Surrey Rest Homes Limited

Avens Court 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out this unannounced inspection to Avens Court Nursing Home (Avens Court) on 9 August 2018. Avens Court is a service which provides accommodation and nursing care for a maximum of 51 older people, many of whom are living with dementia. People in care homes receive accommodation and nursing or personal care as a 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 had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager assisted us with our inspection.

We last inspected this service in July 2017. We found improvements had been made to the service following our previous inspections when we had identified a number of concerns. We used this comprehensive inspection to check whether the improvements had been sustained. We found that not all of them had and that there were shortfalls within the service.

People's medicines were not being managed or stored in a way that was following best practice and risks to people were not being effectively managed. Staff were not following the principles of the Mental Capacity Act 2005 in relation to people's consent and any restrictions imposed on them. People may not always receive appropriate care because some care plans lacked important information about people. Some care files lacked specific plans in relation to people's medical needs and end of life wishes.

Staff did not have the opportunity to meet with their line manager regularly and annual appraisals had not been held with staff. Although the registered manager carried out competency checks on clinical staff and group supervisions with care staff, there were no individual supervisions arranged. Staff however, did undergo a recruitment process before commencing at Avens Court.

Quality assurance audits were carried out by both the registered provider and registered manager. However, we found that these did not always pick up on the shortfalls within the service. Annual surveys were carried out. People living at the service were not given the opportunity to be involved in the service and suggestions they had made had not been responded to.

Services that are registered with CQC are required as part of that registration to notify us of specific incidents, such as falls resulting in an injury or potential safeguarding concerns. We found incidents that had taken place within the service, falling into these categories, had not been reported to us as they should have.

People were cared for by enough staff, however there were periods during the inspection that we found deployment of staff could have been better organised. We have made a recommendation to the registered

provider. Risks to people were identified although staff were not always recording or monitoring to help ensure that they had sufficient information to respond. This included a lack of recording of people's pressure relieving mattress settings. Although people had access to activities, further work was needed to ensure that activities were individualised and meaningful to people, particularly for those people who expressed a wish to take trips out.

People told us they enjoyed the food that was prepared for them at Avens Court. However, we found there was a lack of choice for those people who were on a pureed diet and there was little opportunity for people to be involved in menu choices. We have made a recommendation to the registered provider.

We saw individualised caring interactions between staff and people and staff showed empathy with people when they became upset. Although most people lived with an advanced level of dementia they were enabled to move freely around the home, have privacy when they wished and remain as independent as they could.

Safeguarding concerns had been reported to the local authority, although not always to CQC, and the service worked well with this agency to investigate concerns. Accidents and incidents were recorded and responded to. Where people were unhappy about the service they received, there was a complaints policy available for them.

People lived in an environment that was cleaned daily and the environment had suitable facilities and adaptations for people living with dementia. Health and safety checks were undertaken and there were appropriate procedures in place in the event of an emergency.

When people needed it, staff arranged for healthcare professionals' involvement. People were monitored for a deterioration in their health and staff told us they had been praised by health professionals for their ability to pick up on infections quickly.

Staff told us they felt very supported by the registered manager and the service had changed for the better since she had started. We were told there was good teamwork and the culture within the team had improved. Staff worked with external agencies.

During our inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We also made two recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff did not follow robust medicines management procedures.

Staff did not always record or monitor risks to people.

There were enough staff to meet people's needs but deployment of staff requiring reviewing during busy periods.

Staff were recruited safely.

Staff maintained appropriate standards of infection control.

Staff understood what abuse was and how to report it.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had adequate induction, however supervision and appraisal did not always take place.

People's consent was not always sought in line with the principals of the Mental Capacity Act 2005.

People's nutritional needs were assessed; however, people did not receive a choice of foods.

People's needs were assessed prior to moving into Avens Court.

People had access to appropriate healthcare professionals when needed.

The decoration and design of the premises was suitable for people.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People's privacy was respected and people were supported to be as independent as they wished.

