate they had the correct skills and knowledge to fulfil the requirements of the role, and the provider the opportunity to ensure they were the right person to work for the service. Some staff were concerned staff had been asked to leave on occasions, which made them feel unsafe within their roles. The provider informed us this worked both ways and staff could also tell them they were leaving if they were not satisfied with their employment.

The home was well maintained and dementia friendly. This means consideration had been given to the needs of people with dementia including clear definition of doorways, toilet seats and handrails, the use of colour and light. The entrance of the home was spacious, with a large television screen informing visitors who was on duty. Administration staff were on hand in the reception area to guide people visiting the home if they needed it.

To ensure the environment for people was kept safe a maintenance person was employed. They discussed their role and the importance of keeping the environment safe for people. Records showed tests and the maintenance of the building were being kept up to date, weekly fire tests were completed. There were environmental risk assessments in place relating to health and safety of the building. We were informed in the event of an emergency requiring people evacuation there was a reciprocal arrangement with one of the providers other homes. We observed detailed plans of the building for emergency service use.

Requires Improvement

Is the service effective?

Our findings

People did not always receive care that promoted their health needs. For example, two people who had medical conditions that required them to have dressings applied to wound areas did not always have the care when needed. The wound care plans gave guidance when their dressings needed to be changed. For both people it was every two to three days. The first person's records showed an eight day gap meaning their dressing had not been changed for eight days. The second person's wound care plan stated the dressing had been changed four days apart instead of two to three days. The provider agreed this procedure had been missed on occasions. This placed people at risk of not having their wound care completed in a way which promoted healing.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations

The home arranged for people to see health care professional according to their individual needs. We observed good communication with external professionals. One health professional felt palliative care at the service was "really good". Records identified the dates of external professional contacts, visits and recommended treatments.

We received different levels of satisfaction from care staff about the level of training and supervisions they received. Most staff felt that although they had received an initial induction into the home, their inductions had not been completed or signed off by the provider or training manager. One member of staff informed us "I was given an induction booklet to complete, it has not been checked and never finished". Another member of staff informed us "We do not get the training to support people with behaviours that are complex." A third member of staff informed us they had asked for specific training relevant to their role but had not received it. Staffing files showed staff had received an initial induction period, their induction training records had not been signed to say the induction had been completed.

The provider provided us with a copy of their training matrix this showed some staff had completed a variety of training linked to their induction such as manual handling, health and safety. Signatures in staff files showed staff were aware and had read policies such as privacy and dignity whistleblowing and health and safety.

Staff told us they did not receive regular supervision sessions. Supervision helps to monitor the skills and competencies of staff and identify any training needs staff might have. Records showed some staff had recently received supervision, however the supervisions were not on going The provider informed us "I remind staff at handover every morning what induction needs to be done and remind staff to make sure you chase your supervisions. I rely on staff to do the supervisions and encourage them to do them".it had been difficult to complete all supervisions, but they were now beginning to complete some with their senior staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: StaffingStaff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights

protected. However they did not always consider these rights when restricting someone's liberty or movement around the home. For example, we observed one person was sat in a reclining chair in a lounge area away from the main lounge areas. This person was unable to move without support and told us they did not wish to be in this lounge area. They were clear in their discussion they did not wish to be in this lounge area. The person was shouting for staff throughout the inspection period. The person told us "it is lonely in here, I would like a bell to call, I shout so they [staff] come". When we asked staff why this person was in this lounge area we were told it was because the person shouts a lot. Staff told us they were unhappy this person was "made" to stay in the lounge away from other people. One staff member told us "[person's name] can no longer weight bear and is at risk of falls so the chair is used to prevent falls. It upsets me that people are made to stay up here just because they make a noise". Another member of staff told us "I was going to raise a concern today about people left in lounges when they don't want to be, it upsets me, the inspection is giving staff the confidence to speak out". The provider informed us the person can be very loud and it upsets other people in the main lounge, they felt it was the best room as the person liked the TV and had the opportunity to watch what they liked. There were no records of any assessments of the person's capacity or discussions held with them regarding the restriction of movement. Therefore the restrictions placed on this person were not in accordance with current legislation and their human rights.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.
There was recorded evidence of staff meetings. Staff discussed there had been at least one staff meeting but did not recall seeing the minutes. The provider told us that minutes of the staff meetings were always displayed in the nursing office for staff to read if they choose to do so. A senior member of staff informed us a meeting had taken place and an agenda had been put up for staff to see or add items for the agenda. Staff meetings are an opportunity for staff to speak up and raise any issues or concerns. We spoke with staff members who could not recall when their last staff meeting took place, however, the provider gave us evidence in the form of a meeting agenda and minutes showing that both a meeting for nursing staff and general staff had taken place.
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.

