HC-One Limited

Avandale Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Avandale Lodge on the 22nd and 23rd of October 2018. The first day was unannounced and the second day announced.

The service had a registered manager who was registered with us in January 2018. 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 manager was present during the days of our visit.

Avandale Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Avandale Lodge is registered to accommodate 48 people living with dementia. At the time of our visit, 39 people were living there.

During the last inspection on 7th, 9th and 12th March 2018 we found that there were a number of improvements needed in relation to safe care and treatment, staffing and good governance. These were breaches of Regulations 12, 13, 17 and18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated as requires improvement overall and inadequate in the Safe domain.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well Led to at least good. The provider sent us an action plan that specified how would they would meet the requirements of the identified breaches.

During this inspection we found that whilst some of the required improvements had been made, other required improvements had not been met and that other areas of improvement had been identified.

Improvements had been made to the management and administration of medicines. We found that medicines were managed safely in accordance with good practice guidelines. Staff had received training and had their competency assessed.

Improvements had been made with regards to the submission of notifications to the CQC where specific incidents had occurred that adversely affected the wellbeing of people. This is a legal duty which the provider is required to meet.

Some improvements had been made to ensure that agency staff had more information about the needs of people who used the service. This ensured that agency staff were better placed to meet the needs of people.

This visit found that some improvements had not been made and as a result breaches had been repeated. These related to care and treatment with the registered manager not reporting low level safeguarding concerns to the local authority, not taking steps to investigate events where people who used the service sustained unexplained injuries and not using the registered provider's systems fully to report incidents that had occurred. Another related to the governance of the service whereby shortcomings in the quality of the service had not been identified during audit undertaken. Further shortcomings were identified in respect of managerial support for staff when the registered manager had been absent.

The use of agency staff had decreased but all registered nurses on nights were still sourced by an agency.

We have raised a recommendation in respect of the premises being supportive for those who live with dementia.

Despite shortcomings in the following of local authority procedures, staff were aware of the types of abuse that could occur and were familiar with the reporting procedure.

Staff recruitment was robust and included appropriate checks on new members of staff.

The premises were clean and hygienic. Assessments were in place to minimise the spread of infection.

Risk assessments relating to malnutrition and the development of pressure ulcers were now completed and more effective.

Equipment used was subject to regular checks to ensure that people were safe.

Staff received the training and supervision they needed to perform their role.

New staff received a structured induction as an introduction to their roles and responsibilities.

The nutritional needs of people were met. Links were in place to health professionals to ensure that the health needs of people were met.

Sensitive information was kept secure at all times. As a result people could be confident that their personal details were appropriately and safely secured.

When staff interacted with people, these were conducted in a kind and respectful manner. People's privacy was upheld.

People were encouraged to be as independent as possible.

A robust complaints procedure was in place. Arrangements were in place outlining the wishes of people when they reached the end of their lives.

Staff told us that the registered manager was supportive and approachable to them. Relatives told us that the registered manager maintained a presence within Avandale Lodge and was available to deal with their queries.

The views of people were gained by the registered provider. The rating following the previous inspection was on display.

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

People were not fully safeguarded by the registered provider.

The registered provider had sought to reduce the use of agency staff within the service.

Equipment used in the service was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager did not work in line with the principles of the Mental Capacity Act.

The nutritional needs of people were met.

Work was needed in respect of the environment to further assist people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff felt stretched and did not always have the opportunity to sit and talk with people. As a result people were at risk of social isolation.

Sensitive information was kept secure at all times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The standard of activities meant that people did not receive appropriate levels of stimulation.

Information did not consistently take the communication needs of people into account.

Care planning was now more consistent.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had not identified shortcomings within the service.

Key information had not been made available for the registered provider or other stakeholders to oversee the quality of the support provided.

People had the opportunity to comment on their care provided.

Avandale Lodge 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.