People could make their own choices and were supported to maintain relationships that meant something to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's care plans did not always include relevant information about the care they needed, which meant people may not receive responsive care.

People had access to activities, however further work was needed to ensure these were individualised and meaningful. Particularly in relation to activities outside of the service.

People knew how to complain and felt comfortable doing so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of effective quality monitoring systems to monitor the quality of the care people received. People were not given the opportunity to be involved in the service and action had not be taken in response to their requests.

Audits that were undertaken did not identify the shortfalls within the service.

Notifiable incidents had not been reported to CQC.

We received positive comments about the registered manager in relation to how supportive they were and the improvements they had made.

Staff and relatives were encouraged to contribute their views to the running of the service.

There was partnership working with other agencies.

Avens Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This unannounced inspection took place on 9 August 2018. The inspection was carried out by four inspectors. One inspector acted as our expert by experience and spent the inspection speaking to people and relatives. An expert by experience is someone who has experience of caring for someone who lives in this type of setting.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that occurred at the service. Statutory notifications include information about important events which the provider is required to send us by law. We also looked at the PIR (provider information return) which we had asked the provider to fill in and return before the inspection and a report from the local authority's quality assurance monitoring visit.

During the inspection we spoke with six people, five relatives, seven members of staff, the chef, the registered manager and one healthcare professional and one social care professional.

As part of the inspection we looked at nine care plans for people living at the service, training records of all staff, staff information which included nine recruitment records, accident and incident records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that staff made them feel safe. One person said, "Yes, I feel safe. Night staff are understanding." A relative told us, "I know the staff will keep him safe. He won't come to harm here."

However, despite the comments we received, we found improvements needed to be made to ensure that people received safe care at Avens Court.

People's medicines were not always managed or stored in line with best practice. People's medicine administration records (MARs) contained their name, GP information, allergies and any specific instructions relating to their medicines. However, medicine counts showed that not all medicines had been correctly administered. We saw that one person missed three of their pain patches since and another person missed one of their tablets since 26 July 2018. Where people were on covert medicines (medicine disguised in food or drink) there was authorisation from the person's doctor. However, there was no pharmacy advice on how best to prepare the medicines, for example which medicines could be crushed.

Not all cream and liquid medicines were dated upon opening and opened prescription creams had been left in a room which was no longer used. There were no body maps to show where staff were placing pain patches on people. This is particularly important as if a patch fell off, staff would not know where the new patch should be placed. We also found the temperature of the main clinical room had frequently been recorded as above the recommended 25°C. The registered manager told us they had sent a request to head office for two air conditioning units but had not received a response. This had not been followed up and as such this meant that medicines were not being stored at their optimum temperature.

People living with dementia may not always be able to express when they are in pain. As such it is important that services ensure they have protocols in place for PRN (as required) medicines. These give staff information on how a person may demonstrate pain, what medicines they can be given, the dosage and frequency. We found that no PRN protocols were in place.

A person told us they felt they were at risk of falls and said, "I walk with my frame and usually someone watches me, or they take me in a wheelchair to my room." Staff told us, "People are safe because we know them and the risks. We know people individually so can spot quickly if there are issues, such as risk of falls and sometimes a person's behaviour can be aggressive."

However, although people had risks associated with their needs we found that not all risks had been assessed and guidance put in place for staff. We found staff did not always record information related to a person's risk. One person had wound assessments in place for a pressure sore which they moved into the service with. Daily notes showed some entries relating to the dressing being changed but nothing was regularly recorded and no photographs had been taken. From the description on this person's Waterlow (skin integrity) assessment it appeared that the pressure sore healed around April 2018. However, in July 2018 a body map for this person showed 'reddening and broken skin' in the same area. We looked through the records and found no wound care plans or notes for that day relating to this. We spoke with a senior staff

member about this who was aware of the wound and advised us that photographs of the area would commence. This same person had information in their care plan that staff should check their air mattress every day. However there was no guidance to staff on the setting of the mattress and as such staff would not know if it was correctly calibrated. We were told by staff that the registered manager carried out audits of the air mattresses, however upon speaking to the registered manager they told us that staff did this. A further person had, 'at risk of aspiration, therefore on risk feeding as inappropriate and non-complaint with tube feeding' written in their care plan but there was no further information or risk assessment around this.

