Avon Care Homes Limited

Bybrook House Nursing Home

Inspection report

Bybrook House
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Date of inspection visit:
23 February 2016

Date of publication:
14 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bybrook house nursing home provides accommodation which includes nursing and personal care for up to 24 older people. At the time of our visit, 17 people were using the service. The inspection took place on 23 February 2016. This was an unannounced inspection. The home was last inspected on 24 June 2013, this was a focused inspection where we found the provider had made the necessary changes identified from the previous inspection.

There was a registered manager in post when we inspected the service. 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 registered manager was accessible and approachable throughout our inspection. Staff, relatives and people who used the service told us the registered manager was available if they needed to speak with her and had confidence in her abilities to manage the service.

Risks to individuals and the service were not always managed effectively and assessments put in place were not being followed correctly. This meant there was the potential for harm to come to people.

The home's medicine management systems required improvement in order to fully protect people.

Staff understood their responsibilities in reporting any safeguarding concerns and had confidence in the registered manager that these would be fully investigated to keep people safe.

Not all staff had received regular training, suitable for their position which meant they potentially lacked the knowledge and skills to effectively fulfil their role.

Staff were receiving regular supervisions, which the registered manager had put in place so staff could be supported in their development.

People and relatives were very complimentary about the food and choices available. Mealtimes were an enjoyable experience and menus were tailored to meet individual's preferences.

Staff were knowledgeable about people's needs and people's privacy and dignity was always respected. Staff explained the importance of supporting people to make choices about their daily lives. People told us they were involved in decisions about their care and systems were in place to monitor and review people's changing needs.□

Care plans were in an accessible format and contained information about the person which enabled person

centred care to be provided. However the recording of information was not always completed, meaning people's needs were not monitored effectively for changes to be identified in a timely manner.

The registered manager had created a positive and open culture in the time they had been in post. Relatives spoke about the changes they had seen and felt reassured the home was moving in the right direction.

Quality audits were undertaken; but some findings indicated that action was not always taken in response to these audits and some recordings were not an accurate reflection of events in the home. We saw that an event that is notifiable to CQC, concerning a pressure wound had not been reported.

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 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.

Risk assessments relating to pressure care were not being followed appropriately to ensure people's skin integrity was maintained.

Medicines were not always managed safely.

Staff were aware of their responsibilities in reporting any concerns to ensure people were kept safe from potential abuse and harm.

The home maintained high standards of cleanliness and took steps to minimise the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had completed the necessary training to maintain the skills required of their roles.

The registered manager ensured that staff were having access to regular supervisions and were able to discuss their performance and development.

People and their relatives spoke highly of the food, there was plenty of choice and mealtimes were an enjoyable experience for people.

Is the service caring?

Good

The service was caring.

Staff knew people well and we saw people were comfortable in the presence of staff and had developed caring relationships.

People said they were treated with dignity and respect. Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

People were empowered to make choices and there was evidence in place to show they were consulted and had consented to their care.

Is the service responsive?

Requires Improvement

The service was not always responsive

Recording and monitoring charts had not been completed regularly or filled out correctly.

There were mixed reviews on the levels of activities that the home provided for people to participate in.

Care plans were personalised and had a graphical format making it easy to draw information from.

Concerns and complaints were dealt with appropriately and in a timely manner. People and their relatives had confidence in taking these to the registered manager.

Is the service well-led?

Requires Improvement

The service was mostly well led.

Audits were completed as part of the quality assurance process, however they had not identified some of the gaps we found during our inspection.

A notifiable event had not been reported to CQC by the manager.

The manager was approachable and very visible within the home. People, relatives and staff spoke highly of the manager's leadership.

Improvements had been identified and some changes had been made. There was evidence that learning had taken place after an event and preventative measures put in place.

Bybrook House 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 February 2016 and was unannounced. The inspection team consisted of three inspectors. The home was last inspected on 24 June 2013, this was a follow up visit and the home had made the necessary changes identified from the previous inspection.

Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with four people living at the home and five relatives, six staff members, one health professional, and the registered manager.

