HC-One Limited

Averill House

Inspection report

Averill Street
Newton Heath
Manchester
Lancashire
M40 1PF

Tel: 01616886690
Website: www.hc-one.co.uk/homes/averill-house/

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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 10 and 11 February 2016. The first day was unannounced, which meant the service did not know in advance when we were coming.

The previous inspection had been on 24 September 2014, and the inspection before that on 28 April 2014. At the April 2014 inspection we found the service was not meeting two regulations, relating to reporting safeguarding allegations, and staffing levels. At the September 2014 inspection we found that the service had improved and was now meeting those two regulations.

Averill House is a purpose built care home providing accommodation, with nursing care, for up to 48 older people. At the start of this inspection there were 32 people living in the home, and two more people arrived on our first day. The home specialises in care for people living with dementia. People live on two separate floors, each with its own dining room and lounges. People with needs classed as 'residential' live on the ground floor. The first floor caters for people who require nursing care. Two people with nursing needs were living on the ground floor in line with their family's wishes. There is a car park within the grounds. The home is situated in the Newton Heath area of Manchester, close to local amenities and with good transport links.

There was a registered manager who had started working in Averill House in December 2014. 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.

We saw that the building was spacious and suitable for the needs of the people living there. However, due to its size it was difficult for staff to monitor all parts of the building especially at night when there were only two staff on duty on each floor. We knew of an accident that had happened unobserved in the ground floor corridor causing an injury that required hospital treatment. One of the two staff on duty had been upstairs at the time. We considered that this meant that the provider had not done everything reasonably practical to reduce risks. This was a breach of the relevant regulation.

We noted however, that the registered manager had acted to try and prevent a recurrence of this accident, by purchasing a chair sensor. This relied on staff being nearby when the person got out of their chair.

We saw that recruitment processes were robust, and that staff were trained in safeguarding and knew what to do if they had any concerns about abuse.

Records showed that staffing levels had been increased during 2015 by one staff member on the day shift. Given the complex needs of some of the people, all of whom were living with dementia, and the size of the building, the registered manager needed to regularly reassess the numbers of staff required. We considered that there were sufficient staff on duty. We were concerned that one member of staff was working excess

hours.

We were satisfied that medicines were managed safely and properly. The home was clean. There was a smell of urine on a downstairs corridor but the carpet was due to be replaced with laminated flooring in a refurbishment. We saw that the building was maintained to be a safe environment and there was a refurbishment planned in the immediate future.

Training was up to date and a high percentage of staff had completed both mandatory and additional training. Most training was by e-learning on the computer but there was some classroom training as well. Some staff had completed training in dementia care. We have recommended that training in dementia care be reviewed and improved and delivered to all staff.

We saw the supervision schedule for 2015. The schedule required that staff receive supervision at least six times a year, but this had not always happened during 2015.

We checked whether Averill House was working within the principles of the Mental Capacity Act 2005 (MCA). We saw that the correct procedures to obtain consent were followed, where the person lacked mental capacity.

There were three people whose liberty was being restricted under a Deprivation of Liberty Safeguards (DoLS) authorisation. Six other applications under DoLS were awaiting a decision.

We saw that the food was nutritious and was enjoyed. It did not match what was on the menu. The dining rooms were pleasant places to eat, although we noticed that the posters on the wall were not really for the benefit of people living in the home. There was scope to make the visual environment more suitable for people living with moderate to advanced dementia.

Relatives made mainly favourable comments about the care provided in Averill House. We observed kind and considerate gestures by staff towards people living in the home.

We received information of concern about the provision of care and treatment to people who were at risk of pressure sores and found that the care and treatment of pressure areas could be improved. This was a breach of the relevant regulation.

On the whole staff treated people with respect. We noted that some disrespectful language was used about people, but it was not malicious. People's dignity was upheld, and the registered manager had a considered policy about intimate relationships. Family members were encouraged to be involved in the care of their relatives.

There had been a serious safeguarding issue in December 2014 regarding a failure to provide proper end of life care. Since then training in this area had improved, but there was room for further improvement.

There was a comprehensive set of documents in the care plans but we found little about each individual's personal history. Some booklets had been introduced to fill this gap but had not yet been completed. The care plans were reviewed regularly but we found some errors in them.

Several care staff, including someone who had worked at Averill House for over a year, told us they had not read any care plans. This meant that people were at risk of receiving inappropriate care and or treatment. This was a breach of the relevant regulation.

Averill House had an activities co-ordinator. An outing was arranged on the first day of our inspection but had been badly planned, without a risk assessment. We observed that people were not always engaged in appropriate activities.

Surveys of relatives were conducted annually and meetings took place quarterly. Relatives were given the opportunity to contribute ideas to the running of Averill House. We saw that complaints were responded to promptly.

The registered manager was supported by the provider who supplied a comprehensive set of policies and procedures. Within the home there was a management team and good communication among the senior staff. Staff meetings were not well attended which meant that issues discussed there were not necessarily shared with all the staff, although the minutes were displayed after the meeting.