Some people did not have risk assessments in place for the use of bed rails. During the morning we witnessed one person regularly trying to stand up from their chair and when they had successfully managed this they used side tables to support themselves to walk out of the room. However, they appeared very unsteady and their care plan stated they were at, 'medium risk of falls' and, 'guide constantly whilst mobilising'.

The failure to manage medicines properly and safely as well as manage risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and healthcare professionals gave us positive feedback in relation to staffing levels. One person told us, "The staff are very nice. I feel safe." A healthcare professional told us, "There are good staff ratios." A staff member told us, "It's better now." Another staff member told us they felt there were enough staff. A relative said, "They (staff) are alert to things and there's always someone around. I have never visited at a time when I haven't seen lots of staff." A staff member told us, "Staffing is okay but levels could be better at times. We could do with five down and four upstairs."

However, although we found there were sufficient numbers of appropriately trained staff with adequate experience to keep people safe. We observed at times during our inspection that deployment of staff, particularly on the ground floor, could have been better organised. During lunch time staff were seen to be rushing people. We saw one staff member support a person to eat and they were trying to feed the person their next mouthful when they were still chewing. Another person had their plate removed even though they had not eaten all their food. This person's care plan stated, 'needs constant supervision and prompting to eat' however we did not see staff take the time to do this. One staff member was assisting a person to eat at lunch time and they took time and made sure the person had as much as they wanted. However, another person who required assistance to eat had to wait for their lunch as this was the only staff member assisting in the dining room. Two other people who would have benefited from some further interaction or encouragement to eat were left alone pushing their food around their plates.

During the afternoon there were several occasions when there were no staff in the main lounge area. Over a 20-minute period of observation we saw five people who had no interaction from staff. During this period, we saw staff cleaning and folding tablecloths from lunch. We did not find any such concerns on the first floor in relation to staff deployment.

We recommend that staff deployment is reviewed particularly during busy periods to help ensure people receive the care they require, when they require it.

Staff were aware of how to recognise signs of abuse and lessons were learnt when things went wrong. We read that safeguarding alerts had been sent to the local authority safeguarding team and that the service worked in conjunction with them to investigate concerns or allegations. However, we found that safeguarding concerns had not been notified to CQC. A staff member told us, "Neglect or abuse or risk. We have a responsibility to report." Another said, "I have done my own training including safeguarding. There

are systems in place and we need to report it." Following a safeguarding incident, the registered manager had carried out an internal investigation. This had resulted in them identifying shortfalls in record-keeping by both the nursing and care staff. The registered manager had carried out a full audit of all care plans and used nurse and staff meetings to discuss the outcomes and learning. In addition, mandatory record-keeping training had been arranged for all staff, the first session of which was being held during our inspection. There were very few accidents and incidents within the service and the registered manager was aware of all of those that had happened and we read appropriate action had been taken in response to them.

Safety checks were carried out on the building and equipment. There was a grab bag in place which contained all the information necessary for the fire services should there be a fire and people required evacuating. Electrical testing was carried out as well as gas checks and Legionella checks. Each person had a personal evacuation plan which was held in the grab bag. We saw these included information relevant to each person in the event of a need to evacuate, such as what equipment may need to be used to get them out of the building safely and any conditions they had such as a visual impairment. The service had worked closely with the fire service over recent months as there were some actions required of them. The registered manager told us these had all been completed.