The inspection took place on the 22 and 23rd October 2018. The inspection was unannounced on the first day and announced on the second day.

The inspection team consisted of one adult social care inspector.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at ten care plans, training records, policies and procedures, medicines management and various audits relating to the quality of the service. In addition to this we spoke to four relatives. We also spoke to the registered manager, area manager, managing director, four care staff and kitchen staff. We spoke with members of the local authority commissioning team and safeguarding teams prior to and after our visit.

The nature of the needs of people at Avandale Lodge was such that it was not always possible to gain their views. To reflect this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection, we ask registered providers 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. A PIR had been returned in a timely manner by the registered provider when we asked. We used the information in the PIR to inform this inspection.

We checked to see if there had been a recent visit from Healthwatch. Healthwatch is an independent consumer champion created to gather and represent the views of the public. No recent visit had been made since we last visited the service.

Requires Improvement

Is the service safe?

Our findings

The nature of people's needs was such that we were not always able to gain a direct account of their experiences. People appeared to be relaxed and at ease with staff. Facial gestures and body postures indicated that people appeared to be quite happy with the support they received and felt safe in the company of the staff team. Staff were a focus to people who used the service and those receiving one to one support trusted to staff team to support them.

Our last visit identified two breaches in regulations which meant that people had not received safe care and treatment. One related to the registered manager not following the local authority's safeguarding process and in keeping people safe. This had not been addressed.

We had identified that the registered manager was not following the local authority's safeguarding processes and as a result people were not fully protected from harm. Information received by us as part of the inspection process outlined that the service was not reporting low level concerns relating to events that affected the well-being of people. Low level events are those which do not meet the threshold for a more detailed investigation. Information received outlined that twenty-five events affecting one person had not been reported.

Systems were in place for the analysis of accidents and incidents. These were uploaded onto a database so that the registered manager could analyse patterns or trends of incidents or accidents. Information we received during the inspection process outlined that one person had experienced skin tears and unexplained bruising over the past twelve months. Out of the incidents that had occurred only a third of those incidents had been inputted into the registered provider's systems. This showed that these processes were not being followed appropriately and placed other people at risk of harm. We asked the provider to review all information relating to accidents and incidents by the 30 November 2018 to determine if this was a wide spread issue or not. This had subsequently been actioned.

Staff were able to indicate possible types of abuse that could occur and those circumstances where people could be at risk of poor or abusive care. They were clear about the process for reporting such concerns and were confident that the management team would progress these instances further. We found that the registered manager was not fully completing the process for raising incidents of potential poor care. Body maps were included within care plans. These provided a pictorial guide to any changes that people had had in their body structure, for example, unexplained bruising or any other marks sustained by individuals. These had been recorded appropriately yet in most cases we did not see any evidence that unexplained marks had been reported or any action taken to investigate how this had happened.

The above evidence demonstrates a repeated breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A breach identified at our last visit related to the arrangements for managing medicines. We had found that the registered provider could not be assured sufficient time had always been left between the

administration of people's morning and lunch time medicines. The guidelines for when 'as and when needed' medicines could be administered to people were not clear. This increased the risk of people not receiving their medicines as they needed them.

This inspection found that medicines management was robust. We observed the timings for medicine administration rounds and these were done in an effective manner which meant that sufficient time was available for people to receive morning and lunchtime medicines. Arrangements for people being offered medicines when needed (known as PRN medicines) were in place with clear care plans as to when such medicines should be offered to people. This involved the use of assessment tools enabling staff to identify when people who could not express pain verbally, for example.

People received support with their medicines by trained staff. There was an up to date medicines administration policy in place; this contained information in relation to staff training, ordering and receipt of medicines, storage, record keeping, disposal and administration, self-administration, and controlled drugs. Controlled drugs (CDs) are prescription medicines that have controls in place under the Misuse of Drugs legislation. We checked to see if controlled drugs stocks tallied with records and found that they did. Medicine administration procedures were continuously assessed.