There was a system of regular audits, which the provider monitored. Lessons were learnt from accidents and incidents, and from any physical encounters between people living in the home.

We learnt that the registered manager had acted firmly in relation to a disciplinary issue in order to protect people living in the home.

In relation to the breaches of regulations, you can see what action we told the provider to take at the end of the full version of the 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 always safe.

We found that risks to people living in Averill House were not always monitored and reduced. We did find that action was taken to reduce the risk of an accident recurring.

We found that staffing levels were sufficient but that the need for more staff needed to be monitored closely.

Medicines were managed safely and the building was well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a good uptake of training, except around dementia where more was needed. Supervisions had not always taken place during 2015, to support staff in their roles.

The service applied the principles of the Mental Capacity Act 2005 and associated legislation.

People enjoyed the food. The building was about to be refurbished and the provider had plans to make it more suitable for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives in general had a high opinion of the care provided, although there were exceptions.

Concerns had been raised about the care of two people with pressure sores. We found that care in this area had room for improvement.

Staff treated people with respect and maintained their dignity. Care for people at the end of life had improved but there was scope for further improvement.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not enough personal information about people's life histories in care plans. Several staff said they had not read any care plans, which meant they could not deliver person-centred care.

Activities and outings took place but we found there was a need for better organisation of the outings.

There were relatives' meetings and surveys to enable them to give their views about Averill House.

Is the service well-led?

Requires Improvement

The service was not always well led. Our findings regarding end of life care, pressure area care, staff supervision and training indicated that there was scope for improvement in this area.

There was a management team within the home which worked well together. Staff were involved through staff meetings although they were not well attended.

There was a well-organised system of audits which was monitored by the provider. The registered manager was able to use an extensive set of policies and procedures supplied by the provider.

We saw the registered manager had acted robustly in a staff disciplinary matter demonstrating effective leadership.

Averill House

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 10 and 11 February 2016, and the first day was unannounced.

There were two members of the inspection team: an adult social care inspector and a special adviser with expertise in caring for people living with dementia.

Before the inspection we asked the registered provider to complete 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. It was submitted to us on 12 January 2016. We reviewed the PIR along with other information we held about the service, including notifications received, communication with relatives, and minutes of safeguarding meetings.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. We contacted Healthwatch who held no information about the service.

During the inspection we talked with three people who were living in Averill House, and with two relatives. We spoke with seven members of the care staff. We spoke with the registered manager, the deputy manager, and with the assistant operations director. We talked with two district nurses who had come to visit two of their patients in Averill House.

We looked around the building and observed mealtimes and interaction between staff and people living in the home. We carried out an observation known as a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

We looked at four care files in detail, three recruitment records, records of incidents and accidents, policies

and records of audits. We examined medicine administration records (MARs), the medication policy, and medication audits. We looked at minutes of staff meetings and relatives' meetings, records of compliments and complaints and maintenance records.

Requires Improvement

Is the service safe?

Our findings

All of the people living in Averill House were living with advanced dementia. This limited their ability to respond to our questions. We therefore relied on our observation and on other sources of information to determine the answer to the question whether people were safe. We looked at two sets of relatives' surveys from January 2015 and January 2016. We saw that the majority of family members had ticked the box to answer the question "Does your relative feel safe?" However, there was scope to improve the style of question in the survey. Around a third of relatives had left that box and other boxes blank and had responded that they could not answer that question because they could not tell how their relative was feeling.

The physical layout of the building was well designed to keep people safe. The corridors were wide so there was plenty of space for people to pass each other. On both floors there was no access to staircases except through doors which were kept closed. This reduced the risk of people falling on the stairs. However, because Averill House was not fully occupied there were also fewer staff on duty, than there would have been if all bedrooms were occupied. This made it difficult for staff to keep observation on all parts of the floor. The building layout was one long corridor with two shorter corridors at each end. This meant that staff working at one end of the building were out of sight and earshot of events at the other end. We saw in the minutes of a staff meeting on 2 June 2015 that the registered manager had reminded staff that they needed to cover the whole floor: "Carers must not congregate together in one lounge, on occasions it has been noted that carers are all sitting together in the lounge with no interaction with the residents." The registered manager told us that since he gave that instruction staff had followed it and there had not been any more such occasions.

The layout of the building meant that especially at night, when there were only two staff on duty on each floor, there was a risk that incidents and accidents might not come to the attention of staff immediately. We were aware of one such incident in January 2016 because family members had contacted us shortly before the inspection. One of the two staff on the ground floor had gone upstairs, at around 9.15pm, and when they returned they found someone had fallen in the corridor and injured their head, requiring treatment in hospital. This person was someone who was prone to falls. The member of staff who had been left downstairs in a different area had not been aware of the accident.

