Alma Care Homes Avens Limited

# Avens Court Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Avens Court Nursing Home is a care home providing personal and nursing care to 51 people aged 65 and over, many of whom may be living with dementia. The home, which is in a converted house and is set over two floors, each floor having its own lounge area. At the time of our inspection, there were 40 people living at Avens Court.

People's experience of using this service and what we found
People told us they felt safe and well cared for and that staff were kind. However, our observations on the day were that people may not always be kept safe as staff did not always follow safe practices. We also found staff did not always demonstrate a respectful approach towards people. There was also evidence that people may not always receive care in line with their care plan. People's care records lacked detail in some areas and were contradictory in others.

Although people were seen to be given their medicines, medicines practices were not robust and clinical staff did not always follow good practice.

People did not receive care when they wanted it due to a lack of a suitable number of staff deployed within the service. People were left without interaction for long periods of time as staff were too busy to spend time with people. Much of what we observed was task orientated care from staff.

Improvements had been made to the service since the registered provider had taken it over. People lived in an environment that was undergoing refurbishment. This would improve the décor and layout within the premises. There was an open and transparent approach with the Commission, the introduction of a better auditing process and better communication between the staff team and people and their relatives. Although some of the auditing had not picked up the shortfalls we identified at our inspection.

Staff had the opportunity to access a wider range of training as well as meet with their line manager to discuss their role and progress.

People had good access to healthcare professional involvement to help ensure they stayed well and people's consent was sought in line with the legal requirements relating to the Mental Capacity Act 2005. This was because people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

Feedback was sought from relatives and was being used to start to improve the service.

We have found evidence that the provider needs to make improvement. Please see the Safe, Caring, Responsive and Well-Led key question sections of this full report. You can see what action we have asked the provider to take at the end of this full report. For more details, please see the full report which is on the

CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (report published 2 October 2018). Since this rating was awarded the registered provider has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on our methodology of inspections.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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.

Details are in our safe findings below.

### Is the service effective?

**Good**

The service was effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-Led findings below.

# Avens Court Nursing 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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and a specialist nurse.

Service and service type
Avens Court 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.

The service did not have a manager registered with the Care Quality Commission. This meant that the provider was legally responsible for how the service is run and for the quality and safety of the care provided. There was a new manager in post who had yet to register with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received from the service, such as statutory notifications of accidents and incidents and any safeguarding concerns. We used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service and five relatives about their experience of the care provided. We spoke with nine members of staff including the provider's relief manager, who was overseeing the service whilst the manager was off sick, and the provider's operations director. 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.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

# Is the service safe?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not enough staff on duty to meet people's needs. A relative told us, "There doesn't seem to be enough staff. [Name] needs two people to take her to the toilet and often only one member of staff is available."

● Feedback from staff and our observations supported this view. One person was heard calling out for help at 11:30. We found the person in bed and they told us, "I've waited so long I'm past caring. I don't know if I've had breakfast. I'm fed up waiting ages." We rang the call bell for care staff who told the person they could not assist them immediately and they would have to wait 15 minutes as they were helping another person. This person was only assisted out of bed at 13:05. They told us they were very hungry. Staff said they would have given them their breakfast at 08:00, but they had not had time to give them a snack between then and lunch.

● There were numerous occasions throughout the inspection, especially in the morning, when there were no staff in the lounge area with people other than activities staff. This resulted in these staff being taken away from their role as they were having to attend to people, rather than spend time on activities with individuals.

● The provider's relief manager told us, "We have four care staff on duty on each floor." However, staff told us this was not the case. At 12:10 two people were still waiting to be helped to get up and a staff member told us, "There really isn't (enough staff). We need five carers. We have three upstairs and four down." A second staff member told us, "They reduced the staff levels to seven recently – three up and four down – this isn't enough." A third member of staff told us, "It is a difficult home as the clients are so demanding."

● Feedback from a recent relatives survey showed that some relatives felt more staff were needed in the service.

The lack of appropriate number of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff went through a recruitment process before commencing work at the service. This included providing references, previous employment history and undertaking a Disclosure and Barring Service (DBS) check. A DBS check helps to ensure staff are suitable to work in this role.

Using medicines safely

● Medicines practices within the service was not consistently robust, meaning people were at risk of not receiving the correct medicines.