People were protected from the risk of infection. The home was clean and decorated to a reasonable standard. There was an on-going programme of redecoration and staff told us, "We have access to aprons and gloves. We put them in the yellow bin and wash hands every time before going to help the next person." Cleaning checklists were held by staff and audits of infection control carried out.

People were cared for by staff who underwent safe recruitment processes. We saw that staff had had DBS (Disclosure and Barring Service) checks carried out in addition to two references. DBS checks help employers make safer recruitment decisions. Identity checks and authorisation to work in the UK was also checked. We saw that clinical staff had their professional registration recorded. This meant people would be cared for by staff suitable to work at this type of service.

Requires Improvement

Is the service effective?

Our findings

People were looked after by staff who underwent induction and regular training. However, staff were not given the opportunity to meet with their line manager on a one to one basis for supervision. This is important as it gives a member of staff the opportunity to discuss their performance, any training needs or concerns. We looked at the information relating to supervisions and noted that clinical staff received individual as well as group supervision from the registered manager. This was to check their competencies. However, care staff only received group supervisions. A staff member told us they could not remember when they last had supervision. We asked the registered manager about this who told us, "I don't carry out one-to-one supervision with care staff as there are too many of them. To be honest, there have been more important things to address so I have focused on those first."

We also found that annual appraisals were not held with staff. This meant staff were not able to reflect on their performance over the year or plan towards professional development or progression. The registered manager told us, "I haven't done appraisals. I know this is something I need to do." A staff member told us, "No, I haven't had an appraisal. I don't think I would need one." This was despite them having worked at the service for over a year.

Failure to provide staff with appropriate support and professional development, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we did receive comments that staff were competent in their role. A bank member of staff told us, "The staff are competent. I rely on them. They know the preferences of each person and each person has a keyworker." Another staff member said, "We check the care plan for any changes; we must use the hoist safely and correctly with two people." A relative said, "From what I've seen the staff are competent. I know some people wander about, the staff deal with people well."

In addition, staff told us they felt the training they received was good. A staff member told us, "I had induction for a week and the training was good. I felt more comfortable in the role after the training." We also observed staff transferring one person from their chair to a wheelchair and this was done in a safe manner with the staff talking to the person throughout. A healthcare professional told us, "They're (staff) aware of pushing fluids in hot weather and of people's nutritional needs. They seem to be very well trained."

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 when needed. When they lack mental capacity to make 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Although staff had a good understanding of the MCA, one staff member told us, "We have to assume everyone has capacity," they were not following the principles of the Act. Staff had not always assessed people's capacity to check whether they were able to make decisions for themselves. One person had no capacity assessment in place. A best interests form for them stated, '[Name] is facing a decision to stay at Avens Court including all activities of daily living. Lacks capacity expressed informed wishes about living and received care here'. We noted this person had bedrails in place and the service had a locked front door, however the DoLS application for this person did not mention either. Another person had a capacity assessment which stated, 'lacks capacity to make decisions'. It was not decision-specific in any way which capacity assessments should be. We saw a DoLS application had been submitted for this person living in an environment with a locked door, but saw no capacity assessment or best interests decision around this. A third person had a capacity assessment for, 'staff anticipate support and assistance needs' and a best interests decision for, 'staying in Avens Court 24-hours a day'. Their DoLS application did not refer to the locked doors at the service or the fact that they were receiving their medicines covertly. A further person had a best interests decision for living at Avens Court but there was no capacity assessment to support this. Another person had bed rails in place and although there was a risk assessment, no capacity assessment or best interests discussion had been undertaken. A professional told us, "They've got a great (capacity) form, they just need to apply it. There are no decision-specific capacity assessments relating to this person."

Failure to act in accordance with the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the food at Avens Court. One person said, "I had bacon for breakfast. I don't get hungry here. Somewhere there might be a menu but I prefer to be surprised. I could ask for something else I think." Another person told us, "I like that I don't have to cook my dinner. The food is okay. There's not much variety, but it's good." A third said, "I always eat all my food, it's very good." A relative added, "The food is very good here. I often stay for lunch too."