Medicines were appropriately stored in locked trolleys within locked clinic rooms. The temperature of the refrigerator and clinic room were monitored and recorded daily. We viewed a sample of Medicine Administration Records (MARs) and found that they were correctly completed and in line with the medicines administration policy.

Further breaches had been identified at our last visit. These included risks to people from inconsistent risk assessments. These related to risks of malnutrition and the development of pressure ulcers. These were now found to be up to date and accurate.

We found at our last visit that there were not always sufficient staff on duty to meet the needs of people. This had resulted in a breach of regulation 18 of the health and social care act 2014.

We had found that there was a reliance on agency staff and that this had been raised by relatives who were concerned about continuity of care for their relations. We had identified that the service used agency nursing staff particularly at night with agency nursing staff being utilised. In addition to this, the registered manager had not always ensured that agency staff were provided with sufficient information about the service and people's care needs before they started work.

This visit found that usage of agency staff had improved on days and this was confirmed by relatives and permanent staff members, however, this was not the case on nights. This was confirmed through the staff rota and discussions with the registered manager. The use of agency nursing staff on nights had not changed since our last visit with no registered nurse being directly employed by the registered provider at these times. The registered manager maintained that there had still been a degree of difficulty in employing permanent nursing staff hence the use of the agency. The use of agency staff was mitigated by the fact that the same agency nursing staff had been utilised during these times to ensure consistency and that more information was now available to these individuals about the needs of people and arrangements within the service. One registered nurse employed by the agency commented that they had worked within the service for three months and had requested that they receive supervision as permanent staff did given that they had worked there continually for a period of time. This request had not yet been responded to. The registered provider subsequently informed us that the responsibility for the supervision of agency staff rested with the agency who employed such staff as opposed to the organisation. The registered provider also subsequently

informed us that agency staff at nursing levels would be involved in handovers and other mechanisms for reviewing the progress of people who used the service.

Despite the usage of agency staff, we did not witness that this use was having an adverse affect of people who used the service.

Relatives commented "the home is short staffed at times" and "they try their best but there are times when they are running around".

A staff dependency tool was in use. This was completed as the dependency levels of people changed. Records indicated that dependencies were generally rising. Staffing levels had been maintained and it was unclear what process was being used to match staffing levels up with the dependency tool. Our observations saw that staff were stretched and did not have the opportunity to sit with people and talk to them other than interact with people through personal care and other support. This combined with the absence of meaningful activities meant that people were at risk of social isolation. While care staff were meeting the physical needs of people and maintained good practice, there was a risk that care was becoming task orientated as opposed to person centred.

There were processes in place for regular checks to be undertaken in relation to the safety of the premises and equipment. Portable electrical appliances were tested on a regular basis to check they were safe to use. Fire-fighting equipment was serviced regularly and the gas safety and insurance certificates were up to date. There was a plan in place for the safe evacuation of the premises in case of emergency including a personal emergency evacuation plan (PEEP) for each person. PEEPS included details of the support individuals needed in the event of an emergency evacuation of the premises.

The premises were clean and hygienic. The registered provider employed domestic staff to ensure that all areas were clean. Domestic staff attended to their tasks during our visit. Domestic staff had been issued with personal protective equipment (PPE) such as disposable gloves and aprons to help minimise the spread of infection. When cleaning was needed, for example, when food had been dropped, domestic staff were quick to remove it.

All key areas such as toilets and bathrooms had supplied of PPE for care staff to use when supporting people with personal care.

The recruitment process was found to be robust. Information in recruitment files of people who had come to work at Avandale Lodge recently included an application form, interview notes and references. Further checks included a Disclosure and Barring Service check (known as a DBS) meaning people were suitable to support people living at Avandale Lodge.

We looked at how the service learned lessons from issues relating to the quality of the service. Following our last visit we received an action plan highlighting those areas of improvement and how improvements were going to be actioned and sustained. While some improvements had been made; others had not and also we identified on this visit that some other shortcomings had arisen, for example, the standard of the provision of activities within the service.

