Avonwood Manor Care Ltd

Avonwood Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Avonwood Manor is a nursing home registered for up to 49 people. At the time of the inspection 37 people lived at the home.

The service had a registered manager. 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.

People's care and support were not managed safely. Risks to people were not mitigated and the delivery of care for some people was unsafe.

Insufficient numbers of staff on duty meant people did not receive a responsive service. Medicines were not fully managed safely and there were shortfalls in the follow up to accidents and incidents.

People felt staff were competent but a significant proportionate of people and staff said that lack of staff on duty meant people were not supported in a caring and compassionate way. People's privacy and dignity was not fully respected and our observations showed staff had a task orientated approach, mainly due to their time constraints.

Staff received the training they required, however, we have recommended an area of improvement that the service establish systems to ensure staff are fully supported.

We have also made a recommendation to ensure the service understands and acts on The Mental Capacity Act 2005. In addition, people's rights were not protected because some people were unlawfully deprived of their liberty.

Care was not delivered in a way that met people's assessed needs. Care plans were person centred but staff did not have time to follow the plans in place. Some care plans were inaccurate and care delivery was not responsive.

There was a complaints system in place.

There was ineffective governance. Audits and other forms of monitoring were in place but these had not identified the issues found at the inspection.

The registered manager took some actions during and following the inspection in response to shortfalls we identified.

Full information about CQC's regulatory response to any concerns found during inspections is added to

reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not managed safely.

There were not sufficient numbers of staff on duty to meet people care needs.

Medicines were not fully managed safely.

Is the service effective?

Requires Improvement

The service required improvements to be effective.

People told us staff were competent when they had time to support people.

Staff had not adhered to the Mental Capacity Act including DoLS and people's rights were not protected.

People were supported to access healthcare professionals such as their GP when they were unwell.

Is the service caring?

Requires Improvement

The service required improvement.

A significant proportion of people living at the home did not feel staff had time to be caring. Staff discussions and our observations confirmed this.

People's dignity and respected was not protected.

Interactions between staff and people were largely task focused.

Some people had personalised bedrooms and things to occupy them.

Is the service responsive?

Inadequate

The service was not responsive.

Some people had person centred care plans, however other people's plans contained conflicting or inaccurate guidance for staff.

The delivery of care was not responsive and concerns about people's welfare were not always followed up.

There were activities including group sessions and time spent individually with people.

Is the service well-led?

Inadequate

The service was not well led.

There was ineffective governance. Audits and other forms of monitoring were in place but these had not identified the issues found at the inspection.

There was not an effective system in place to seek the views of people. Relatives' views were sought and the provider told us they were developing a survey to help them understand the experiences of people who lived at the home.

Avonwood Manor

Detailed findings

Background to this inspection

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

The inspection took place on 9 and 10 March 2017. The first day was unannounced.

On day one the inspection team comprised of two adult social care inspectors, an observer (who was a CQC employee) and a specialist nursing advisor. On the second day of the inspection one adult social care inspector visited the home.

Before our inspection we reviewed the information we held about the service. We also contacted commissioners of the service to establish their view.

During the inspection, we met 30 people living at the home and spoke with 15 of them to find out about their views of the care and support they received. We also talked with three visiting health and social care professionals and two relatives.

We talked with 15 members of staff, the registered manager and the provider's quality assurance and service development lead. We used SOFI (a formal observation tool) to help us understand the experience of people who could not talk with us, and reviewed care plans and other records for 23 people.

We looked at records relating to how the service was managed. These included four staff recruitment records, staff rotas, training records, audits and quality assurance records as well as a range of the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

Staff received training on safeguarding adults and understood what to do if they were concerned or worried about someone. During the inspection we identified someone who required a safeguarding referral to the local authority because the service had placed them at risk of harm. The registered manager made a safeguarding referral on the first day of the inspection. However, we needed to ask them to review and amend their safeguarding referral on the second day of the inspection as it was inaccurate and the registered manager had misunderstood the risks we were alerting them to.