We considered whether anything could have been done to prevent that accident or similar accidents. We spoke with the registered manager who told us that they had purchased a chair sensor for this person, which we saw being delivered. The plan was that this sensor would make a noise when the person got out of the chair, and staff would be alerted to observe them and ensure they were safe. The system would only work if a member of staff was close enough and free to respond to the sensor.

Purchasing the sensor was a response to the accident which showed that the registered manager had taken action to reduce the risk of a recurrence. Nevertheless when there were only two staff on duty on the whole floor, for one member of staff to go upstairs clearly increased the risk of not discovering the person immediately, if an accident occurred. This was a breach of Regulation 12(1) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014 with reference to 12(2)(b). This regulation requires providers to do all that is reasonably practicable to reduce risks to the health and safety of people using the service.

We looked at the recruitment records of three staff and found that all the necessary checks had been made and references obtained. One person had left gaps in their employment record on their application from, but there was a note to say that the reason for those gaps had been checked at interview. We saw that a certificate from the Disclosure and Barring Service (DBS) had been obtained before they started work at the home. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups.

We saw that 93% of staff at Averill House were up to date with their safeguarding training. Staff we spoke with knew what signs of abuse to look out for and were confident they knew how to report it. Telephone numbers to report any whistleblowing concerns were displayed in the staff room. We knew from notifications received that the registered manager reported to the CQC any safeguarding matters promptly and fully.

Staffing levels both during the day and night had been an issue at our previous inspection in April 2014. Following that inspection Averill House had been rearranged so that people with nursing needs were on the first floor, and people without nursing needs, classed as 'residential', were on the ground floor. Three families had objected to their relatives having to move floors, and two of these people were still on the ground floor. The new arrangement had allowed for a more effective deployment of staff. At our last inspection in September 2014 we found the numbers of staff were sufficient to meet the regulation.

At this inspection we found that during the day, a nurse and three care staff were on duty on the first floor, and a senior carer (or unit manager) and three care staff were on duty on the ground floor. At night there was a nurse and a carer on the first floor, and a senior carer and a carer on the ground floor. We checked the rotas for four consecutive weeks and confirmed this was the case. Earlier, at a staff meeting on 2 June 2015, the staff had raised the issue of there not being enough carers on the ground floor. The same issue was raised by two different family members in June and July 2015. We saw that the number of carers on the ground floor day shift had been increased by one carer in September 2015, to the current level

The registered manager told us that the provider had a policy of assessing the needs of people living in Averill House and allocating staff accordingly. We saw these assessments on individual care files. At the time of this visit there was nobody who needed one-to-one care and attention. One family member, who was a frequent visitor, told us that they sometimes had to wait when they summoned staff to assist with taking their relative to the toilet, but it was never more than five minutes. The deputy manager told us they could be a member of staff 'down' during a trip. But this was not always the case. The staff rota showed that extra cover was sometimes brought in if there was a trip out and a member of staff accompanied the trip. We saw that staff were busy, but based on the numbers of people on each floor and their assessed needs the current number of staff was sufficient for the number of people in the home and their needs but the numbers and deployment of staff should be kept under constant review.

The registered manager told us that agency staff were used from time to time, but that he was building up bank staff, to cover any sickness or other absence from the rota. After the inspection visit, we checked the rotas to see that staff were working reasonable hours each week. We saw that most staff were, but there was one exception. One member of staff was on the rota to work 72 hours in three weeks out of four, and 60 hours in the other week. The 72 hours were made up of six 12 hour shifts in succession. We had seen that staff had signed an exemption to the working time directive, which meant that they could legally work such long hours, but there was a risk of this member of staff being tired and less alert while on duty, and

potentially making mistakes.

We saw an outing to a museum was being arranged on the first day of our inspection. When we learnt that a person with a history of episodes of challenging behaviour was due to go on the outing, we asked whether there had been a risk assessment, which ideally would contain contingency plans. The deputy manager told us that they had not been aware of the trip until that morning and they did not have a risk assessment in place. The lack of a risk assessment made both the person concerned and staff vulnerable.

We looked at how medicines were managed in Averill House. Nurses and senior carers had a record of 100% completion of medicine competency assessments. Medicines were handled separately on each floor. There was a clinic on each floor where medicines were stored safely in locked trolleys. Fridge temperatures and room temperatures were recorded twice daily. We checked a sample of the medicine administration records (MARs) on both floors, and found they were all completed correctly. The staff in charge of medicines told us that Averill House had a policy where twice every day at 7.30am and 7.30pm the two floors exchanged and checked one another's MAR sheets for any discrepancies. Any errors that were found were then reported and acted upon immediately. This gave an additional degree of confidence that the MAR sheets were monitored effectively.

We checked the controlled drug records and these were kept correctly and matched the controlled drug stock. We saw that controlled drugs were kept in secure cabinets in line with regulations.