Requires Improvement

Is the service effective?

Our findings

People who used the service were not able to give an account of their experiences with the service or whether they considered that the staff team met their needs. People appeared to trust staff members and used them as a focus to provide assistance or reassurance. Relatives told us that the staff team "did their best" to assist their relations. They told us that they were happy with the food provided and that there always appear to be "a lot of choice" at mealtimes.

Our last visit had identified that the registered provider had not always ensured that agency staff were provided with sufficient information about the service and people's care needs before they started work. There had been a lack of an induction process for agency staff and no summary of the main needs of people who used the service. This meant that there was a risk that people's needs could not be effectively met. This visit found that measures had been put into place enabling agency staff to access the main needs of the people who used the service as well as give a general orientation in the policies and procedures of the service. In addition to this, the registered provider now had a clear indication of the skills and training that agency staff had.

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 to receive care and treatment with appropriate legal authority. 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 , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The registered provider was not always operating within the principles of the MCA. Some people received covert medicines. In those cases, a clear best interests process was in place to ensure that people received medicines to best promote their health in the least restrictive manner possible. However, best interests were not extended to all.

One of the principles of the MCA is the presumption of capacity. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. Care plans outlined that people did not have capacity to make decisions for themselves. There was no evidence of any process that had been undertaken for this decision of people's capacity to be assessed. This meant that there was a risk that people's capacity to make any decision had been overlooked and demonstrated that the approach to people's right to make decisions were not person centred.

Our discussions with staff found that there was inconsistent knowledge of the Mental Capacity Act and how this impacted on people who used the service in their everyday lives. Staff were not always clear about whether they had received training in this area.

The above evidence demonstrates a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received the training they needed in respect of mandatory health and safety topics as well as training in dementia awareness and safeguarding. A training matrix was available indicating the percentage of staff that had completed training and this was overseen by the registered manager. Training certificates were also available.

New staff had a structured induction process in place to enable them to prepare for their role. One member of staff we spoke with was able to outline the induction process that they had been through and felt that it was good and prepared them for their role. This had included a period of shadowing until they were considered competent by the registered manager to work unsupervised. Training had also been provided. The registered provider also had arrangements in place for catering for new staff who had not necessarily had experience in the care profession before. The registered provider followed the principles of the Care Certificate in those instances. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if people are 'new to care' and should form part of a robust induction programme.

Staff confirmed that they received individual supervision with their line manager. They told us that this was frequently held. This was confirmed through supervision records and a supervision matrix.

We looked at how the nutritional needs of people were met. The kitchen was a well-equipped and clean facility. It had received a food hygiene visit in August 2018 and had received five stars. This is the maximum that can be awarded. We were asked to wear protective clothing and make use of the hand washing facilities before we entered the kitchen. This demonstrated that the staff were committed to ensuring good standards of hygiene. The kitchen was organised and kitchen staff had clear information about the nutritional needs of people and their likes/dislikes.

A menu was available. This indicated a rolling menu suitable for the season and included details of alternatives that were in place. This was presented in a written form in dining rooms although kitchen staff showed us a pictorial menu that was also available to best enable people to make decisions about their preferences.

Meals were served in the two dining rooms on each floor. The impression was that the dining rooms did appear crowded and we raised the issues that there were other facilities in the building such as a large communal space on the upper floor and a diner area on the ground floor that could be utilised to enhance the dining experience for people.

For those using the dining rooms, staff were attentive to the needs of people and ensured that they received the support they required. We did observe one person being assisted to eat by a member of staff who was standing while providing this assistance. This meant that communication with the person could not always be effective. We raised this with the registered manager who told us that they would ensure that this was fed back to the staff team. Some people preferred to have meals in their bedrooms and other were being assisted by visiting family members.