There were risk assessments and management plans in place for people. However, these plans were not consistently followed by staff.

One person had a safe swallow plan in place from the SALT (Speech and Language Therapist) and they had been assessed as at high risk of choking. The plan included that the person needed to have their fluids thickened, a soft diet and to avoid high risk textures such as dry, crumbly and chewy foods. The plan also included that the person needed to be supervised whilst eating in case they choked. During the morning of the inspection the person was in bed and was eating biscuits. Whilst we were talking with them they coughed and needed to have a drink. They were aware of the need for them to have soft diet and thickened fluids. There was not a copy of the safe swallow plan in the person's bedroom. Staff we spoke with were aware the person needed their fluids thickened and they had a soft diet. However, they were not clear as to whether the person could have biscuits or cake or whether they needed to be supervised whilst eating. We advised the staff of what the plan specified and they immediately stopped an agency member of staff taking the person a piece of cake. The person was placed at risk of choking and harm and we asked the staff and registered manager to take action to ensure the person was supported safely.

This person was also cared for on a specialist air pressure mattress. The care plan specified that their mattress should be checked twice a day to ensure that it was operating properly. There was a blank mattress check record for the person and another person in their room records. This meant we could not be sure the mattress had been checked to see if it was working and was at the correct setting.

There were soft crash mats next to people's beds in case they fell out of bed. These mats had loose straps that were a trip hazard. Some people also had pressure alarm mats with wires placed on top of the soft crash mats or on the floor. The wires again presented a trip hazard. Consideration had not been given to how someone living with dementia and or had poor eye sight may see or perceive the pressure mats. As the pressure alarm mats were a contrasting colour compared to the crash mats or flooring they could be seen as a hole or gap in the floor and people could attempt to step over them increasing the risk of them falling. Some crash mats looked visibly dirty and were damaged and porous so they couldn't be effectively cleaned.

Systems were in place record and investigate accidents and incidents to reduce the likelihood of a recurrence. The registered manager reviewed all accidents or incidents and recorded any action that needed to be taken. However, our analysis of the system identified that where the registered manager asked for action to be taken this was not always followed up and the system in place did not easily allow the

registered manager to monitor this.

The provider had some systems and processes for the safe management of medicines. There were systems in place to obtain the medicine people required, including non-routine medicines such as antibiotics, and medicines were stored securely. Staff administered medicines safely and were kind and gentle with the people they were supporting to take their medicines. Medicine administration records (MAR's) that we examined were completed correctly. People who required PRN (as required) medicines had plans to provide staff with guidance. There was a system for the safe disposal of medicines. One person was having medicines administered covertly. Appropriate guidelines were being followed including pharmacist instructions and authorisation by a GP. Staff were trained in the administration of medicines and had received medication competency assessments in accordance with the provider policy.

Where medicines needed to be stored at a certain temperature this happened and the fridge and medicine room temperatures were checked daily. However, staff were not sure what action to take in the event of the fridge not working effectively, and did not know if there was a policy in place.

One person had a homely remedy (cough linctus). This had last been administered in April 2016 but the medicine had expired in October 2015.

Some of the people who required prescribed creams received these as prescribed. However, three people had care plans that provided staff with guidance on the daily application of prescribed topical creams. For each person there were significant gaps in their records including one person who had only three records of application between the first and ninth of March 2017. Staff told us they understood what to do if people required CPR (Cardiopulmonary resuscitation) however, staff did not know if there were resuscitation masks available.

One person told us their pain was not managed and that staff did not always give them pain relief when they asked for it. We reviewed the person's medicines records and they had been routinely given paracetamol four times a day even though it was only prescribed as PRN (as needed). The person was also prescribed PRN 'as needed' codeine for pain relief up to four times a day. There were pain assessment records completed each day with the person and this indicated the person was reporting to staff their pain was mild. However, the person was not aware they could have codeine in addition to the paracetamol and they told us this was not offered to them. This meant the person was not receiving the pain relief they needed and they told us, "I need painkillers; I don't get them when I need it".

