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Avalon Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Avalon Care Home is a residential care home providing personal care for up to 26 people. The service is registered to provide support to people living with dementia, people with a learning disability or autistic spectrum disorder, people with mental health needs, people with a physical disability and or sensory impairment, and younger adults. There were 23 people living at the care home at the time of the inspection.

The care home has two floors and are adapting the ground floor to become a communal area for younger people and people with a learning disability.

People's experience of using this service and what we found
During the inspection we found that people did not always receive safe care and treatment. Clinical risks to people were not always assessed or monitored and people did not always receive their medicines safely. Records did not adequately guide staff on what actions to take. Staff shared safeguarding concerns with the local authority although their processes for monitoring this required improvement. There were cleaning schedules in place although some areas were cluttered. People told us they felt well cared for living at the home. A relative said, "I feel that my relative gets safe care." We made recommendations about the safeguarding processes and learning lessons if things go wrong.

Although staff training was up to date, further training in managing clinical needs was required, which we have made a recommendation about. People were not always supported to give consent about their care and treatment in a lawful way. Although people had access to healthcare facilities, staff did not always involve external professionals to make sure people's care and treatment was co-ordinated and consistent.

The provider did not make sure there was effective governance to protect people from risks and promote safe and high-quality care. Managers did not always identify problems or concerns and therefore they missed opportunities to improve the safety of care and treatment people received.

Staff spoke positively about their roles and told us they felt supported by their managers. People and relatives spoke highly about the care, one person said, "It is a really, really good care home." We found that people and relatives were involved in their care planning and managers kept in regular contact with relatives.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: People were not always supported to have maximum choice and control of their lives and

staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: Although we found gaps in the support and culture, staff were very caring in nature and upheld people's dignity and privacy. Care plans were written respectfully and put the person at the centre.

Right Culture: Although staff and managers had values to support people to lead confident and inclusive lives, the environment of the home made this difficult. Younger people who had a learning disability lived within a care home environment, meaning opportunities for choice and control were limited. It was difficult for staff to meet the needs of everyone, due to a wide range of service user groups, with different sets of guidance for staff to follow.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 March 2022).

Why we inspected
The inspection was prompted in part due to concerns received about infection control, record keeping and timely requests for medical input. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Avalon Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, managing risk, consent to care and treatment and the overall governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Avalon Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was conducted by two inspectors who visited the premises. A third inspector contacted staff and relatives by telephone.

Service and service type
Avalon Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Avalon Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 10 August 2022 and ended on 24 August 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people that used the service and three relatives. We spoke to different types of staff including the registered manager, senior staff and care staff.

We looked at a range of records including five care plans and medicine records. We looked at health and safety records, audits and three staff recruitment records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People did not always have risks to their health and safety managed effectively.
- Staff did not complete robust assessments about the risks to people's health and did not always recognise when further medical input was required. For example, staff failed to recognise when a person was at risk of dysphagia and did not request a specialist assessment to make sure the person received appropriate treatment. Dysphagia means when someone has difficulty swallowing certain foods. People at risk of dysphagia require specialist assessments to determine how the risks should be managed to minimise the risk of choking. This meant there was a risk to the person's health and safety.
- We found that bed rails were in use for some people, however staff did not complete risk assessments about the use of these. Staff did not make referrals to external professionals to make sure that people had the correct equipment. We found two examples in incident records where people had sustained minor skin tears from using bed rails.
- We found that staff did not document what actions they took after someone experienced a fall. We were not assured that staff would recognise if someone became unwell following an injury, take necessary action or seek medical input.

The service did not have systems to make sure that risks to people's health were properly assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (1) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager took steps to make sure people received proper risk assessments, that staff made referrals to external professionals, and made sure staff received up to date guidance about managing people's needs. This was still being embedded.

- We checked environmental health and safety records and found that risk assessments were up to date and necessary checks had been made regarding fire, gas and electrical safety testing.
- There was a process in place to take action for anything that required fixing or replacing in the care home, which was an improvement following the last inspection.

Preventing and controlling infection

- People were not always protected from the risk of the spread of infection.
- The registered manager took the decision for staff to stop wearing masks to reduce the risk of spread of Covid-19 in July 2022. However, there was no risk assessment to underpin this decision, and no mitigation recorded for people that were at very high risk or clinically vulnerable. The home was experiencing a Covid-19 outbreak during the inspection and staff had begun to wear masks again as a result.

● There were cleaning schedules in place and the home looked clean. However, some areas were cluttered, and we saw a used Covid-19 test and mask had been left in a communal area.
● We found one hand sanitisation station was empty.
● We saw personal hygiene items stored in communal bathroom cupboards. This could be a risk of cross infection.