We reviewed records relating to people's care and other records related to the management of the home. These included the care records for five people, medicine administration records (MAR), five staff files, the provider's policies and a selection of the services other records relating to the management of the home.

We observed care and support in the communal lounge and dining area during the day and spoke with people in their bedroom. We spent time observing people's experiences at lunch time and observed the administering of medicines.

Requires Improvement

Is the service safe?

Our findings

People were not always protected against risks and action had not been taken to prevent the potential of harm. One person had been assessed as being at 'high risk' of developing pressure sores. We saw they had been provided with a pressure relieving air mattress. The mattress had been set at an inflation pressure too high for the person's weight. This meant there was a risk of increased pressure on the person's vulnerable areas. The National Institute of Clinical Excellence (NICE) guidelines relating to maintaining skin integrity recommend that people who are at very high risk of developing pressure ulcers have their position changed at least every four hours whilst in bed. The person's care plan relating to the risk of developing pressure damage did not state the frequency the persons position should be changed.

Our observations, allied to the person's records of positional changes, indicated they were not having regular positional changes. For example, we found the person to be lying on their back at 11.00 am yet their repositioning chart recorded they had been moved onto their left side at 6.30 am that morning with no further entries on the chart made. The person was unable to move without assistance. We checked the person again at 12.40 pm, 2.30 pm and 4.00 pm and found they were in the same position. There was an entry recorded on their chart that they had been moved onto their back at 2.30 pm, yet we had observed they were already in this position at 11.00 am. The registered manager was made aware of our findings, who told us that they would ensure that people received assistance with repositioning according to their individual assessments, and that the recording of this was maintained.

We observed another person who also had been assessed as at 'high risk' of developing pressure sores and had been provided with a pressure relieving air mattress. This had been set at an inflation pressure appropriate to their weight. However, there were no records of positional changes being kept. The registered manager said that this was because the person refused to be repositioned. We recommended that the person's care plan was reviewed in order to reflect this. The person had capacity to make this decision.

This was a breach of Regulation 12 (2) (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had a falls prevention checklist in place. Risk assessments had been completed identifying the potential risks and actions to take to minimise these risks. One relative told us "[X] can be unsafe; they are putting things in place to help with the falls". We saw several people had been assessed as needing bed rails. A risk assessment had been completed and guidance on how to ensure bed rails were safe was in place for staff to follow.

People's medicines were not consistently managed safely. A selection of medicine administration records (MAR's) were reviewed. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies were recorded. When a person had refused or had not received a medicine, the appropriate code had been recorded on the MAR. The majority of MAR sheets, (which detail the medicines prescribed and administered to people) had been pre-printed by the pharmacy, however some contained hand written additions. This was when staff had transcribed details of a prescription onto the MAR sheet. We

found that in three cases, hand written amendments had not been signed by the person who did the transcribing and that a witness signature had not been obtained to reduce the risk of transcription errors. We raised this with the registered manager who is going to address this with staff responsible for managing medicines.

The MAR folder contained information relating to the use of 'homely remedies' at the service. These are medicines that are available without prescription, such as cough mixtures and paracetamol. It was noted that the information on file was dated 2008 and did not correspond with the providers own 'domestic medicines' policy. This meant appropriate guidance was not in place for staff to follow should a person require a homely remedy.

Individual protocols for the use of 'when required' (PRN) medicines were not always available. The Avon Care Homes policy regarding PRN medicines stated 'To ensure the medication is given as intended, a specific plan for administration is recorded in the service user's care plan and kept with their MAR charts'. This was not being followed. We brought this to the manager's attention in regard to one person who was receiving a sedative medicine if they became very anxious. The manager had produced a protocol for this person's medicine by the end of our visit.

The temperature of the medicine storage room, in which the medicine trolley was also kept, was not being checked to ensure that medicines were being kept at the correct temperature. The manager said that arrangements to do this each day would be put in place. A fridge was available to store medicines that required cold storage and this temperature had been checked and recorded daily.