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to people and medicines were not managed safely to ensure people received care and treatment in a safe way.

At the time of the inspection the registered manager told us there were nine staff on duty between 8 am and 8 pm. These were a mixture of trained nurses, care team leaders and care workers. At night time the registered manager told us there were four members of staff on duty. There were also ancillary staff including a chef, maintenance, domestic and activity workers. The registered manager told us they had carried out a dependency assessment to determine the staffing levels required. We asked if the dependency assessment included an assessment of the building geography which our observations showed impacted upon staff time and ability to support people responsively. This was because people were accommodated over three floors and high numbers of people were cared for in their bedrooms. The registered manager told us this had not been assessed or included in the determination of staff required.

Some people told us that there were not enough staff to be able to respond quickly to call bells. One person said, "Sometimes they [staff] don't respond, I'm not convinced they [call bells] work or it might be that staff don't bother to respond; there is not enough staff absolutely not". Another person said, "I press the button and the only complaint I've got it is that it takes quite a while for them to arrive. I think it's due to staff shortages". A third person told us, "They do help us but they'll only come if you shout them, they're busy". We found there was a very high number of people who remained in bed on the first day of the inspection, for example at 11:15 am 25 of the 37 people living at the home were still in bed.

Call bells were audible in the communal areas of the home and at times were ringing for up to ten minutes. The noise of the call bells and repetitive sounds were likely to have a negative impact on people's wellbeing. The registered manager did not complete call bell audits. The provider wrote to us following the inspection and told us the registered manager would, 'Undertake call bell audits to assess response times and continue to carry out daily manager walkabouts to observe practice'.

Staff confirmed there were insufficient numbers of staff on duty to support people in a timely way. We asked staff whether there were enough staff to provide good quality care and received a range of comments including, "No. I try to do my best… but there is no time really" and, "No. Today for example was awful. We need four care workers on both sides; we have three. Sometimes it's easier but we are short of staff. We need better organisation from the duty manager" and, "Two carers to do ten doubles [people who need two staff to support them] is a big ask" and, "So busy so can't chat, just doing duties" and, "I can't do it anymore, it's just pressure, pressure until you're broken".

There were handovers between day and night staff and the handover record included sections to check that people's room records, food and fluids records had been completed. However, the records we saw had not been fully completed and this meant that important information about people had not been handed over to the staff so action could be taken. For example, one person had not reached their fluid target in all of the 12 days records we reviewed. The day prior to the first day of inspection the person had only drank 800 mls of fluid and their target was 1350 mls. This information had not been handed over to staff so they could increase the person's fluid intake to make sure they were hydrated. A member of staff told us, "If there were enough carers, residents could be got up and go to the lounge. They also need fluids and time to give them. They don't get enough fluids because of time". This meant there were insufficient numbers of staff deployed to be able to meet the assessed needs of people and maintain the records required.

We also asked what happened when staff rostered on shift did not work, for example if they were unwell. Staff told us they had to seek the permission of the registered manager before covering any staff shortages with permanent or agency staff and that this was not always agreed. They said in these circumstances they would work with a shortage of staff and this then had an impact on whether people were able to get out of bed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the numbers of staff deployed was not sufficient to meet people's care and treatment needs.

Following the inspection the provider wrote to us and told us, 'Staffing levels have been increased by one member of staff to 10 care staff since the 10th March 2017. Reassessment of resident's dependency will take place within the next 2 weeks'.

Recruitment procedures existed to ensure that people were kept safe. Records showed staff had completed application forms, which included a full employment history. We also saw evidence of Disclosure and Barring Service (DBS) checks, proof of identification and two references.