We saw a note in the minutes of the staff meeting held on 12 August 2015 that "medicine ordering on the ground floor is not happening on a timely basis." We asked the unit manager on the ground floor whether this was still a problem. They told us that the problem had been addressed and that there were no problems with ordering and obtaining medicines on time. We were not aware of any issues regarding medicines not being available when needed.

The home was generally clean and tidy. We saw that two relatives had made comments to this effect in the recent relatives' opinion survey. We did notice the odour of urine on the carpet in the long corridor on the ground floor. The registered manager told us he was aware of this problem and of its cause. As part of a planned refurbishment that was due to happen soon he had requested that the carpet be replaced with laminate flooring which would be easier to clean and keep fresh. An officer from Manchester City Council had conducted an infection control inspection on 6 May 2015. We saw that Averill House had developed an action plan and implemented the suggestions made in that report.

We saw an indexed file of maintenance certificates. This showed that the fire detection system, emergency lighting and fire extinguishers had all been serviced during 2015. The provider had carried out an internal fire risk assessment in June 2015, but there had not been a recent visit by Greater Manchester Fire and Rescue Service. We saw that individual care files each had a personal emergency evacuation plan (PEEP) which would assist the staff and the fire service if they needed to evacuate the building in the event of fire or other emergency.

The electrical installation, fixed wiring system and electrical appliances had been tested. The lift had been serviced. The building was being maintained to a satisfactory standard which reduced the risks to people living there.

Requires Improvement

Is the service effective?

Our findings

We looked at how well staff were supported in their roles by training, supervision and appraisal.
We saw from records that staff at Averill House had a high rate of achievement of mandatory training. Manual handling training was done in a classroom setting, while other training was done by e-learning. There was a dedicated training room on the top floor of the building where staff could access the Internet. There was a wide range of other training available by e-learning. There were high rates of completion of this training as well. The registered manager told us this training was popular with staff. There was specialist dementia training called "Open hearts and minds", which was completed over five sessions. The first four were e-learning, and the fifth was a classroom based session. One member of staff told us they had attended the fifth part of this, and said they had found this beneficial. However, there was a low uptake of this fifth part of the training. Given that Averill House specialised in care for people living with advanced dementia and speaking with staff, we found in some cases their basic knowledge around dementia could be improved.

We recommend that training in dementia care be reviewed and improved and delivered to all care staff.

We looked at the record of staff supervisions and appraisals in 2015 and 2016 to date. Annual appraisals were called performance reviews. We saw that supervision was planned to take place every two months, and the registered manager confirmed this to be the case. The supervision schedule stated: "Formal Supervision must take place a minimum of 6 times a year with each Staff Member." A few staff had received supervision less often than this. For example one member of staff had received two supervisions and an annual appraisal in 2015.

Records of the supervision were kept on each staff member's personal file. Supervisions were carried out by various members of staff: the registered manager, deputy manager and unit manager and some senior carers. When they were carried out by another supervisor, the registered manager signed the form to indicate he had read it. This meant he was aware of issues raised by all staff during their supervisions. On one file we found two identical supervision records for two successive supervisions. The registered manager explained that this was purely an administrative error, and showed us the correct record. There had been a few gaps in 2015 but the registered manager stated that it was his intention to ensure that staff received all the supervisions they were supposed to during 2016.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Under the legislation a provider must issue

an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

We checked whether the service was working within the principles of the MCA. We saw that the care records included consent forms. For example on one file there was a photography consent form to record whether consent had been obtained to the taking of photographs of that person and their use on MAR sheets and elsewhere. The form stated at the bottom "If the resident lacks capacity please complete a mental capacity assessment including a best interests decision prior to taking any photos…" We saw that a mental capacity assessment had been completed which related to the specific decision about taking photographs. There was also a record of a best interests decision. This showed that the service was following the procedure set out in the MCA. However, it was also recorded on the same photography consent form that a close family member "gave permission" for photographs to be used. This suggested a possible misunderstanding of the principles of the MCA, as a family member cannot give consent on behalf of a person who lacks capacity to do so themselves. We mentioned this to the registered manager.

We saw that mental capacity assessments had been done for each person by the same member of staff, a registered nurse. We saw that in all cases separate assessments were completed for each significant decision, which is the correct practice.

On one care plan we saw the statement that care staff would make best interests decisions on a daily basis for that person. This demonstrated a good understanding of the MCA, as such decisions can be made informally depending on the nature of what is being decided.

On 9 October 2015 the registered manager notified the CQC of three DoLS authorisations, as required under regulations. One of them had been authorised nine months earlier, in December 2014, but the Council had delayed sending out notification.

These were the only three current authorisations of which we were aware. In the PIR returned on 12 January 2016 the registered manager had stated that nine people "were subject to authorisation under the Deprivation of Liberty Safeguards." At the inspection we enquired about the discrepancy, and the registered manager stated that it had been a misunderstanding of the wording on the PIR. There were only three authorisations. There were six applications still with Manchester City Council. The registered manager produced a list of these applications which summarised the reasons why they had been made.