The receipt of medicines was not always being recorded. The nurse told us that when medicines were received from the pharmacy, this was recorded on the MAR sheets. We found several examples where this had not been done. Disposal of medicines was being recorded; however there were no signatures on disposal documents to indicate who had disposed of the medicines, and whether this had been witnessed. This meant that clear records of medicine management in the home were not being maintained, which could hamper detection of misuse. The disposal of controlled drugs (CD's) had been recorded and signed as witnessed by two staff members.

Registered nurses were responsible for the administration of medicines in the home. The manager told us that checks to assess nurses' competency to administer medicines were not routinely being carried out. They found records of one competency check in 2015 and one in 2013. There were seven nurses employed. The manager said that she would arrange for competency checks if she felt it necessary; such as after a medicine error had occurred, or following monthly medicine management audits. There was no policy document that related to staff competency checks in the providers medicine policy. This meant the service was not routinely monitoring nurse's competency levels in order to identify areas of support or extra training if required.

The nurse on duty said there were no people who currently received their medicines covertly. A policy for covert medicine administration was available. There was one person who self-administered their medicine in the home. We saw a record which showed the person's capacity to self-administer the medicine and this had been agreed by the person's general practitioner.

We observed the nurse on duty on part of a medicines administration round and saw they were well organised and safe practice was observed. For example, the nurse took one person's pulse to ensure it was at the correct rate before giving them a particular medicine. However, during the afternoon, whilst an inspector was talking with a person in their bedroom, they observed the nurse arrive with the person's

medicine in and leave it on their table. They did not check that the person had taken the medicine before leaving the room. This meant they could not be certain this person medicine had taken their prescribed medicine.

This was a breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff commented "I have never had concerns but would go to the manager or sister in charge and am confident it would be dealt with", "I am happy to raise concerns and would go to the manager" and "Where I have previously raised concerns they were taken seriously and I was supported". We reviewed the accidents and incidents log and saw events were being recorded and the manager undertook a monthly audit in respect of this.

Relatives felt confident their loved ones were kept safe commenting "From the day they moved in we never had the slightest concern", "When I leave [X] I know she is being well cared for", "My [X] is absolutely safe, I always see two people hoisting" and "They lock the doors in the evening for security which is a good thing".

There were 17 people living in the home at the time of the inspection. The manager said there were 29 staff employed in total, seven of which were registered nurses. The manager said they only used agency staff to cover emergency sick leave, and shifts needing cover were offered to regular staff with a pay increment. The manager would also cover shifts herself where needed. Staffing levels were calculated using a dependency tool which assessed the level of people's need to determine how many staff were required to meet those needs. The dependency tool showed the home was above the level of staff numbers currently required.

One care assistant said there were normally three care assistants and a nurse on duty in the mornings and two care assistants and a nurse in the afternoon, evening and over-night. They said that they felt this was enough but added "We don't have much time to talk to residents". Another member of staff said "We have enough time to support people, there is enough staff". Relatives felt the staffing levels were adequate to meet people's needs commenting "There's enough staff, if [X] rings the bell someone is always there in under five minutes", "It's very calm, the staff are not stressed" and "There is enough staff, they seem well trained, can't fault them".

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. The manager informed us that when recruiting potential new employees, she assesses their background to check for stability in previous employment and if a similar role to the one being applied for has been experienced. Questions around safeguarding and offering people choice were asked during the interview process.

All areas of the home appeared clean and there were no malodours. We spoke with housekeeping staff who were able to explain the precautionary steps to take in minimising any potential risk of infection by wearing aprons and gloves and using the appropriate colour coded equipment for specific tasks. A cleaning schedule was in place and people's bedrooms were cleaned every day and deep cleaned once a month. One relative told us "The home is very clean, there are fresh flowers and it gives a good impression". The home had received a 4 star rating out of 5 following the last inspection by the local authority food hygiene inspector.

Requires Improvement

Is the service effective?

Our findings

People were being supported by staff who did not have the opportunity to maintain their skills and knowledge. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. One staff member we spoke with was unable to explain to us what mental capacity meant even though they were supporting people who lacked capacity. Other staff members said "I haven't had dementia training and I don't know about mental capacity", "Mental capacity is when they have dementia, but I haven't had training on this yet" and "A lot of my training is out of date".