We observed in a person's care plan a referral had been made for an Independent Mental Capacity Advocate (IMCA) This is a person who is appointed to advocate for people who lack capacity to make decisions and have no known or involved family members or friends. This meant people without capacity had their rights protected.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS applications had been authorised for two people who had restrictions on their movement and others had been applied for. Best interest and capacity checks were held in care plans. These were reviewed by the provider. Some people living at the home had some limitations relating to their capacity to make decisions. A senior nurse had the responsibility for identifying people who were potentially deprived of their liberty and several applications for assessment had been made. We were informed there were six outstanding applications to be completed. Care plans identified the process that had been followed.

Concerns were raised regarding the home boiler system being faulty for a number of months, which caused undue distress to some people living in the home. For example one member of staff informed us. "We work in teams, we have had to get hot water from the servery to help people with personal care, we had to carry the hot water in jugs to people's rooms. The hot water does come through but can take up to half an hour to get hot". Another member of staff said "Having no hot water for many months has caused huge issues for [person's name] there have been incidents where they have got upset as they were unable to have a shower in the mornings . Sometimes we had to carry hot water to people's rooms to support them with personal care, people were put at risk." Incidents had been recorded of people becoming upset over being unable to shower in the mornings. The provider explained it was an old boiler they had inherited in the home, they said the reason the boiler had taken many months to repair was out of their control due to contractors awaiting parts to mend the boiler. The provider explained they had shown staff how to reignite the back-up boiler but staff had not done this. The new boiler was being installed at the time of the inspection which would resolve the above issues.

People's nutritional needs and preferences were recorded. We observed people's experiences over a lunchtime period. People in the dining area who were assisted to eat were given time and support to eat in an unrushed way, they were given choice and efforts were made to maintain people's independence as far as possible. People were seen to have good interaction from a range of staff.

The quality and appearance of food looked appetising. There was a blackboard in the dining room which displayed the meals offered for the day. The home had a new system that involved offering people a lighter lunch of soup, sandwiches and snacks with a larger cooked meal for dinner. A menu in the dining room informed people of the choices. Staff told us "I think the people here are well cared for. The food is homemade and healthy like freshly made soups." One member of staff confirmed that since the introduction of the new system people were not requesting snacks at night as had previously been the case. Several members of staff told us the new system was working well. People told us they were generally satisfied with the food. Snack boxes were used to encourage additional nutrition for people, as well as fresh fruits biscuits and cake.

Requires Improvement

Is the service caring?

Our findings

Some people said they were supported by kind and caring staff. However care was seen to be task focused rather than person centred, for example, people who remained in their rooms received interaction from staff when receiving personal care or support with their meals. Staff informed us they did not get time or opportunities to sit with people. One member of staff informed us. "It would be nice to sit with people but we don't have the time"

Care plans documented people's preferences to spend time out of bed or in lounge areas, these preferences were not always acted upon in a consistent manner. For example one person informed us they did not like spending time in their room they told us they wished to go into the lounge areas and leave their bedroom sometimes during the day. Although the person was allocated one to one staffing, and staff said they would like to support the person into other areas of the home, the staff remained in the person's room to deliver the one to one support. A number of staff said they did not understand why the person could not access other areas as although they were at risk of falls they would be there to support. This meant the person was not being given choice on how to spend their day. However staff were seen to be kind and caring with the person.

On one day of the inspection the person was supported out of their room for personal care, and became very upset when taken back to their room. We saw and spoke to the person who clearly did not wish to go back to bed. We discussed our concerns with the provider who told us the person was at risk of falling which was why they needed to remain in bed until specialist equipment arrived. The provider had put procedures in place to support this person and was seeking advice and equipment to rectify the situation.

One family member informed us they did not know what care their relative received when they were not visiting them, they informed us "There seems a lot of staff today, my [relative's name] is unsettled, I worry if we are not here what care they are getting." They went on to give an example of when their relative had needed support with personal care, two members of staff said they would come back to the room to support but did not return as their shift ended, they explained they did not bother to come back and tell us they were leaving.

The lack of person centred approach is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person Centred Care

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. All relatives visiting the home told us they could come in at any time. One relative informed us "Yeah the care here is OK. I have had to have a word about fluids. The doctor came out to see [person's name] yesterday. They told me they would keep a fluid chart. Every time I come in [person's name] is well cared for. Every time I go to their room it's been clean and clothes put away. I have no concerns. Communication is good. They ring me on a regular basis."