If a person dies while the subject of a DoLS authorisation the death is investigated by the coroner. During our inspection we learnt that such an investigation was underway for someone who had died in January 2016. Averill House had not been notified that this person's application under DoLS had been authorised, and consequently had not notified CQC. The assistant operations director contacted Manchester City Council while we were there, and was informed that the DoLS application had indeed been authorised on 29 December 2015, but that due to procedural difficulties notification had not yet been sent out. This was therefore no fault on the part of Averill House.

We noted a comment on one care file where it stated at each monthly review "[the person] is on a DoLS." However, there was only an urgent authorisation and a standard application for that person. The urgent authorisation only lasted for seven days and had not been renewed. This meant that this person did not have an authorised DoLS in place and staff needed to be aware of that.

We looked at the menus and the food, and observed lunch on both floors. We talked to two assistant cooks.

The menu was on a four week cycle. The menu for lunch on Wednesday 10 February 2016 was potato hash, or sandwiches followed by rice pudding. The menu books were outside each dining room but appeared to be more for the benefit of visitors than people living in the home. In fact, the food served bore little resemblance to the menu. One assistant cook told us they were making fish cakes because people preferred them. They added that people tended not to like many of the items on the four weekly menus, so the kitchen staff prepared other meals instead. From our observation the food served on the days of our inspection was wholesome and nutritious.

Diet notification forms were kept in individual care files and copies were kept in a folder near the kitchen. The form gave details of dietary needs – for example whether the person was diabetic – and also of their likes and dislikes. This meant that the kitchen staff could make themselves aware of people's dietary requirements and preferences. We noticed that forms for people living in the sister home next door, served by the kitchen in Averill House, were kept in the same folder and there was no order so it was difficult to find a particular person's form. The folder needed updating as some of the forms in it belonged to people who were no longer living in Averill House.

We saw that people were enjoying their meal at lunchtime. One visitor who was assisting his relative to eat commented, "The food is not bad at all. Sometimes they serve too much, which puts [my relative] off eating it. There was a problem with the food not being warm enough, but they bought a new trolley and now it is fine provided they set the right temperature."

The tables were laid with metal cutlery and glasses and tablecloths, which created a pleasant environment to eat in. People wore napkins while they were eating. There was a noticeboard which contained a picture of a fried breakfast, but there were no other pictures of food which might have been of benefit. Instead there was a poster with dense information about food allergies and intolerances. Two further pages about allergens were laminated and fixed to the wall. Next to this was a notice about the staff working extra shifts, which would have been better placed in the staff room.

People's weight was monitored regularly and help was sought from dieticians when needed.

Many aspects of the design of the building were suitably adapted for people living with dementia. For example wardrobes in people's rooms were specially designed to allow people to see their clothes more easily. There were chests of drawers for rummaging in the corridors. However, we found there was scope to improve the environment for people living with dementia. The curtains in the lounges were patterned, which can often cause visual hallucinations. Toilet seats were not all distinctive colours, which could prevent people from seeing them. More could be done to enable people to recognise their own bedrooms, for example by painting the doors in different colours. The registered manager told us that the provider had set aside funds for a refurbishment which was in the planning stages. He stated he would feed these ideas and others into the new design.

Requires Improvement

Is the service caring?

Our findings

One person living in Averill House told us, when we asked about the staff, "They're doing a good job." We looked at the results of two relatives' opinion surveys carried out in January 2015 and January 2016. Some relatives had recorded their opinions of the care provided at Averill House. One relative had written, "Overall I feel the care is good and the staff are caring and well trained to cope with the demands of the job." Another person had written, "The carers are extremely hard working and compassionate with the people they are caring for. They understand my dad's needs which puts my mind at rest." Another relative, answering the survey, wrote, "My [relative] is in the final stages of dementia, so I cannot answer most of the questions. I think and hope that they are being well cared for."

There were some written compliments recorded. One person wrote, "All the team and all the staff made my [relative] very welcome, they have all looked after her."

There were also some critical comments in the surveys. One relative, who was unhappy about certain aspects of their loved one's care, wrote, "To the best of our knowledge, my [relative] has always been treated well by staff who seem to be genuinely caring people. The only issue is that the staff are that busy that they do not seem to have time to spend socialising with the residents and because of this residents can be left to their own devices with no staff in evidence."

Another relative wrote, "Carers seem to have too much paperwork which takes them away from caring." Another person complained about items of clothing going missing in the laundry, and their relative wearing clothes which did not belong to them. However, the same relative concluded by saying "Overall, good care provided."