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made Deprivation of Liberty safeguarding (DoLS) applications to the supervisory body. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act, providing 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. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. We saw capacity assessment in one person's care file indicated they lacked capacity to make decisions about their health and welfare. The home had applied for a DoLS assessment to be carried out. This had been completed and a standard authorisation for 12 months had been granted. There was a copy of the application and authorisation in the file. This person's relative had power of attorney (POA) for health and welfare. Records indicated that they had been consulted and involved in the DoLS decision. A copy of the POA document was in the file.

We reviewed the training records which recorded what training staff had completed and saw large gaps. Training records indicated that 17 out of 29 staff had not received infection control training.
Twenty out of the 29 staff employed had not received fire safety training. Out of those that had, two had received it in 2012 and seven in 2014. The registered manager said that some fire training had been booked for the week prior to the inspection, but this had been cancelled by the trainer and was rebooked. There were no fire drills recorded as having taken place in 2015 or 2016. The registered manager said that one had been held, but could not find a record of this.

Training records indicated that staff had received training relating to adult safeguarding; however this had not included staff employed as kitchen assistants. Three nurses had attended a palliative care course in December 2015, however no care staff had received palliative care training. Nobody being supported at the time of our visit was receiving end of life care. We spoke with the manager about this who said training sessions have previously been cancelled or staff have been too busy on the floor to attend. The registered manager said that the home had an 'in house' trainer and a training plan had been devised for 2016. This included sessions on managing challenging behaviour, dementia and dying, death and bereavement.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were being supported to work through the care certificate as part of their induction and informed us this prepared them well for their role. Comments included "The induction went over everything I needed to know, I shadowed for two weeks", "My induction was good, we worked on certain areas then moved on, I felt supported. The manager told us during this induction new employees are given a mentor, an experienced member of staff who helps them settle into their role and offers further support. One relative told us "My [X] feels well cared for by the staff".

Supervisions, which are an opportunity for staff to discuss their performance, role and future development had not previously been in place. The manager had put this in place so staff were receiving regular supervisions and had assessed the work load of staff to ensure responsibilities were fairly distributed. One staff member told us "in my supervisions we discuss how I'm getting on, and any issues, they are useful and regular". Another member of staff said "Supervisions can be useful, it's an opportunity to raise any concerns".

Staff supported people who could become anxious and exhibit behaviours which may challenge others. We saw for one person they had a care plan relating to this behaviour and guidance was in place for staff to follow to support the person. Staff were knowledgeable on how to support this person saying "We take time and talk with the person, and record all behaviour", "It's not physical behaviours but mental, they can be stressed and scream, they like company to help them calm down" and "We give the person time, space and reassurance, their visitors may need support also". We viewed records that showed external healthcare professionals were also involved in supporting this person and devising a treatment plan.

The food appeared well cooked and nutritious. People were complimentary about the food. The chef brought out a bowl of fresh fruit and offered this to people after their main meal. They were heard asking people if they had enjoyed their lunch. One person told us they "enjoyed the food and had plenty of variety". Another person said "There's enough choice of food, and two roasts a week, can choose what we like". Relatives comments included "The choice of food is very good, if it wasn't on the menu they make it" and "My relative needs to be tempted by food, they adapt the menu to suit [X] and staff need to encourage them to eat". One member of staff said "People are asked what they like and have input into the menu, they choose the menu on their birthday".

The tables were set to a good standard, with menus put out and people had ample space to eat their meals in comfort. They were served promptly and meals came directly from the kitchen, so were served hot. Drinks were available, and tea or coffee was served after the meal. The chef was aware of the people who had specific dietary needs, such as those with diabetes, swallowing difficulties and a person who required a gluten free diet. This information was recorded and visible in the kitchen. The chef said the nursing staff told them of people who were not eating well, and for those people they provided nutritious milk shakes, and build up drinks between meals.