People were encouraged to the dining rooms at lunch time and food was served promptly, although we did not observe many attempts at offering choices of meals in one of the dining areas. We also found that people who were on a specialised diet, such as pureed, were not given a choice of foods. The two choices for lunch during our inspection were beef stew or lamp hotpot and the chef made the decision on which dish to puree. We asked the chef why there were two meat dishes on offer and they told us the menu was put together by the head chef. We spoke with the registered manager about this at the end of our inspection. They told us that today's menu was unusual and there was usually a vegetarian option available.

We recommend the registered provider ensures that people have access to a choice of foods to meet people's individual needs.

Staff worked well as a team. A staff member told us, "Teamwork here is very good. I can trust them (other staff). I like working with the manager and can always report to her and know things will be done." A relative said, "They got him here as an emergency because they couldn't cope at another home. They are very careful here, learning about him and what he is like." A second staff member told us, "We have handover every day when we talk about a person whose needs may be changing, so all staff are aware of what to look out for." People's needs were assessed before moving into the service to help ensure staff had the knowledge, expertise and training to meet their needs. We also saw copies of people's funding authority assessments in care plans.

People had access to healthcare professionals to help ensure their health and wellbeing was maintained. One person's care plan held a detailed assessment which covered their health needs and circumstances. We

saw evidence that people had seen the GP, chiropodist, optician, psychiatrist, district nurse and physiotherapist. A relative told us, "They (staff) noticed something was wrong, he had a fever and they called the paramedics. He was taken into hospital." Another relative said, "They will call the doctor if needed. He is now under the palliative team." A third told us their family member had been referred to the GP and said, "I am happy with the way [registered manager] explained things to us They picked up on it and did something. He is happier now and copes better." A healthcare professional told us they felt staff always referred people to them appropriately and followed any advice they gave, "To the letter." They said each person was reviewed when they first moved in to the service and as such they had managed to reduce people's medicines for depression and behaviours, telling us, "We've been able to reduce them as staff are well trained." Staff provided effective care to people. We read information from a healthcare professional which stated, 'have seen a significant improvement and as such discharging them from (our) service'.

People lived in an environment that suited their needs. The design of the building meant there was a large area to move around in downstairs. Bedroom doors had names and some had pictures on them for identification. There were several communal areas for people to use and we saw people sat on the sofa in the hall area where it was quieter during the afternoon. One person told us they had seen improvements in their room. They said, "My bedroom was decorated and new flooring down. There was some decoration downstairs too." Where people required specialist equipment such as beaker cups we saw this was provided.

Good

Is the service caring?

Our findings

People, relatives and professionals gave positive feedback about the staff. One person told us, "I love it here, everyone is so lovely." A relative told us, "They are very kind and patient with [family member]." Another said, "I liked the calmness of this place when I first came. It's peaceful because staff are calm. They have the patience of saints! The care is the priority." A healthcare professional told us, "It's excellent, probably the best care home I visit. Staff know people very well."

We did see some examples were staff were attentive to people. We observed one staff member interacting nicely with a person during their lunch, holding their hand and singing with them to encourage them to eat. Another person was made comfortable, sitting up properly whilst being supported to eat by a staff member who chatted to them throughout. A third person was seen being supported to eat in the upstairs dining area. The staff member was informing the person what each spoonful was and informing them how much was left, for example, "You've only got one more mouthful left." A relative told us, "Staff are always happy, that's the best thing and it's a hard job for them."

When staff had the time to interact with people we observed the interactions were friendly and caring. We observed one staff member sitting holding a person's hand and looking at a magazine and another staff member walked around with a lady and their doll for some time. We saw staff singing with people on an individual basis and one staff member spoke basic phrases such as 'thank you' to a person in their native tongue. A relative said, "I have seen them with people that don't have visitors. They are always kind and helpful. They sit with people one to one and engage with them."