Staff respected people's privacy. All rooms at the home were used for single occupancy. Bedrooms were personalised with people's belongings, such as, photographs and ornaments to help people to feel at home. Staff knocked on doors and waited for a response before entering. Staff addressed people using their preferred name and they were discreet when offering people assistance with personal care needs. People told us they were supported by kind and caring staff, one relative informed us. "The care is absolutely brilliant, it could not be better [person's name] is looked after so well, they are treated with dignity and respect." A person told us "The care is very nice it's very good, they do look after me". The provider was visible around the home each day and spoke with people on a daily basis.

People who had difficulties with communication or memory were supported appropriately For example one person who had difficulty remembering when their medicines were due had the times written on a large notice board in their room. We saw staff communicating well with people seeking consent and explaining the care they were offering. Staff understood the importance of treating people with dignity and respect, for example by shutting doors when carrying out personal care. People also told us the staff were kind and caring.

There were a number of compliments with comments such as "My mother is looking the best I have ever seen her for four years". "We are delighted with the care". In the main entrance to the home there was a suggestion box for staff and relatives to express their views on the service. The home had good signage in different areas that kept people and their visitors informed of up and coming events. Relatives told us they were always made to feel very welcome when they visited.

The provider told us. "The environment is designed to encourage people to be sociable with each other by having many lounges and a number of two seater chairs. It also allows for people to have quiet one to one time away from a busy activity area. At Avalon we operate a 24 hour visiting policy. Families are encouraged to become a part of Avalon life". People and their visitors had opportunities to sit and socialise with each other in many quiet areas within the home, including a sensory lounge. The garden was secure with many seating areas. One relative informed us "We love to come along and sit or walk in the garden, other people come and join us, and it is very sociable".

Requires Improvement

Is the service responsive?

Our findings

There were mixed comments from friends and relatives regarding the service being responsive. Comments included "I would complain to whoever is on duty, I'm not sure if they would respond to my complaint. I don't know what the care is like when I am not here. There is not normally many staff around but lots today". Another relative informed us "I once rang the home as I had some concerns, a girl answered and said they would get someone to ring me back, they didn't". A further visitor informed us "It a lovely home, but I am not sure [person's name] would get the support if we were not around, once they were ill nobody checked to see if we were ok, I am not sure if this was because the staff knew we were there".

Care plans and behaviour management plans were in place to support people when they became anxious confused or upset. The provider and deputy manager told us that they were 'work in progress' and that they were aware that the care plans needed to improve. Work has started on this with every person allocated a registered nurse and a carer.

People's records were not securely stored. When asked staff were aware of issues of confidentiality. However staff were not responsive in protecting people's personal and confidential information from being seen or shared. For example files containing daily records and behavioural management plans were stored on a table in the main lounge area. The main lounge area was used by many visitors to the home it was also an area where visitors to the home could sit and socialise. This meant there was a risk people's personal information was not kept confidential.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations

Each person had a senior worker and care worker allocated to them as a keyworker. Keyworkers had the main responsibility to update the care plans and involve people in their care planning. Activities staff also helped to complete 'This is me' document which went alongside the care plans. These documents gave details of a person's life history, preferences, and important relationships.

Although there was a programme of regular activities in the home people's social needs were not always met. A number of people who remained in their rooms did not receive very much stimulation. Involvements in activities were recorded, although this documentation was confusing. One person was recorded as not having any activity in their room for a total of 17 days. The same person was also reported to have undertaken activity on two occasions within the 17 days in their care plan.

Activities co-ordinators were available in the home seven days a week. One of the activity co-coordinators informed us they had lots of plans to develop the activities, the plans included more trips out for people, they explained they were working alongside people and their keyworkers to get as much information as possible to ensure people choose the activity they would most like. On the first day of our inspection to the home, a person living at the home had a friend playing the piano, a number of people clearly enjoyed the 'sing along'. The home had a minibus so visits and trips out were possible. One of the activity coordinators had set up a file with appropriate risk assessments for mobility, baking, armchair activities and pet therapy.

There were plans for themed events such as, film sessions with popcorn and sweets and a 'pub' recreation was planned as well as a herb garden and vegetable patch in the garden areas for residents interested in gardening. Cookery sessions were held once a week for people who wanted to cook and the previous week people had been involved in making pizzas with a variety of toppings. On Valentine's day they arranged to have heart shaped cakes and an Easter Egg colouring competition was planned.