Although we found no evidence of harm, there was not an effective system to make sure the risk of the spread of infections was reduced. This placed people at risk of harm. This was a breach of regulation 12 (1) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider immediately took actions following the inspection and had re-commenced the use of face masks following a Covid-19 outbreak in the days prior to the inspection.

● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the service supported visiting in line with current guidance.

We have also signposted the provider to resources to develop their approach.

Using medicines safely

At the last inspection we made a recommendation about the management of medicines. Not enough improvement was made, and the provider was now in breach of regulation.

● People were not protected from the risks of unsafe medicines management.
● We looked at medicine records and found several examples where staff had not signed to say people received their medicines. Therefore, we could not be assured that people received their medicines as prescribed.
● Some people were prescribed medicines to be given 'as required'. There was no guidance available for staff in care plans about how these medicines should be managed, and some medicines were given regularly rather than 'as required'.
● The storage of medicines was not always safe . Some medicines were required to be stored in a fridge at a specific temperature. Staff were not monitoring or recording fridge and medicine room temperatures. We found the medicine fridge to be frozen. Important items were stored in here and some were frozen; we could not be assured these medicines would be effective.
● Some people were prescribed medicines covertly (where medicine is mixed with food or drink). We found this had not been agreed by a pharmacist to say the method was safe and effective, and staff did not have any guidance. We could not be assured that the medicine would be effective, meaning people's health could be put at risk.

Although we found no evidence of harm, systems were not established to manage medicines safely. This placed people at risk of harm. This was a breach of regulation 12 (1) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took actions following our feedback to address the concerns raised, including purchasing a new fridge and daily checking of medicine records.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.

● The provider had a thorough and up to date safeguarding policy for staff to refer to.
● The registered manager provided safeguarding training to staff and staff could describe processes they would take if they had concerns.
● The registered manager made referrals to the local authority for any safeguarding concerns and took immediate actions to safeguard people.
● People told us they felt well cared for living at the home. A relative said, "I feel that my relative gets safe care."
● However, there was not an effective system to keep a track of historic safeguarding incidents, meaning there was a risk that recommended future actions were not taken.

We recommend the provider update their safeguarding processes to include tracking.

Learning lessons when things go wrong
● The provider had an incident recording process in place and staff knew how to report issues.
● Staff and managers completed incident forms and documented if for example a person sustained a fall.
● However, actions taken were not recorded and 'lessons learned' boxes were left blank. Therefore, we were not assured that incidents were analysed and opportunities to improve practice were missed.

We recommend the provider seeks advice from a reputable source to update their processes around learning lessons when things go wrong.

Staffing and recruitment
● People were protected through safe staffing and recruitment processes.
● We checked recruitment records for staff recruited since the last inspection and found that necessary checks such as references and Disclosure and Barring Service (DBS) checks were made. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were enough staff to keep people safe and the service did not use agency staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we recommended the provider consider guidance around the completion of MCA assessments. Some improvements had been made, however not enough and we found further problems. This meant the provider was now in breach of the regulation.

- People and/or their relatives had not always consented to the use of bedrails, which is a restriction placed on people if they are at risk. Staff had not completed MCA assessments or sought consent for their use. This meant there was a risk that people had not given their consent in line with the MCA for this type of restriction.
- The provider had installed CCTV in communal areas, however had not followed our guidance around this, consulted with people or sought their consent.
- The registered manager completed best interest decision making for certain decisions, however we found this was not thoroughly documented to show what steps were taken to be assured this was in line with the MCA.
- The registered manager made applications to the local authority when people were at risk of being deprived of their liberty. However, staff were not keeping a record of who required a DoLS and for whom they had made applications. Therefore, there was a risk of the DoLS authorisations expiring or no longer

being appropriate.

Although we found no evidence of harm, steps were not taken to make sure that people gave consent to their care and treatment lawfully. This put people at risk of harm. This was a breach of regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps to address this following our feedback, and this was yet to be embedded.

● Staff understood the principles of the MCA and considered this throughout their care and support to people. Staff were reminded to consider mental capacity throughout people's care plans.

Staff support: induction, training, skills and experience
● The registered manager arranged training for staff, and this was up to date, for example in first aid, awareness of mental health, dementia and learning disability, and moving and handling.
● However, staff were not trained in managing more complex, clinical needs such as dysphagia, use of bed rails and falls. This meant there was a risk staff would not recognise signs and symptoms and take appropriate actions to address.

We recommend that provider considers up to date training from a reputable source.