● An agency nurse was on duty downstairs during our inspection. We observed them having trouble using

the electronic MAR (medicine administration record) system. As they did not know people, they were calling out people's names to try and identify them. Despite this we did not hear them confirm with people who they were before giving them their medicines.

● Likewise, the agency nurse working on the first floor was being accompanied by a team leader because they were not au fait with the system and did not know people. The team leader demonstrated a good knowledge of medicines practices, however the nurse did not. They dropped a tablet on the floor and it was only due to the team leader intervening that stopped them picking it up and giving it to the person whose medicine it was.

● The same nurse dispensed medicines for one person not realising they resided on the ground floor. Instead of going downstairs immediately to give the person their medicines, they left them on the top of the medicines trolley whilst they went to another person on the first floor.

● We asked the operations director how they checked agency nurses' medicines competencies. They told us they received profiles which recorded their training. However, they were only able to show us one. We noted this did not mention when they last had their medicines competency assessed.

● The medicines fridge on the ground floor was unlocked and dirty. This was stored in a temporary clinical room due to the refurbishment that was taking place. We spoke with one of the clinical staff about this, who rectified this immediately. However, we also found the clinical room dirty and untidy. This had also been identified during the provider's August 2019 audit visit.

● There were two suction machines, one had the suction tube already attached which meant the tube had been exposed to the air. The second machine did not have all the parts and was dirty.

The lack of robust medicines management processes was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People lived in an environment where good infection control may not always take place.

● Some people's rooms had a malodour and people's bed bumpers were found to be torn and frayed, meaning they would be difficult to keep clean. Following our inspection the operations director told us they had started to address this area.

● However, other areas of the service were clean and without malodours and there were stocks of protective equipment for staff to use. A staff member told us they used gloves and aprons and soiled items went in a clinical bag.

Assessing risk, safety monitoring and management

● Risks to people had been identified. However, there were times when staff did not adhere to guidance in a person's care plan to help ensure a person was kept safe. This included staff using inappropriate moving and handling procedures.

● One person, according to their care plan should be sitting on an air-cushion whilst seated in an armchair. We noted there was no cushion under this person for the whole of our inspection which presented a risk of pressure damage. A further person required (according to their care plan) staff to, 'support [name] at mealtimes and not leave her unassisted to reduce the risk of choking' but we noted they were left alone to eat their meal.

● Other risks were addressed. One person was leaning forward to pick something up and a staff member supported them to get up and reminded them to use their frame. A relative told us, "She has less falls now."

● One person was at high risk of falls and they had a crash mat and sensor mat in place. There were also good risk assessments in place for people who smoked.

● A clinical risk register was kept and reviewed fortnightly by the manager and clinical staff. This covered people at high risk of falls, skin breakdown, choking or weight loss.

● Staff were aware of their role in the event of a fire. A staff member was able to describe to us what they would do if the alarm sounded and where the meeting point was outside should they have to evacuate people.

Systems and processes to safeguard people from the risk of abuse

● Relatives said they felt their family member was safe. One relative told us, "I feel she is very safe. She seems happy in herself." A second relative said, "I am impressed with staff and how they deal with people."

● People were safeguarded from the risk of abuse as staff had completed safeguarding training and were aware of their responsibilities to report any concerns.

● Information was available to people and staff regarding who to contact should they have concerns.

● Where concerns were identified, records showed these had been reported to the relevant authorities.

Learning lessons when things go wrong

● Where people suffered accidents, information was recorded and action taken to help prevent reoccurrence. Accidents and incidents were reviewed and signed off by the manager. We read that people had sensor mats placed in their rooms to alert staff if they were high risk of falls.

Good

# 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.

This is the first inspection for this newly registered service. This key question had been rated Good. This meant people's outcomes were good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs

- People lived in an environment that was not always well maintained or adapted to meet their needs. Some people's rooms contained items of furniture that were not in good condition and there was a lack of signposting or orientation aids to support people living with dementia. However, the provider was in the process of refurbishing the service and much of this would be addressed as a result.
- We did see people being provided with adapted cutlery to help them to eat independently.
- We also saw chairs in the ground floor lounge were now set in clusters to help promote conversation and tables were placed besides people for them to use for drinks. A relative told us they felt positive about the changes in the building décor and commented to us, "They have taken it (the refurbishment) slow so the residents' lives are not interrupted. The colours are lovely and the whole building is being renewed."