People told us they felt confident they could speak with the manager or the staff if they had any complaints or concerns. Complaints had been investigated with outcomes of investigation appropriately recorded. Complaints files were visible for staff to see. The provider had a written complaints policy and procedure. Written information about how to raise a complaint was given to people and copies of the complaint procedure were available in the main reception area of the home, Relatives told us they would be comfortable to make a complaint. We were shown a number of compliment cards and letters referring to the excellent care people had received at the service.

Requires Improvement

Is the service well-led?

Our findings

The home was managed by the provider who was also applying to the Care Quality Commission to become the registered manager whilst a permanent registered manager was appointed. We saw they were visible around the home and knew people well, The provider had a clear vision for the home they informed us. "People are the centre of all we do, this is their service. Relatives play an important role so we involve them as much as we can."

We found the provider did not always have an open and positive culture which did not provide a happy and relaxed atmosphere. Some staff felt unable to speak out when they felt care and treatment was wrong. Examples of this were given in the report relating to some people's freedom of movement and choices being restricted. Some staff felt the provider was not always supportive or constructive in their approach to managing the service. We spoke with staff regarding their experiences of working at the service and their knowledge of the vision of the service. There were mixed comments about the current management of the home. Some of the staff did not feel the provider was approachable. Staff morale was seen to be low, one member of staff commented. "We have had two good registered managers, they have both left". Another member of staff told us "The provider is passionate about the home and wants things to be done the right way". The provider told us that the previous manager had left the home a few weeks before the inspection. This had left the staff feeling unsettled, but they were seeking a new manager and trying to make positive changes to the way things were done in the home.

The provider's quality assurance system included audits of key aspects of the service. Audits included medicines, nutrition, staffing, accident training and the environment. These audits and quality monitoring systems had not identified the issues we found. These related to inconsistencies in people's care records, poor monitoring of some people's care, some people's movements being restricted without the correct authority to do so, insufficient staffing levels, and poor supervision and training for some staff. In addition, staff meetings and staff supervisions were not held on a regular basis. The provider acknowledged that the quality assurance systems required further work.

Accidents and incidents had been recorded in an accident book. However the accidents had not been reviewed to consider the potential risk of further accidents or incidents, such as managing people behaviours and putting systems in place to prevent them happening again. For example we looked at incident records relating to a person putting themselves at risk by trying to leave the premises. We observed the person trying to leave the building on two separate occasions, no management plan was in place to reduce the risk of it happening it again.

The lack of good governance is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations

In the provider information return (PIR), The provider stated "All staff now have an allocated line manager who will be responsible for supervision. However as this is a new development and staff teams are still being created. Any disciplinary matter is promptly dealt with. As our residents care is paramount, we empower our

nurses to take responsibility and accountability of their practice and the daily running of the shifts".

The provider informed us their values and vision for the home "Our residents are centre of all we do here, we involve them and their relatives where we can". The provider told us each person that comes to live at Avalon has a pre assessment meeting where they find out about the person's likes and dislikes including sleep patterns, this information would be included in the person's care plan. The deputy manager informed us "There is a lot of work to do, we try to communicate with families as much as possible, for example if someone fell we would contact their family. It is important to have continuity of care".

The home had a training manager who covered the three homes which belong to the company. The provider said "We have a training policy so all staff are encouraged to take learning opportunities during the year. When they have completed the required training then staff can claim for their time spent on training. In dementia care the involvement of relatives and friends is crucial."

The home also plans to commence the Gold Standard Framework. (GSF) in 2016. The Gold Standard Framework provides a comprehensive training and quality assurance system to enable care homes to provide quality care for people nearing the end of their life. This would ensure staff understood the principles of best practice when working with people who were nearing the end of their life.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment provided did not reflect service users preferences. Regulation 9(1)(c)

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 were not always provided in a safe way. The provider did was not assessing and doing all that was reasonably practical, including ensuring staffing levels were constant, to mitigate the risk to the health and safety of people. The provider did not ensure sufficient quantities of equipment were available at all time to meet people's needs. The provider did not have systems in place in regards controlling the spread of infections. Regulation 12 (2)(a)(b)(c)(e)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Safeguarding service users from abuse and improper treatment Legislation was not being taken into account in the control and restriction of movement of people. Regulation 13(4)(b)

Regulated activity	Regulation
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 systems to assess monitor and improve the quality and safety of the service. Where risks had been identified measures were not introduced to reduce the risk. Audit and governance systems were not effective. Records were not kept securely at all times Regulation 17 (2) (a)(b)(c)(f)

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 Staff did not receive appropriate and ongoing or periodic supervision in their role to ensure competence was maintained. Regulation 18(2)(a)