We observed kindness on the part of staff. One member of staff was about to accompany someone outside to the cigarette shelter, and when the person said they were cold the member of staff offered their own coat. We also saw good interaction in one of the lounges during our observation. Staff were engaging with people, offering them books to look at and ensuring they were comfortable. We saw staff defuse a potentially tense situation between two people at lunchtime, by offering to move one of the people to a different chair. We also saw one example where staff failed to recognise a person's needs. A person in a wheelchair, who had no ability to move independently or communicate verbally, was left facing direct sunlight through the window in one of the lounges. We mentioned this to staff who then moved the person into the shade. This showed that staff were not always mindful of the needs of people who could not communicate.

We met two district nurses who had come to attend to two people who had pressure sores. The registered manager had notified us in December 2015, as required, that one of these pressure sores had deteriorated to Grade 3, in other words become quite serious. One of the district nurses told us they were concerned that the person was not on the right mattress, and was not being repositioned often enough especially by the night staff. Their evidence for this was that the repositioning was not being recorded as often as it should be on the chart, and that the pressure sore had deteriorated. They added that this person had a second

pressure sore on one knee, and staff were supposed to ensure that a pad was placed between their knees to avoid further chafing. The district nurses said that often when they visited the pad was not in the right place.

We raised these issues with the unit manager and the registered manager. They told us that the mattress was correct and suitable. After speaking to their manager the district nurse confirmed that this was the case. The staff at Averill House stated they were doing all they could to treat the pressure sores and to stop them deteriorating, but pointed out that the person's limbs were constricted and friction was unavoidable. They suggested that the pressure sore had deteriorated naturally, and that the pad moved about when the person moved in bed.

We considered seriously the allegations made by the district nurses. They alleged that pressure sores had deteriorated as a result of poor care. We considered there was sufficient evidence to show that pressure area care required improvement. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that staff treated people respectfully, and in a friendly way. One relative commented in the survey, "Staff do respect people's privacy as much as they can bearing in mind that people need help with washing dressing toilet etc." We did notice that some staff used language which might appear disrespectful. When referring to people who needed assistance to help them eat, staff described them as "feeders" and talked about "feeding" people in their rooms. The same language was used in care plans, for example on one entry in a care plan we saw "[person's name] continues to feed and drink independently." This language was not respectful to people However, this was an isolated example and did not reflect the general approach and attitude of staff to the people they were supporting. We mentioned it to the registered manager during the inspection.

With reference to a notification to the CQC in July 2015 we discussed with the registered manager how the service responded to the issue of intimate personal relationships in the home between people who use the service and whether people's rights to intimacy privacy and dignity were respected. We were satisfied that the service and the registered manager had a thoughtful and considered policy on this issue.

Some family members were regular visitors to the home and were encouraged to be involved in their relative's care. One family member had completed the social and psychological assessment form for the person living in the home. One family member was helping their relative to eat at lunch and then sat by their bedside while they had a nap. This showed that if they were able to family members could be involved in caring for their relatives.

We considered how well Averill House was able to care for people at the end of life. We obtained a copy of the provider's end of life care policy. We had attended a series of safeguarding meetings in early 2015 following concerns raised by district nurses that staff at Averill House had failed to obtain and administer pain relief drugs for someone who was at the end of their life. It was also alleged that a needle had been left in their arm unnecessarily, and thirdly that staff were not well trained in end of life care. These allegations were substantiated by the safeguarding meeting. Recommendations were made that Averill House should improve its end of life training and that this should be monitored by the local authority.

Some staff had attended an end of life training programme which started in April 2015. But specific end of life training was not one of the courses regularly undertaken by all staff. Averill House had not yet participated in Six Steps, which is an end of life training programme developed for care homes in the North West. The registered manager told us they might do so in the future. At the date of the PIR 11 people out of the 33 people in the home had a DNAR form in place. This is a form which instructs paramedics and staff not

to attempt cardiopulmonary resuscitation in the event of a cardiac arrest. We knew from notifications that where appropriate a Statement of Intent was also created when death was imminent. This is a document which confirms a GP has predicted that a person's death is likely within the next 14 days; it also allows the cause of death to be recorded in advance.

These measures showed that the staff were prepared to work with doctors and district nurses to make the process of dying easier both for the person concerned and for their families. However, we considered the service had not yet addressed all the recommendations of the safeguarding meeting by training the staff and equipping them to care for people at the end of life. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

In the relatives' opinion survey, one relative had written "Very nice staff. They always give me a report of my mum's last few days." This showed that staff were aware of people's health and welfare and reported on it to families.

The care plan documentation supplied by the provider and used by the service promoted the idea of person-centred care. The front page of the file was headed "Person centred care plan. Living with dementia." However, the care plans which we looked at contained very little life history information, with only a small amount of detail included in the social and psychological assessment. Person-centred care takes into account each individual's unique history, qualities, abilities, interests, preferences and needs. If those details are not recorded and known by the staff then it is very difficult for staff to engage with each person individually.