Charts were maintained in relation to nutrition. These related to people's weights as well as the food/fluids that they had taken during the day. In respect of weights, these were monitored appropriately and in line with risk assessments. Food and fluid charts included details of how much people had taken and a running total and target was included in records to ensure people were hydrated. We did observe that while this was being achieved; these were not always recorded immediately with a delay in recording taking place. One staff member relayed information to another regarding fluid intake but there had been some time elapsed since this had occurred. This meant that there was a risk of an incorrect recording being made. We raised this with the registered manager who sought to address this.

Some work had been done to the design of the building to ensure that it was suitable for people who lived with dementia. A period diner had been created on the ground floor and this was authentic in appearance. This facility seemed to be under utilised during our visit. Some people who preferred their own company did use this facility but otherwise it did not appear as a main focus for people to use. Some signage was in place to assist people with their orientation in the building and period pictures but some aspects of the decoration, for example, adaptations such as contrasting handrails and doors were not always in place to assist people.
The registered provider subsequently informed us that advice sought from a dementia-specialist was to be implemented.

We recommend that the registered provider refers to good practice guidelines in relation to the environmental considerations for those people living with dementia.

The health needs of people were met. Records indicated that people had regular access to other external health professionals in order to promote their health. Records showed details of appointments made, the reasons for appointments and any specific outcomes for people. Assessments summarised the health needs of people and care plans outlined any health conditions people had and how these could best be supported.

Requires Improvement

Is the service caring?

Our findings

.People who used the service were not able to outline their experiences of the support they received from staff because of their communication needs. We observed that individuals appeared relaxed and comfortable with the staff team and did not express any distress while being supported. Some people received one to one support from staff members. In these cases, people demonstrated trust in staff supporting them and felt at ease with them. Relatives told us "They are a caring staff team but are under pressure to meet people's needs" and "Yes they do treat [name] with respect".

Our observations of interactions between staff and people who used the service found them to be positive and respectful. Staff were able to outline the practical measures they would take to ensure that people who they supported with personal care had their privacy and dignity promoted at all times.

Staff considered that their interactions with people were becoming more limited with people due to the increased dependency of people. Staff told us that they missed the opportunity to sit and talk to people which they considered to be part of their care and felt that this was to possible due to work pressures. Staff felt that they felt "stretched" and that there was a danger that their work was becoming more task orientated with little time for meaningful interaction. We observed staff disagreeing over whether a task had been completed and this was done in front of a person who used the service. This potentially could have cause distress to the person and we raised this with the registered manager who stated that they would address this. We observed instances where staff had the opportunity to greet people and enquire about how they were but were busy with other tasks, for example, completing records. This meant that there was a risk of people becoming socially isolated.

People receiving one to one support were given the space and freedom to pursue their own routines. Staff in these instances were patient with people and allowed people to talk to whoever they wanted and go wherever they wanted within the building.

People's confidential information was safeguarded at all times. Sensitive information was secured and could only be accessed by those who needed that information. This meant that people's rights to privacy were maintained.

People were able to maintain their independence where possible. For example, where people had a level of independence with their mobility, they were encouraged and enabled to walk with minimal assistance or without support. The same applied to those who were independent with eating. People were able to have items within their personal space that reflected their past interests or items of sentimental value. This demonstrated that people were enabled to be surrounded by possessions which enabled them to remember events within their lives or past interests.

Relatives played an active part in the support of people. They told us that they always "Felt welcomed" and were "Able to assist in helping [name] out". Relatives were observed having the chance to talk to their loved ones in private and assisting them in eating at mealtimes. Relatives were always greeted and welcomed by

the staff team.

Information about local advocacy services were available. These are independent people who can assist with people's welfare and rights. We did not determine if people were accessing advocacy services at this time.

Requires Improvement

Is the service responsive?

Our findings

Our last visit identified that the quality and detail of care plans had been mixed. Some care plans had been very detailed and provided specific guidance whereas others had been out of date, were not as detailed and some had not been completed at all. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2014.