People were offered two main choices at mealtimes. If they did not want the choices offered, the chef said that they would prepare an alternative dish for them. One person was eating an alternative meal which was not on the menu that day. The chef said that wine and beer was available on request. People were offered sherry before their Sunday lunch and champagne and canapés were offered on Saturdays.

We saw that people had 'eating recommendation' guidance in place stating the position the person should be in to eat and if they needed assistance. One person who had swallowing difficulties was being supported to eat their meal whilst in bed. The care assistant was sat at the same level as the person and did not rush them, ensuring they had swallowed what they had been given, before offering another spoonful. Another

person had been assessed as requiring supervision whilst eating and drinking. It was stated they required a beaker with a spout for their drinks. We observed a care assistant supporting them with a drink and saw they were using an appropriate beaker. However, on two other occasions it was witnessed that care staff were standing over people when assisting them with meals in their room and there was minimal conversation made during this interaction. We have fed this back to the manager to address.

Where people required health care, referrals were made to professionals and they were involved in planning the person's care. One health professional told us that they had witnessed two people who have improved greatly since coming to live at Bybrook which was testament to the home. A relative also said "[X] health has improved since they have been in Bybrook". We saw in people's care plans that they had been supported to attend eye appointments, however two people required regular podiatrist appointments for foot care, and there was no record that these visits had been arranged or attended. The registered manager said this would be addressed so these people received the appropriate health care.

Good

Is the service caring?

Our findings

Bybrook House had cultivated a relaxed and calming atmosphere for people who appeared content, unrushed and comfortable in the presence of staff. We observed people enjoying chatting to each other and being able to choose how and where to spend their time.

People received care and support from staff who knew them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. People we spoke with said "The staff never have a cross word, they are caring, they look after us well, and they ask us what we prefer", "Staff are very kind, I like living here, I have a lovely room and view, I'm happy" and "Staff are good and friendly, they spoil me".

Relatives praised the high quality of care commenting, "Anything you ask for is done, they go out of their way to make people happy", "Staff are kind hearted and very professional", "All the things that matter are in place", "As soon as I walked through the door I thought [X] would like it here" and "Staff are nice, and very good with my relative, they endeavour to do everything for [X]". A healthcare professional we spoke with said "It's a nice place, a nice setting, they know people well".

People were empowered to make choices and have as much control and independence as possible. A staff member commented "We see how much people can do for themselves". Relatives also commented saying "They support people with independence, they find a balance between that and making sure everything is done" and "They are being very good they encourage and understand, they are taking the time with her".

We saw that records kept in the Medication Administration Record file indicated people had given their consent to having their medicines administered in communal areas. Care plans had also been signed by people themselves where they were able to consent to the care provided. People commented "I can choose when to get up or go to bed", "There are no restrictions on me living here", "I have my freedom, I have a car and can go out whenever I choose, the door is not locked, I just tell someone I'm going out and where" and "My relative said it was a nice place so I chose to come here".

We viewed some people's bedrooms with their permission and saw that they were furnished and decorated with the person's own belongings. One person told us "I have got all my things from home in my room". A relative said "All [X] clothing and personal items are looked after, and cared for, nothing has gone missing". A Staff member said "We have a good team that care and respect this is people's home".

Requires Improvement

Is the service responsive?

Our findings

Care plans were personalised and each file contained information about the person's likes, dislikes and things that were important to them. They were clear and the typed format and graphs made them easy to draw information from. One relative told us "The staff like me to talk about [X] so they can learn more about him".

We attended a handover session at 2.00 pm, held for care assistants who were coming on duty. This meeting ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. However, the recording of information was not always completed correctly. For example, where a fluid monitoring sheet had been put in place for people to ensure their fluid intake was sufficient, these amounts had not been totalled. This would make it hard to identify if people were receiving below the recommended amount for their optimum level, and for staff to then raise concerns. During our inspection we observed people being offered drinks and encouraged to drink. Jugs of water, fruit squash and glasses were left around the home for people to help themselves.