We discussed this with the deputy manager, who showed us a booklet entitled 'Remembering Together, Your life story' which when completed would contain much of the information described above. We were told that the blank booklets had been given to the activities co-ordinator to complete. We discussed with the registered manager whether it might be more appropriate for each person's keyworker to complete the booklet, as they should know the person better. We also considered that, given the level of ability to communicate of the people coming to live in Averill House, it would be useful to incorporate completion of the document into the assessment process, by asking families or other sources for the relevant information.

We were concerned to note that several staff, particularly newer staff, did not have any knowledge of the history of the people they were supporting. We asked two staff who were due to accompany one person on an outing whether they knew anything about their life history. Both told us that they did not, and that they had not read the person's care plan. This was particularly concerning as the person had previously shown episodes of challenging behaviour. There was a risk because the staff were unprepared that they might not be able to cope appropriately. The two care staff told us they had not read any care plans. We also talked to a member of staff who had been at Averill House for over a year, who told us they had never read any care files.

The lack of personal history recorded in care plans, and in particular the fact that staff we spoke with had not read any of the care files, meant that some staff could not deliver person-centred care that was appropriate and met people's needs. This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans were laid out in sections with an index so it was easy to find a particular section. Each section of the care plan had a review sheet and we saw that the plans were reviewed and updated regularly. We saw that the review process did not pick up every error in the files. One person's daily activities sheet recorded that they were to be "observed closely every [blank] due to having a risk of falls." The blank had not been filled in, making it difficult for staff to know how to carry out that instruction. We saw that people living on the residential floor had care plans referring to a named nurse, but in fact they had a named carer or senior

carer. One person's care plan stated they were "profoundly deaf", but we had spoken with this person and found they were able to hear what we were saying.

The registered manager stated in the PIR, "HC-One's policies ensure all residents are provided with the opportunity to engage in activities which are purposeful in order to maximise their abilities and self-worth. Activities are always available in the Home."

A comment was made in the January 2016 relatives' opinion survey about a shortage of activities for people living in Averill House. The relative suggested, "Some activities are needed like reading to residents, and talking to them." They added that the activities co-ordinator was present in the home between 10am and 4pm on weekdays, but in their view activities should be arranged outside those times as well. They went on to comment that books and magazines were always put away in cupboards with the result that "The home looks like a medical facility and should look more like a home." We mentioned this comment to the registered manager who explained that it was the home's policy to keep such items safely stored and to maintain an uncluttered environment.

An outing had been organised to a museum. In the event the person expected to go did not go on the trip. A member of staff was preparing someone else to go, and putting on their coat, when another member of staff said that two other people were now going. We considered that greater liaison within the home was needed to avoid possibly causing distress and disappointment.

We discussed this with the registered manager who said that previous trips had been held without a problem. He stated he would ensure that risk assessments were implemented from now on.

We saw that the planned activity for the morning was decorating the home for Valentine's day. We saw that the activities co-ordinator did this entirely on their own. There were some parts of the activity such as arranging table decorations, or folding napkins, that some of the people might have been able to participate in, had they been asked. This was symptomatic of a more general failure to engage people in appropriate activities. We went into one of the lounges where three people were dozing or asleep. A member of staff was present. The television was switched on. We suggested that the television was switched off and some old-time music played. Immediately one of the people opened their eyes and started moving to the music. The member of staff then tried successfully to communicate with one of the other people.

We also noticed that a radio station playing music from the 1970s and 1980s was played constantly in corridors, the dining room and communal areas. This music was not most appropriate to the age of the majority of the people living in Averill House.

The activities co-ordinator had been in post for about six months and was enthusiastic. A comment by the registered manager recorded in the minutes of a staff meeting on 30 October 2015 suggested that other staff sometimes felt that they could leave the activities co-ordinator to organise activities: "it is not just up to the activities co-ordinator to be involved with activities on and off the unit, but the rest of the staff as well."

We found that improvements were needed to ensure people were given the opportunity to participate in activities they enjoyed and were meaningful to them.

We saw the results of relatives' opinion surveys conducted annually in January. Ten surveys out of around thirty had been completed in 2016, which is a fairly good rate of return, suggesting that relatives were keen to make their views known and felt it was worthwhile. We saw comments of both praise and criticism, some of which have been mentioned elsewhere in this report. We also saw a note from the operations director,

with the surveys which had just been returned. They requested the registered manager to identify lessons learnt from the feedback and to publish them on a "You said we did" noticeboard. There was also a relatives' comments book in the front hall, but it was not very conspicuous. It contained only two comments since November 2014.

Relatives' meetings were held quarterly, instead of every two months, at the request of relatives. We saw from the minutes that their ideas were welcomed. Although only around six relatives attended these meetings they were an opportunity to be involved in matters affecting their loved ones' care. The registered manager told us he was planning to hold meetings with relatives to discuss the planned refurbishment and to seek their input.

We saw the record of formal complaints; there were four recorded in 2015. They had been dealt with promptly and in line with the provider's policy. In two cases the assistant operations director met with the complainants to talk through the issues. Another complaint had concerned staff use of mobile phones, and the operations director had responded to it. A new set of guidelines on staff mobile phone use had been introduced. This demonstrated a willingness to act upon and learn from complaints.