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; Supporting people to live healthier lives, access healthcare services and support

- People's needs were assessed before moving into the service. The pre-admission assessment formed the basis of their care plan.
- Staff used evidence-based practice national tools in support of the care they delivered. This included the use of malnutrition, skin integrity and pain assessment charts.
- Communication across the service and amongst staff had improved since the new provider had taken over. A fortnightly clinical risk meeting had been introduced and a handover done to help ensure staff were up to date with people's care and health.
- People were supported to access health care professional input when needed. A relative told us, "The nurses support with her medical conditions. She has improved since she's moved in."
- There was evidence of the GP, mental health team, district nurse, dentist and optician being involved in people's care.

Staff support: induction, training, skills and experience

- People were cared for by staff who underwent training. A staff member said they had appropriate training for the role and had the opportunity to meet with their line manager on a one to one basis.
- Staff training included dementia, safeguarding, infection control, food and nutrition, moving and handling and fire safety. We noted good compliance with training. However, we have reported in safe that staff did not always use their training in practice which put some people at risk especially when being helped to move.
- In addition, new staff were given a competency pack to complete over a 12-week period as part of their

induction. Existing staff were undergoing competency assessments as part of their appraisals to give a baseline of what, if any, additional training was needed.
● Staff supervisions and appraisals had not been taking place regularly, but the manager had developed an action plan to help ensure these would be completed by the end of the year.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they the food was good, with one relative saying, "Always been well fed. She wasn't eating before she came here."
● People were offered a choice of food and during lunch time we observed staff show some people visual choices of the meal. During the inspection, we saw people being offered hot and cold drinks.
● Where people were at risk of malnutrition or dehydration, food and fluid charts were in place to monitor their intake.

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 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found they were.

● People were asked for their consent. A member of staff was heard asking for someone's consent to have their medicines.
● Where people required their medicines to be given to them covertly (without their knowledge) the correct processes had been followed to firstly check their capacity to understand this decision, a best interests discussion about this restrictive practice and guidance and agreement from the GP and pharmacist in how to give the medicine.
● There were also capacity assessments and best interests decisions for living at Avens Court, sensor mats and bed rails.
● A staff member said, "The mental capacity act protects people without capacity."

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Relatives told us staff were caring towards their family members. One relative said, "The long-serving staff are caring." Another told us, "Staff are caring. They ask her how she is," with a third telling us, "I think the staff are excellent."
- Despite this feedback we observed that staff did not always treat people with respect. We observed one person asleep from 11:10 until after 12.45 with no interaction from staff. This person was only woken when lunch was due to be served. Other people dozed in their chairs, without interaction from staff for over an hour. This demonstrated an uncaring approach from staff in that they did not take the time to engage with people to keep them stimulated and less at risk of social isolation.
- At lunch time one person's meal was pushed to one side whilst a staff member put drops in the person's eyes and another person was heard saying, "Could I just finish my mouthful first?" when a staff member asked them to take their medicines when they were eating their food.
- One person had to ask several times at lunch time for cutlery to eat their meal. We also noted they had been seated with their back to others, facing the wall and directly beneath the television to have their lunch.
- We noticed some people's (who were assessed as requiring support with personal care) hair and their nails were dirty and one person sat with a clothes protector on all morning. A relative told us, "Her appearance could be better. She needs to have her hair cut and she is always in the same top."
- One person had a poster in their room which had written on it comments about their behaviours. This was placed in a prominent position where anyone entering their room could see it. The provider told us following our inspection that this information was in place to ensure staff who may not know the person well could recognise triggers to their behaviours. However, this information could have been included in the daily handover notes and resident's report which is made available to staff.
- We observed a staff member take a person's blood pressure twice whilst they were asleep.
- A staff member told us people's protective underwear was shared out amongst everyone and people did not have their own individual items. They said, "Everyone has the same. They are not labelled." This demonstrate a lack of dignified personal care.

The lack of dignity and respect shown to people was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- However, individual staff demonstrated a kind, attentive approach to people with some staff crouching down to people's level when speaking with them or responding to people's requests. This included moving

one person's wheelchair footrests and asking the person, "There you go [name] is that better for you?"
● Another person, who had had no interaction from staff for most of the morning, was engaged with by a member of staff just before lunch. They interacted with them smiling and talking, using a tactile approach to get a response from the person.
● A staff member regularly stroked a person's head and we observed them rubbing one person's shoulder whilst they chatted to them about a magazine they were looking through.
● We saw people walking around their home and sitting in different areas of their choice.