This visit found that care plans were more consistent in detail and provided the staff team with a clear indication of how people could be best supported in all aspects of their daily lives. Care plans were relevant to the needs of people and went into detail about their likes/dislikes and individual preferences and routines. Where people's capacity meant that measures had to be used to best support people this was being done. For example, in some instances best interest processes had been used where covert medicine was considered necessary. However, as mentioned previously, other care plans had a blanket assessment of people's capacity with no process evidenced as to how this conclusion had been reached. This meant that any capacity people may have had was not necessarily being taken into account. Care plans were regularly updated to ensure that needs could best be supported. Prior to people coming to use the service; assessments were undertaken. These included all the health and social needs of individuals and had been gained from appropriate sources such as the service's own assessments, hospitals or local authorities. Care plans were accompanied by daily records which indicated the progress made by people.

We looked at the activities provided to people during our visits. The registered provider employed two part-time activities co-coordinators to assist in providing activities. It was not clear whether they were on duty during our visits.

We did not see any evidence of activities taking place for most people during our visits. On the first day of our visit, a hairdresser was in attendance and on the second day, some people were accessing a sensory room available in the service. Our observations for the majority of people noted that they remained either in their rooms or were in communal areas. People sitting in lounge areas received with little or no stimulation other than occasional enquiries into their wellbeing from passing staff members. Three people were receiving visits from their relations.

Staff told us that there was little in the way of activities available and as a staff team did not have the time to sit and chat with people who used the service due to the other commitments they had. Staff told us that they would have liked to have spent more time interacting with people on a one to one basis as they perceived this as part of their caring role. This view on activities was echoed by relatives who stated "There does not seem much going on". Part of our SOFI observations found that people remained in their rooms or did not always receive appropriate interaction from the staff team while in other communal areas. This meant people were at risk of social isolation.

We looked at the information people received and whether it was appropriate to their communication needs. This was in line with the Accessible Information Standard (known as AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must

make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We looked on the information that was provided to people to ensure that people had equal opportunity to access important information. We found that information provided was inconsistent.

One activity board was available. This was located in an area on the upper floor. No activity board was available on the ground floor. The board outlined activities that were on offer but these were presented as a monthly calendar with written information displayed. No accompanying pictures, symbols or other aids accompanied this written information to assist people in knowing what activities were available and to meet their communication needs. We raised this with the registered manager on the first day and on the second day all written information relating to activities had been removed with a photograph of a sensory being displayed for that day but with no other information for the rest of the month available.

Written menus were available. These were accompanied by a pictorial menu outlining meals on offer.

This meant that there was an inconsistent approach to ensuring that information for people was accessible to take their communication needs into account.

The above evidence demonstrates a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place. Relatives told us that they were aware of this and that this would be used if they had any concerns. The complaints procedure outlined the timescales involved for the investigation into any concerns. Records indicated that any complaints received were responded to appropriately.

We looked at the systems in place to help support people at the end of their life. No one was at that stage of their lives during our visit but that care plans showed that end of life care had been discussed with people and their preferences had been recorded within their plans. We read one comment from a relative which said "During [name's] last days, that same kindness was also extended to the other members of the family as we gathered around her. We are grateful to the whole team". This meant that the registered provider had taken the needs of the family into account as well as the individual, for instance.

Requires Improvement

Is the service well-led?

Our findings

Our last visit identified a breach in regulation 17 relating to the governance of the service. We had found that systems for overseeing the running of the service and checking standards of the care provided had not been always effective. This visit found that this remained the case.

Audits and systems for the monitoring of the quality of care provided were in place but these were not effective.