Where one person required some personal care during lunch time staff were being discreet in encouraging this person to go with them. One person became upset during the morning and we saw a staff member approach them, putting their arm around them, talking to and reassuring them in a calm tone.

People were treated with respect. We observed staff knocking on people's doors before entering their rooms. People looked well dressed with their hair neat and tidy. People had on suitable footwear and were dressed appropriately for the weather. A relative said, "I know they care because he is always well dressed, clothes are co-ordinated, they take care with that. It's the small things that matter."

People were encouraged to be independent. We read in one person's care plan, 'I can wash my upper and lower body. Can dress myself with prompting'. One person told us, "Staff help with my socks but I want to dress myself. They accept that. I want to go to bed when I choose and get up when I like. They let me do this." A relative also felt staff encouraged independence by saying, "They (staff) encourage them (people) to do thing themselves if they can. They keep everything as normal as possible and involve them." We saw in the upstairs lounge a box of biscuits taken around to people so they could make their own choice.

People were seen moving around all areas of the home throughout the day. People were seen sitting in the lobby area of the home or walking up and down the corridors. One person told us, "I can go outside to smoke when I want. I can ask for a coffee when I want. I can go back to my room when I want."

People were known by staff. A staff member told us, "We mix up the skills, upstairs and downstairs to get the right mix of staff for people each day. The keyworker system works well as we get to know someone in depth." A relative said, "When [name] first came here he was very disorientated and confused. Staff managed him extremely well. They understand the person. They know how to calm people down, speak quietly, they know what to do. I know he is as happy as he could be here."

Visitors were welcomed. One relative told us, "Welcomed at any time and can stay as long as we like." Another told us, "It's like one big family, they all know me and I can chat to anyone of them (staff). When I was ill they were worried about me."

Requires Improvement

Is the service responsive?

Our findings

Although we had no concerns that people we not receiving responsive care, people's care plans did not always contain sufficient, person-centred information. There was little personal information in people's care plans and some of the care plans we reviewed had no background history on the person. One person was diabetic and although the chef was aware of this there was no guidance in place for staff relating to this.

We also found care plan reviews and daily notes were very task-focused in the way they were written and much of the handwriting was very difficult to read. Assessments were carried out with people before they moved in, but we found that some information had not been translated across to their care plans. For example, one person's assessment recorded, 'doesn't like fish or spicy food' but this was not mentioned in their nutritional care plan. This same person had in their communications care plan, 'ensure she is wearing her hearing aid at all times' and yet, we found that they were not wearing it throughout the inspection.

Where people had particular behaviours or conditions that affected their mood, information was noted in their care plan but we did not always see staff follow up on this. For example, one person wished to go home and had made attempts to leave the service on occasions. The registered manager told us that this person had been on 15-minute checks but these had stopped as they seemed more settled. However, we observed two occasions throughout the day when this person attempted to get out of the front door, a window and over a worktop into the nurse's station. When they were rattling the front door, trying the locks and bolts the registered manager saw them and asked them to stop as they had previously broken the door. The person moved away and started to try and get out of the window. The registered manager walked away and no staff were in the vicinity. The person was not given any support or distraction to encourage them to stop what they were doing. We did see however when they attempted to climb into the nurse's station a staff member skilfully distracted and reassured them whilst managing to get them off the worktop and engaged in something else. We also read in this person's care plan that it stated they still required 15-minute checks.

One person had a diagnosis of depression but this was not mentioned in their health risk assessment. This same person's resting/sleeping assessment was left blank even though they asked to go to bed very frequently throughout the day and they liked to rise at 03:00. This person had also been diagnosed with chronic kidney failure but there was no further information around this and it was only recorded on the GP summary, rather than in a separate care plan. Staff on the floor was not aware that they had this condition and when we asked how the staff would monitor this condition they told us they would check the person's pad, but could not elaborate any further. Another person's personal assessment said they were independent with standing/walking/transfers yet this person required hoisting. People were on food and fluid charts; however, we saw no targets or totals on the charts which meant staff were completing them but not reviewing them to check people were taking in sufficient food and liquids. It is important to have a target amount of fluid intake for people as well as a daily total as this ensures staff can monitor whether the person's intake is increasing or decreasing.