We saw in one person's care plan it was recorded they had diabetes and that monthly blood sugar monitoring should be done. There was no record in their file of these checks. When this was raised with the nurse she confirmed it was done and recorded straight onto the computer. We looked with the registered manager for these measurements on the computer and found that the last blood sugar was taken in November 2015. The registered manager said it was been completed but not appropriately recorded and she would place a form in the room folder for this person so that staff can see when this is due as it was difficult for staff to observe this from the computer system. No concerns had been raised for this person around their health condition but without regular recording this person's blood sugar levels could not be monitored effectively.

Another person who had swallowing difficulties required their drinks to be thickened. The person had been reviewed by a speech and language therapist and their recommendations were recorded in the person's personal care file. It was recommended that their drinks were thickened to stage one consistency. Records in the persons bedroom, entitled 'eating recommendation' stated that drinks should be thickened to stage two. This meant there was a risk that the person could be given drinks of the wrong consistency, which would have put them at risk of choking. We asked a care assistant about the consistency of the drinks the person was being given. They told us that it was stage one and were able to state the correct amount of thickener to be used. We informed the registered manager who is going to address this and ensure the correct information was recorded consistently.

We reviewed five room folders kept in people's rooms and saw records relating to repositioning care and application of topical medicines such as creams had not always been completed. For example, one person's record indicated that a prescribed barrier cream had not been applied between the 12th and 22nd of February 2016. Instructions on the record stated that the cream was to be applied after washing and episodes of incontinence. On another person's record, the name of the prescribed cream had not been entered. This meant that there was no clear evidence that people had received these prescribed medicines.

We raised this with the manager who is going to address this with staff. The manager explained the paperwork in place is very clinical and wants to create more user friendly documents for staff to complete.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were reviewed monthly and as required. The registered manager explained these reviews were done with the person, however if a person had complex needs or lacked mental capacity the service would involve their families in the review. One staff member told us "If a person's needs change we write it in the daily log and say in handover, the communication is good".

We spoke with people, their relatives and the staff about the activities on offer for people and received mixed reviews. Staff felt that people did not have enough to do. One staff member told us "There's not enough for people to do, they need activities everyday". One person commented when asked if they were going to watch TV after lunch "There's nothing else to do in this place at the moment". Another person said to the person sat next to them "I wonder what we have now to amuse us". The other person replied "Nothing, it's still midweek". Other people's comments were positive about the activities on offer saying "We have someone come in and do activities, it's enough to do at my age" and "We have raised flower beds outside, I water the plants inside, we are happy here".

At a residents meeting it had been raised that some people wanted more activities. The manager had responded to this request and put in place a movie night at the suggestion of people living in the home. However we were told by staff that many people chose not to attend this event preferring to do their own thing. An activities guide was in the lounge which detailed events happening including champagne evening, movie night and mobile library.

Relatives we spoke with were happy with the activities provided by the home commenting "If [X] doesn't have enough to do it's his choice they do encourage him", "[X] wont partake in any at all, but there are activities and they work hard at it but she's not interested", "[X] hasn't taken part recently but what's there is good. If you want to take part there is things available" and "The activities and social events are good, there are quizzes, singing, lots of effort to provide activities".

People were encouraged and supported to develop and maintain relationships with people that mattered to them. One person told us "We get visitors, there are no restrictions when they come in". One relative said "Staff are welcoming, someone always makes contact".

People's concerns and complaints were encouraged, investigated and responded to in good time. We saw complaints forms available in the entrance hall, and information on challenging poor practice. People we spoke with said "If I had concerns I would feel happy to raise them" and "I didn't have an end-suite room at first, but I asked for one and it was arranged for me". Relatives had confidence that their concerns would be addressed by the manager saying "The reaction is instant if I go to them about anything", "Any concerns I have they are happy to help me with and address" and "Concerns are dealt with appropriately, there are better systems in place now".

We reviewed the complaints log and saw that complaints had been followed up, actioned and closed with documented evidence of the outcomes in accordance with the timelines set out in the provider's complaints procedure.