● The registered manager arranged and conducted inductions for staff. Staff told us they received training during their induction and that it covered a range of topics.
● Although senior staff provided supervision to staff, this was not on a regular basis. However, managers and senior staff operated an open-door policy and supported staff well daily. Staff told us they felt supported by managers.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; staff working with other agencies to provide consistent, effective, timely care
● People's needs were not always assessed in line with guidance.
● Staff did not always make sure that external professionals were involved in the assessment of people's clinical needs, such as assessments for bed rails and covert medicines.
● At times staff did not always work with other agencies to provide consistent and effective care. For example, some people required input and expertise of district nurses, speech and language therapists and occupational therapists to make sure that people had care and treatment plans appropriate to their needs.
● Following feedback, the provider had begun to take action to address this.

Adapting service, design, decoration to meet people's needs
● People could decorate their rooms according to their preferences.
● Communal areas were comfortable and decorated to feel homely and bright.
● The provider was adapting the ground floor of the home into a communal area for younger people with a learning disability, however progress had been slow, and it was not yet in use.

Supporting people to live healthier lives, access healthcare services and support
● Staff made sure that people could access healthcare services such as the learning disability team and mental health team.
● People near the end of their life received assessments and input from the enhanced care team, who provided reviews and care plans to guide staff.
● GPs provided visits to the home and people had access to dental facilities.

● People received annual health checks from practice nurses and learning disability nurses.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink and maintain a balanced diet.
● There was a full-time chef who prepared fresh meals for people and offered a range of healthy and fresh meals.
● People at risk of losing weight had input from dieticians and we saw that some people had fortified diets. This is when food has nutrients added to them to help people maintain or put on weight and improve nutrition.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to make sure there were effective systems to monitor risk and performance. This was a breach of regulation 17 (1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The registered manager did not always understand risk, regulatory requirements and performance.
- The registered manager did not make sure that staff always received appropriate training for them to do their role. Specifically, the recognition of clinical needs and guidance regarding how to meet those needs. This put people's health and safety at risk.
- The registered manager did not complete thorough audits about the practices of the home. For example, medicine, care plan and incident audits. Managers were not aware of the concerns that we found during the inspection, for example with the management of medicines. This meant managers did not have an effective system to identify problems and opportunities to improve the safety of care and treatment were missed.
- The registered manager did not make sure that systems in place reduced the risk to people. For example, 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were stored in a downstairs cupboard, and not easily accessible to staff. DNACPR forms guide staff in what to do if someone suffers a cardiopulmonary event and the heart stops beating. This meant there was a risk that staff or paramedics would be unaware of people's DNACPR status.
- Managers were making statutory notifications to external agencies, including us. However, the provider did not have a robust system to monitor incidents, meaning there was a risk some incidents may not be reported.

Although we found no evidence of harm, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 (1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback, the provider took steps to address. This included taking advice about how to conduct

medicine audits and immediately arranging further training for staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Although there were shortfalls in the governance of the service, we found the culture of the service to be positive.
- Staff spoke positively about their roles and the support of managers.
- Relatives told us that staff kept in touch and were sometimes asked for feedback.
- The provider organised events at the home on a regular basis, such as birthday parties. Relatives were always invited, and this was a good opportunity to discuss feedback.
- Managers engaged well with staff through regular team meetings and used a secure communication app on mobile telephones to share information.
- The service had a webpage on social medial and people and relatives could leave feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had some understanding about their responsibilities regarding the duty of candour.
- Relatives told us that staff kept them up to date if anything went wrong or they had concerns.
- However, due to the lack of effective incident recording processes, we could not be sure that all incidents were reported or shared appropriately.

Continuous learning and improving care; working in partnership with others

- The registered manager was committed to developing some aspects of staff knowledge, for example arranging for further training in how to support people with a learning disability. However, we found that improvements were required to make sure that systems identified shortfalls in staff knowledge, and to therefore improve care.
- The registered manager worked in partnership with others such as the local authority and the commissioning department for support and guidance.
- Further partnership working was required, for example with district nurses, to ensure that people benefitted from co-ordinated care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not supported to give their consent to some aspects of their care and treatment in accordance with The Mental Capacity Act

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used service were not protected from the risks associated with: - unsafe medicines management - lack of effective systems to ensure the risk of the spread of infection was reduced - lack of effective systems to ensure that people's clinical needs were assessed and mitigated.

The enforcement action we took:

We issued a warning notice against the registered manager and provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not protected as the provider failed to make sure there were effective systems to assess, monitor and improve the quality and safety of services, and to assess, monitor and mitigate risks relating to the health and welfare of people. The provider did not ensure their auditing and governance systems were effective.

The enforcement action we took:

We issued a warning notice against the registered manager and provider.