Supporting people to express their views and be involved in making decisions about their care
● Recent survey results indicated relatives felt they did not always have the opportunity to discuss the care, treatment and lifestyle planning of their family member. We noted management had responded to this by inviting relatives into the service at any time to discuss and review care plans. One relative told us they did feel involved. They said, "We are informed of care planning and if (there is) anything we can book an appointment (to meet)."
● Staff told us, "When residents ask if they can do something to their room, etc. we tell them "It is your home." They added, "Residents are free to decorate, request changes and family can visit anytime."
● A relative told us, "Staff are kind and they have offered opportunities for us to bring items in to personalise mum's room." A second relative said staff were very considerate and they felt the service had a homely feel. They also told us they felt staff were always respectful towards people.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Although people's care plans contained information about the person, people may not always receive care in line with what was needed.
- One person's care plan stated their bed should be set at the lowest level, however we found this not to be the case. It also recorded the person should be on a diet low in sugar (due to diabetes) and yet two different staff members told us the person was on a 'normal' diet. In addition, this person was recorded as having seizures but there was no information as to the management of any seizures the person may have and two staff could not give us any more information on this.
- Where people were on pressure mattresses, we could not find a record of what setting the mattress should be set on to protect the person's skin. This meant there was no way of checking whether the setting was correct. This had also been identified during a provider's audit visit. We were told following our inspection that steps were already being taken to address this to ensure that pressure mattress settings were recorded.
- One person was at medium risk of malnutrition and they were required to have their food intake monitored for three days. However, there was no chart and no entries in the daily records for this. A second person's care plan recorded, '[name's] fluid intake will be monitored through the fluid intake chart' however this was not consistently happening. The last entry on the chart was 23 September 2019.
- We spoke with a staff member who had provided personal care to one person. They told us they had given the person a 'shower' wash using a bowl and flannel and brushed the person's teeth. However the bowl in the person's room as well as their towel and toothbrush were all dry. Later the staff member told us when we asked that they had not brushed the person's teeth and they had not had time to give baths or showers. The person was then provided with their personal care and we informed the operations director.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, staff did demonstrate some responsive care. For example, one person needed staff to stand in front of them so they could lip read and we observed staff doing this. A second person required a straw for their drinks and this was provided. A third had limited vision in one eye and as such staff stood to the side where they had better vision.
- One person was noted as liking hand massages and we noted from their daily records staff had being doing these with them. The person also liked to listen to music and we heard their radio on in their room. There were good life histories in place for some people.
- End of life care plans were limited in their information, despite the provider's service improvement plan recording, 'End of Life (Advance) – care plans are in progress'.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were provided with activities and the opportunity to engage in interests of their liking. For example, we read people had participated in exercise classes, cooking, spending time in the garden, trips out and quizzes and games. Two church services were held at the service each month and an external music therapist was involved in running sessions.

● A new, 'people's wishes' programme had started where people could request something meaningful to them. We noted this had resulted in one or two people going on external trips of their choice. Also 'resident of the day' had been introduced to find out more information about people to assist staff in planning activities.

● However, further work was needed to help ensure the range of activities was individualised and meaningful. A relative told us, "Not much at weekends; it's just a case of keeping them quiet." A staff member said, "There are not enough activities. They say they want us to stay in the lounge to do activities but how can we?"

● Observations were such that although some activities took place, we found a lack of structured engagement with people. During the morning in the upstairs lounge, four of the seven people in there were asleep. They remained this way for the majority of the morning, only being woken by staff for a drink. One person sat the whole morning asleep in front of a puzzle and another in front of dominoes. Only one person was doing a jigsaw puzzle.

● Although activities staff were working hard to engage with people, they were not always able to spend sufficient quality time with people. For example, one started a game of dominoes with one person, but they were constantly distracted with helping other people as there were no care staff present. Half way through the game they moved to another person and started to paint the person's nails.

We recommend the registered provider continues to work on activities for people to help ensure people are not at risk of social isolation and that their interests and preferences are met.

Improving care quality in response to complaints or concerns

● Feedback in a relatives' survey demonstrated people knew who to speak with if they were unhappy about anything. A relative told us, "I guess we are listened to."