Care plan audits took place but these had not identified the lack of capacity assessments within care plans. Statements on the capacity of people had been recorded yet there was no process evidencing how this conclusion had been reached. This meant that people were at risk of not having their consent to care fully recognised and evidenced an approach that was not person- centred. Care plan audits had also not identified the inconsistent action taken when adverse events had been experienced by service users. While body maps had been completed to record and recognise unexplained marks or bruising, for example, there was not always details of action taken to investigate these events. Again, these had not been picked up in audits.

Audits had not identified shortcomings in the standard of activities within the service. This visit found that the provision of activities did not provide sufficient stimulation for people who used the service and placed people at risk of social isolation. The registered provider had systems in place enabling a daily check to take place on standards within the service. This took the form of a twice daily walkarounds which enabled the registered manager to take stock of the care provided. The shortcomings in the provision of activities had not been identified in this process. An assessment of whether information provided to people who used the service was effective had not been identified either under AIS guidelines.

Daily walkarounds had not been consistently completed during a recent period of absence of the registered manager. Some walkarounds had not been completed prior to our visit meaning that checks on care standards were not always in place with no arrangements to ensure that these continued given the registered manager's absence.

Information received during the inspection process indicated that arrangements were not always in place when members of the management team were not present. Evidence outlined that there was uncertainty as to who staff should call in the event of needing managerial support either out of hours or when managerial staff were absent. We received information that on an occasion when the registered manager was absent, the area manager was also absent meaning that administrative staff were effectively running the service on that occasion. This meant the registered provider did not have arrangements in place to effective oversee the management of the service on those occasions. The registered provider subsequently assured us that this was an isolated incident.

A system, was in place for reporting and reviewing accidents and incidents within Avandale Lodge. However during the inspection it was identified that this system was not always being used effectively. This had the

potential to impact upon people's safety and wellbeing. We asked the provider to identify the extent to which this may have impacted upon their oversight and monitoring of incidents that had occurred within the service. We asked them to report this back to us by the 30 November 2018. This had subsequently been actioned.

The local authority procedure for the reporting of safeguarding events was not being followed by the registered provider. We received information that low-level safeguarding incidents had not been reported and as a result the local authority was not aware of incidents that had been experienced by people who used the service. Low level incidents are those incidents that do not meet the threshold for a more formal investigation. Twenty-five potential incidents affecting the well-being of people had not been reported. This meant that people were not being protected by good governance.

While links with health professionals and social workers took place, the lack of reporting low-level safeguarding events meant that the registered provider was not always co-operating with other agencies to ensure that the best interests of people were served.

The information above demonstrates a repeated breach of Regulation 17 of the Health and Social Care Act Regulations 2014.

Our last visit found that we were not always informed of adverse incidents that affected the well-being of people who used the service. This had resulted in a breach of regulation 18 of the Health and Social Care Act 2014.This had now been addressed with the registered manager maintaining an audit trail of those incidents that had been reported to us. While this had been addressed; the shortcomings within the reporting systems to the local authority in respect of safeguarding issues meant that a complete picture of notifications to all other agencies was not effective.

Staff told us that they considered that the registered manager was supportive and approachable. Relatives were of the same view and considered that the registered manager had the best interests of their relations at heart. The registered manager maintained a presence within the service and was aware of the progress made by people who used the service. Staff were able to visit the office with queries and were responded to appropriately and in a supportive manner.

People had been asked their opinions about the service through satisfaction surveys. In addition to this, relatives had the opportunity to comment through an electronic feedback point available in the main foyer. The results of comments were available and were positive. In addition to this, people were invited to use the registered provider's website to express their views. We looked at reviews and found them to be positive. Comments ranged from "things have improved following the last inspection in many ways" to "standards have improved following concerns". Staff meetings were held and relatives'/residents' meetings were in place although not always well- attended.

From April 2015 registered providers were legally required to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. Ratings from the last inspection at Avandale Lodge were prominently displayed.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not provided care that reflected individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not operated within the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that appropriate action to safeguard the people from abuse had always been taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes in place to assess monitor and improve the quality and safety of the services provided.