People's feedback was sought through a survey form and a resident and relative meeting held by the

manager. We saw the home had a suggestion box available for people to record comments at any time they wished. Relatives told us they had attended a meeting recently and commented "We are happy with everything", If I have feedback I can just say it", "I have given feedback, if I have concerns I can raise them with anyone and they respond" and "I have nothing but praise for the place". Staff told us that some people who spent most of their time in their rooms had not been encouraged or assisted to attend the meeting. We raised this with the manager who is going to ensure everyone is supported to attend future meetings should they wish to.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place who was newly registered with the CQC and was working hard to make improvements within the service. People's relatives praised the manager for their leadership style saying "She's a really good manager, everything is improving, proper systems are in place now", "The manager is very efficient and competent", "She's available if I need to see her, it's much better managed now", "We have a chat, she's very visible, she really cares about the people she's looking after" and "The manager's office is open and she's always there. If she's busy she gets back to you. It's well managed".

The manager promoted a positive culture that was person-centred, open, inclusive and empowering for people and staff, encouraging communication and input from the team saying "I have meetings with staff to ask them what they think will work, the staff have been here a long time, I have respect for the staff". Staff told us they were well supported by the manager and comments included "We can give our views and we are asked what we think", "The manager is a nice lady and approachable", "Staff morale is good, there is good communication", "There is a family feeling, you can speak to anyone on your level or higher up and they listen" and "The manager has been very helpful, she informs me of things".

Records indicated that one person had developed a pressure sore that had progressed to be classified as grade three. This required the registered person to notify the Care Quality Commission (CQC) which had not happened. The manager had taken action to ensure health professionals were involved in this persons care and treatment contacting a tissue viability nurse specialist, who had reviewed them and advised on treatment. The person had also been seen by an occupational therapist with regard to specialist seating and a hospital consultant regarding a medical condition they had. At the time of our visit the wound was no longer classed as a grade three. We spoke to the manager about their responsibilities in reporting these events to CQC. All other notifications had been sent and received.

Monthly, quarterly and annual audits had been carried out by the manager and heads of departments in relation to accidents and incidents, safeguarding, catering and dining, kitchen, laundry and fire safety. However evidence seen during the inspection indicated that appropriate action was not always taken in response to audit findings; and that the information recorded was not always accurate. For example, on one audit report a staff reply in response to whether staff had attended fire training was 'No, I have not had training for two years and new staff have only been told by myself'. The audit also asked if fire drills were held every three months, the response recorded was three times a year, however we found that only one drill had been carried out in 2015. Fluid monitoring charts had also not been audited by the manager to identify the gaps found in recordings.

Monthly medicine management audits were undertaken and we saw records of these. The most recent audit did not reflect all of the findings of our inspection as previously mentioned. The registered provider, Avon Care Homes, had policies in place that included medicine management, domestic medicines, drug errors, controlled drugs, 'as required' medicines and covert administration. Records evidenced that medicine errors were recorded and investigated by the manager.

We saw that some learning from accidents was in place. For example, one person had experienced a number of falls. The manager identified that these falls all occurred in the early morning and from this arranged for night staff to check on the person around this time and offer assistance as the person would never call for help. This person has since not fallen.

Throughout the inspection we discussed our findings with the manager who was open and responsive to our comments and addressed some of these during the inspection.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely. Individual protocols for the use of (PRN) medicines were not always available. Receipt of medicines coming into the home was not always recorded. MAR sheets contained unsigned hand written additions. Regulation 12 (2) (g) Risk assessments were not always followed appropriately. One person at high risk of pressure ulcers was not receiving support with positional changes. A pressure relieving mattress was set too high. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The recording of information was not being completed regularly. This meant monitoring charts to record people's fluid intake, positional turns in bed, blood sugar levels and prescribed creams application were not able to demonstrate the appropriate care had been received. Information relating to consistency levels of a person requiring thickener in drinks was recorded differently in two places meaning the wrong guidance could be followed. Regulation 17 (2) (c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People were being supported by staff who did not have the opportunity to maintain their skills and knowledge. Training records showed not all staff had received training relevant to their role. Regulation 18 (2) (a)