● We reviewed the complaints received since the new provider had taken over the service. There was evidence that complaints had been responded to.

● We read compliments received by the service, which included, 'I was impressed by the staff's obvious love for the residents, their gentle and kind gestures towards them were a joy to see'. And, 'I have always found the staff at Avens Court caring, helpful and friendly'.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were included in their care plans and understood by staff. This included details of any sensory impairment which staff needed to be aware of, and the person's preferred methods of communication.

● We also noted the handover sheet used to share information between staff included details relating to people around their individual requirements to aid communication, such as whether they needed to wear glasses or hearing aids.

Requires Improvement

# 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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Although the service had moved over to electronic care planning which the operational director told us meant, "Better monitoring of care plans" we found some inconsistencies in the records.
- One person was noted on the front page of their care plan as requiring a soft diet and yet in the main body of their care plan it stated there were no restrictions in their food intake. We checked with staff who told us they provided a soft diet to this person.
- People's care plans lacked detail. One person who moved in a month prior to our inspection had no life history. They also had not had any capacity assessments undertaken despite being recorded as having vascular dementia and 'unable to understand others'.
- Repositioning information for people was not always clearly recorded. We found information both on the repositioning chart as well as within daily records which meant it was not immediately clear when a person had last been moved. One person's care plan reflected they required three-hourly repositioning, however their daily chart stated four-hourly. The repositioning chart showed periods of up to eight hours between a change of position. We reviewed the daily notes for this person and found some evidence of repositioning was recorded there, but between the two records there was still evidence that the person may not be being moved in line with their care plan.
- During the inspection we found shortfalls in medicines practices, infection control, staffing levels, good record keeping and person-centred care. There was also a lack of respectful approach by staff towards people and consistent individualised meaningful activities. This meant the quality of care people were receiving was not as good as they should have expected.

The lack of good governance at the service to ensure people received a good quality of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered provider had notified CQC of significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events.
- Regular audits were undertaken and actions transferred to an overarching service improvement plan (SiP). The provider's operational director had been regularly updating CQC on progress against this plan which included all aspects of the service and planned improvements, together with progress against actions.
- Unannounced night audits were carried out by the manager with the last one done in June 2019. This showed one person's sensor mat was not connected and fire drills to include night staff were not being done. A follow up audit to check progress against shortfalls was planned.

● Dining experience and care plan audits had also been carried out.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us senior management were supportive. A staff member said the provider's operational director sat with people and supported them to eat or drink. They felt there had been positive changes since the provider had changed.
● Relatives also gave good feedback on management, with one saying, "There is much better communication now" and another telling us, "I think it's so much better."
Staff said the culture within the staff team had improved and communication was better. One staff member told us they felt they worked better together and supported each other in order to, "Look after the elderly residents."

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 understood their responsibilities in relation to duty of candour. Where concerns had been raised or accidents or incidents occurred, apologies had been given.
● The provider had been transparent with CQC in relation to shortfalls within the service or when changes in senior management level had occurred. They informed us of adjustments that were made in order to help ensure consistent management oversight of the service. For example, during the transitional period between managers.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Relatives' and residents' meetings were held. The most recent meeting included an introduction from the new manager, food, activities, the refurbishment, training and staffing.
● Relatives' surveys were undertaken. The results of the most recent survey had been collated and an action plan developed as a result, which was in turn part of the SiP. This showed that people had given a low rating in relation to the environment and staffing levels. However, there was positive feedback in relation to staff, communication and access to health input.
● Feedback from surveys was being used to improve the service. For example, relatives' feedback in the recent survey indicated they did not always feel staff knew people. As a result a resident profile page had been introduced to people's care plans. Others comments related to food and food forums were being set up.

Working in partnership with others
● The service worked closely with the local authority as well as the wider community in engaging external interests.
● Avens Court was a member of the Surrey Care Association who provide training and peer support for staff and managers.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider had not ensured people always received person-centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered provider had not ensured that people were always shown dignity and respect by staff. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not ensured robust medicines management practices were in place. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not ensured through good governance that contemporaneous records for people were held and people received a good level of care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

| | |
|---|---|
| personal care<br><br>Treatment of disease, disorder or injury | The registered provider had not ensured there were a sufficient number of staff deployed to meet people's needs. |