There were health and safety systems in place. The home employed a dedicated maintenance person and they told us about the checks they completed to make sure the building and equipment used was safe. There was a contingency plan to guide staff in the event of an emergency or serious issue at the home. A recent health and safety audit had been carried out. The provider's internal quality assurance audit noted a number of areas that required attention. The registered manager was unable to find this audit.

Requires Improvement

Is the service effective?

Our findings

People told us that when staff had time to support them they were confident in their skills. Comments included, "Staff treat me well when they come" and, "Most of the staff are excellent" and, "They know what they are doing".

Care staff told us they felt supported by their colleagues and the nurses. They said they could get informal guidance whenever they needed it. The provider's supervision policy stated that staff should receive a minimum of six supervisory sessions per year (pro rata for part time staff) and the registered manager confirmed this to us. The policy also stated staff should receive an annual appraisal. We looked at four staff supervision records. Two members of staff had received four supervision meetings in the 12 months preceding the inspection; a third member of staff had been in post since August 2016 and had three records of supervision. The fourth staff member's file showed they had not had formal supervision since commencing in the role in December 2015. They had received a probationary review and were also the only one of the four staff records we reviewed that had received an appraisal.

This is an area for improvement to ensure all staff are supported through supervision and appraisals in accordance with the provider policy.

Staff had received the training they required to fulfil their role. The training matrix showed staff had received training in key areas such as moving and handling, safeguarding adults, equality and diversity, dementia, food safety, health and safety, fire safety and infection control. Clinical training for qualified staff also included subjects such as catheter care and wound management. There was a system in place to alert the registered manager when refresher training was required.

Where people had capacity to make their own decisions they said that, subject to time constraints, most staff listened to them and acted upon what they wanted to happen. We observed a staff member asking someone, "What can I do to help you", and another person was chatting with staff who said, "It's up to you, did you want to come into the lounge".

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.

We checked whether the service was working within the principles of the MCA and found that some people had their rights protected because staff had assessed their mental capacity to make a specific decision, and where they lacked capacity decisions had been made in their best interests. However, for other people we found staff had not adhered to the principles of the MCA. This was because some people's capacity to make a decision had not been assessed in accordance with the MCA and the statutory best interests checklist had not been adhered to.

We recommend the service seeks training and support from a reputable source to ensure peoples' rights are protected through adherence to the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked that staff had protected people from unlawful detention. Where people were lawfully deprived of their liberty we also checked that any conditions attached to their authorisations were being acted upon.

The registered manager had not received the training or support they required to fulfil this part of their role and people's rights had not been protected. A significant number of the people living at the service had either a DoLS application made, or a DoLS authorisation in place. There was no system for monitoring authorisations so that the registered manager would know when an authorisation expired or when there were conditions attached to the authorisation.

Four people had authorisations in place that had expired. This meant they were unlawfully deprived of their liberty. The registered manager was not aware of this until we brought it to their attention. They agreed to take urgent action.

Three people had authorisations with conditions. The registered manager and the staff we spoke with were not aware of the conditions. Records showed that most of the conditions had not been adhered to.

Two people who required DoLS applications did not have these in place. We asked the registered manager to take urgent action about this.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had been deprived of their liberty without lawful authorisation.

Overall, people were happy with the meals and drinks they had. One person told us that their, "Breakfast was lovely" and another person described the food as, "Usually good". We spoke with the chef who was knowledgeable about people's individual dietary needs. This included people who had allergies or who were diabetic and people with specific nutritional needs such as fortified foods or soft or pureed meals.

People told us that staff supported them to access medical care such as their GP when they were unwell. One person said staff had been, "Very good" when they had recently been poorly. Records confirmed what people told us, for example showing regular contact with a pressure care nurse specialist, GP and district nurses. One person felt unwell and we saw staff checked on them quickly asking them about whether they were in pain and offering to take their temperature. Some people had pressure care needs. One person was receiving support from a specialist pressure care nurse. They had provided clear instructions to staff including nail care and the pressure relieving equipment required. We checked this person and found they were being supported in accordance with the guidance. The healthcare professionals we spoke with told us staff followed their instructions and sought advice appropriately.