A further person had a history of self-neglect. We noted in their daily records covering a period of 37 days, they refused personal care 15 times and yet we found no care plan giving guidance to staff on what to do in

this situation or suggestions of how to encourage this person in their personal care. This same person also regularly refused their medicines and again out of 37 days we noted they had refused them 13 times. We looked in the GP book to see if the person had been referred to them to follow this up but could see nothing recorded, however the registered manager told us the GP was aware. This same person had no nutritional care plan in the records and despite being a smoker, there was no smoking care plan or risk assessment. Again, there was no background history on this person. A third person was noted as, 'to wear glasses at all times' and yet we found them without them on throughout the inspection.

People were receiving end of life care at Avens Court however we found limited end of life care plans in place. Information around a person's preferences and choices for their end of life is important to help ensure that people are supported at the end of their life to have a comfortable, dignified and pain-free death. The registered manager however told us that families were fully involved and were happy with the care their relatives were receiving. A staff member told us, "We get the doctor out and he makes sure people are comfortable. Families are informed and we keep close observations."

People had access to activities although these were limited, especially the opportunity to take trips out. One person told us, "Someone paints my nails once a week. There's all sorts to do here." The registered manager told us an activities co-ordinator attended Avens Court, "Three or four times a week." We saw the activities co-ordinator arrive on the morning of our inspection, however they only stayed for half a day. Staff told us that activities were not covered by a separate member of staff for the whole week and it was up to them to lead activities in the co-ordinator's absence. The registered manager told us that they were also, "Trialling a lady to come and do exercises with people."

During the inspection we observed staff interacting with people in the way of various activities on the first floor, however, although there was some activity on the ground floor during the morning we did not see much happen during the afternoon apart from seeing staff putting on different music CDs. We noted in one person's 'This is Me' book it included a vast personal history including career, life achievements and events. However, there was no evidence in this person's daily notes that this was being used to deliver personalised care or activities. Another person's 'This is Me' book stated 'none' under personal strengths and attributes which was disappointing to read. People told us they would like to go out. One person said, "I would just like to walk down to the shops. They won't let me go on my own, but there's not enough staff to take me out." Another person said, "I'd like to be able to go out sometimes, even if just to the shops, but this has never happened." The registered manager told us, "The carers are a lot better about doing activities. We do not do trips out, but have been asked more recently by people and relatives about this. Head office is aware."

Other people gave us mixed comments on how they spent their time. One person told us they enjoyed reading the paper which they did every day. However, another person said, "I'm bored here." A relative said, "There are things going on here. They took him outside into the garden in the warmer weather. They did cooking recently. He made cakes and in the afternoon, we ate them." Some people had life boxes and we were shown these by staff. These contained pictures going back over a person's life and staff were knowledgeable in them. One staff member told us, "It helps us appreciate what they are really like and we can get to know people really well."

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

People had access to a complaints procedure although the registered manager told us they had received no formal complaints since the last inspection. They said, "It tends to be a conversation with me and I will sort things straight away." A staff member told us if someone was unhappy about something, "I would talk to

them and see if it was something I could manage. If not, I would escalate it to the manager and encourage the person to make a complaint." A relative said, "I don't know (if I would know how to complain) but the nurse said if I am worried about anything I must tell them, even if a small thing, so I would go to the nurse in charge." We did see some compliments received by the service which included, 'I would personally like to thank all of the team at Avens Court for their hard work and skills in assisting [name] to settle,' 'thank you for all your care and concern for [name]' and, 'your staff are amazing, you made his last month's comfortable.'

Requires Improvement

Is the service well-led?