Requires Improvement

Is the service well-led?

Our findings

In the relatives' opinion survey, one relative wrote "I would recommend this home, with the staff you have. They deserve a medal." One of the comments in the relatives' comments book in the front hall, was "Staff all very friendly and always happy to help." These comments matched our observations of a staff team that was well motivated and enthusiastic.

Another relative wrote, "I find the home welcoming, friendly and able to provide the excellent care [my relative] needs. The senior nurses and manager have been supportive."

We observed that the registered manager was active around the home. He knew all the people living in the home, and a few of them greeted him by name. The registered manager was supported by an operations director and/or assistant operations director and by the infrastructure of the provider. Internally there was a staff structure to which some duties could be delegated, namely the deputy manager, the unit manager on the ground floor and senior carers. There was also an administrator who dealt with some of the paperwork.

We saw that there was a raft of policies, procedures and other files occupying a bookshelf in the registered manager's office. He told us he did not feel oppressed by the volume, but had in fact managed to streamline it since being in post. He saw the paperwork as beneficial.

A 'flash' meeting was held every day at 11am by the registered manager with senior staff to discuss any urgent matters. This meant that the registered manager was communicating daily with senior staff who in turn liaised with other staff. Staff had access to a confidential employment assistance helpline for counselling and support on work related matters.

We saw from minutes that staff meetings had been held every two months during 2015. The registered manager stated in the PIR that he wanted an open culture where staff felt able and comfortable to share concerns. The minutes showed that a wide range of topics were discussed. Issues raised by staff had prompted action by the registered manager and the provider, for example in increasing the staffing level on the ground floor. This demonstrated that the management was flexible. We noted, however, that the attendance at staff meetings was very low – six or eight staff out of a complement of around 35 care staff and 15 other staff. This was despite the meetings being arranged at times intended to be convenient for staff to attend. This meant that any important issues discussed might not be communicated to staff who were not present. Minutes were produced, and were fixed to the noticeboard in the staff room after the meeting.

The provider laid down a system of regular internal monitoring and external inspection of the home. The registered manager was required to produce a detailed monthly report to the provider, about significant events such as falls, medication errors, any pressure sores, weight loss, infections, safeguarding concerns, hospital admissions, and deaths.

All incidents and accidents were recorded in detail, in a folder and on the provider's electronic database. The registered manager told us he monitored these and looked for any trends or danger signals, in order to

try and reduce recurrence. He showed us a graph produced by the provider from the information supplied by Averill House. This identified the times of day when accidents had occurred, and the locations (for example, bedrooms, bathrooms, corridors, lounges or dining rooms) so that lessons could be learned. We found that this graph would be useful in combination with direct knowledge of the events, in terms of reducing the likelihood of recurrence.

There was also an "altercations analysis" which could be used to identify any flash points, for example times of day, individuals involved or locations where altercations between people happened. Because the people living in Averill House were living with advanced dementia, physical altercations between them were an occasional occurrence, as we knew from notifications submitted by the registered manager. It was good to see there was an analysis of these incidents with a view to reducing their chance of recurring.

We saw monthly medication audits and care plan audits. A range of other audits were done, including a monthly catering audit with a series of detailed questions, and an 'enhancing mealtimes checklist'. The registered manager did daily walks around the building and noted any items that needed repair or replacement. We asked about spot checks at night. He told us he sometimes worked through the night or came in early at 6am. We discussed the fact that working through the night meant that staff knew the registered manager was present, which was not the same as arriving unexpectedly for a spot check at 2am. He added that based on his prior experience in other homes if there were any problems on a night shift they would have come to his attention, but none had been reported.

The assistant operations director made monthly visits to the home and checked the audits done by the registered manager. They made a list of action points and checked the following month that they had been done. This meant that the people living in Averill House benefited from a rigorous system of quality assurance.

The registered manager told us he had dismissed a member of staff in November 2015 for being abusive towards people living in the home. He stated he had reported this at the time to CQC, to the police and to the local authority. We asked whether the individual concerned had been reported to the DBS, to limit their opportunity of obtaining similar work again. The registered manager told us that would be done at the provider's head office, and he was not sure if it had yet been done. The registered manager's actions demonstrated a firm policy to protect people living in the home from unsuitable staff.

We considered, however, that the areas for improvement and the breaches of regulations identified in this report, in relation to pressure area care, training in dementia and end of life care, and staff supervision, showed that there were improvements required in the leadership of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Appropriate pressure area care was not being delivered. Some staff were not able to deliver person-centred care that was appropriate and met people's needs. Regulation 9(1)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not done all that was reasonably practicable to reduce risks to the health and safety of people using the service. Regulation 12(1) with reference to 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training in end of life care. Regulation 18(2)(a)