Our findings

Quality assurance was carried out by the registered provider and registered manager. We read the registered provider had carried out a 'general' audit in June 2018. They noted the service was clean and tidy, people's rooms were fine and daily housekeeping checklists had been completed. They also noted that people appeared happy and staff were engaging with them. Audits carried out by the registered manager included call bell checks, pressure relieving equipment, water temperatures and bed rails. There were also monthly health and safety and laundry audits as well as an infection control audit. We noted that none of these audits had identified any shortfalls. The registered manager told us they had just completed an audit of each of the residents' care plans and had identified some gaps in record-keeping. We were provided with a copy of that audit, however we noted that the shortfalls we picked up during this inspection had not been noted in their audit. This included a lack of mental capacity assessments, care plans missing information and information not transferred over from assessments. We also noted that although cleaning checklists were kept these were not always completed. For example, the sluice room upstairs was clean and tidy however the records indicated it had only been cleaned on 15, 23, 28 and 30 March 2018 and 3 May 2018, rather than daily.

There was a lack of evidence of people being involved in the running of the service as no resident's meetings were held. Feedback from people was not always responded to. The registered manager told us this was because, "People would not be able to participate because of their mental capacity." We were told by people they wished to go out and had reported this to management, however action had not been taken to address this other than to inform the registered provider as such.

Failure to implement an effective system to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A satisfaction survey had been distributed in late 2017. We saw from the 11 collated responses that six people felt the overall impression of the service was 'excellent', two felt it was 'very good', two 'good' and one 'adequate'. We noted two people stated they felt activities were 'poor'. Questions included the quality of care, helpfulness, cleanliness, complaint response, meals and privacy offered. The registered manager told us they were due to carry out another survey this month. A relative told us, "The home has an open day, a get together in the summer usually where all the families come. I have met other relatives and made friends with them – we are in the same board. The manager always makes time (for me) if needed to talk with me."

Services registered with CQC have a requirement to notify the commission of any significant events affecting the service or the people who live there. We reviewed the accident and incident records from January 2018 to date. We noted several notifiable incidents which we had not received information about. This included one person who left the building unnoticed and fell in front of the premises, a second person who left the building unnoticed and was found in Woking, two incidents between different people of physical abuse and three incidents of unexplained bruising to people. We found from our records, the last safeguarding notifications received from the service were in 2016 despite some of the incidents above constituting

potential safeguarding concerns.

The lack of reporting notifiable incidents to the CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was very knowledgeable about the service they managed. They knew everyone well and could answer questions on people's care. We also found clinical staff equally knowledgeable and they had a nice way of interacting with people. A staff member told us, "Since [registered manager] came things changed drastically. She is fantastic – we love her! The culture has really changed in the staff team and we all work well now. I think if you ask any of us, we would say the same." Another staff member said, "The manager is very good, very kind. She is always smiling and if there's a problem she sorts it out." A third told us, "We get on well, the registered manager is very supportive and has brought about change." Relatives were equally complimentary about the manager with one telling us, "The manager is good here, a nice person, she always tells me what is going on." Another said, "The manager will give you time if needed. You can ask questions and no-one will mind, or they will find out the answer for you."

Regular staff meetings took place. These were in the form of nurses' meetings and care staff meetings. We read that clinical staff discussed medicines, rotas, evacuation plans and referrals whilst care staff discussed documentation, team work and responsibilities.

The service worked effectively with external agencies. A staff member told us, "We work well with the GP, dietician, speech and language therapy team, physiotherapist. From a nursing point of view, we have been praised for being very good at detecting and managing infections or illnesses early. This means we have had reduced hospital admissions."

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered provider had failed to notify CQC of notifiable incidents in line with their registration requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered provider had failed to provide person-centred care to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider had failed to follow the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider did not have safe medicines management practices in place or manage risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had failed to maintain

	up to date records for people. The registered provider had failed to have robust governance arrangements in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide statutory support to staff.