Attention had been paid to the design and adaptation of the home. For example one lounge had new furniture and had been redecorated and carpeted. Staff told us people had been involved in choosing the décor. There were contrasting handrails in corridors to support people's independence. Memory boxes outside people's bedrooms supported them to recognise their room, and around the home were things that might interest people such as nostalgic pictures, an aquarium and some sensory items such as fiddle blankets.

Requires Improvement

Is the service caring?

Our findings

We found people were not always treated with dignity and respect including treating them in a caring and compassionate way.

Our discussions with members of the permanent care team showed they were genuinely concerned about people's welfare and cared about them.

However, a significant number of staff commented on their inability to support people compassionately because they were too busy. For example, one care worker told us, "I feel like I can't give them the care they need; that upsets me a lot" another said, "You don't have time to talk to them", a third reported, "They get their physical needs but emotional welfare isn't met", and a fourth said, "It's the residents I feel for. It would be nice to just sit down and have a cup of tea with residents. That never happens".

Some people reported they were cared for by compassionate staff but other people were not happy with the way they were treated. We received a range of comments including, "I like all the staff, its different staff all the time but they know what help we need", and, "its super I'd complain if it wasn't", and, "Nurses are nice". However other people commented, "Sometimes good and sometimes bad" and, "Carers don't care; they say they are too busy".

We observed staff were consistently busy and did not have enough time to engage with people in a positive way. There was very little interaction between staff and the people we observed. Any interactions were quick exchanges of information that related to tasks, such as asking a person if they wanted a drink or what was going to happen next. The majority of the interactions we observed were between staff and those people who were able to easily communicate with others.

Most staff who walked through the lounge to go to the dining room did not speak with or acknowledge the people sitting in the lounge. This meant those people who were living with dementia who did not communicate with words and only used sound had very little or no interactions from staff. As staff were so busy they did not have the time to notice when one person looked worried and started to pull at their clothes. They watched staff as they walked through the lounge and the person then started to make noises, but because there were not any staff based in the lounge there was not anyone to respond. This person's communication care plan included that if the person was uncomfortable or unhappy they would show this in their facial expressions and make noises. Staff did respond after the fourth time of the person making a noise as staff walked through the lounge. The staff member offered the person a drink but did not check any other aspects of their comfort. This was of concern because the person had been sat in the same position for over four hours.

One person became distressed and said to an agency member of staff, "Leave me alone" and the care worker responded, "We leave you alone after we have cleaned you". When the care worker left the room to collect some personal care products the person said, "Please don't shut the door, please nurse". The care worker left shutting the door. We needed to intervene to comfort the person and reported this incident to

the registered manager.

In addition, one person was sat on a commode with their bottom exposed and their bedroom door was open. There was a member of staff in the bedroom with them. Another person was lying on their bed with a continence pad on. There was no bed sheet covering the person and their bedroom door was ajar.

Some people who were cared for in their bedrooms had very personalised bedrooms and had things to look at, things to hold and feel, and had music on or television to watch. However, other people, including those people living with dementia, did not have anything to keep them occupied. For example, one person who told us they "sometimes" liked to listen to the radio or music did not have a radio. Another person who was living with dementia was in bed throughout the day but did not have anything to stimulate or occupy them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not consistently treated with dignity and respect including caring for them compassionately.

We saw an example of staff being caring to one person who was very anxious and upset and said they felt sick. The member of staff in the lounge sought the advice of the nurse on duty who responded immediately and offered to take the person to their bedroom so they could examine them. The staff and nurse reassured the person.

We looked at one person's end of life care plan. This included information for staff on the support the person may have required and also considered their emotional needs saying, 'Staff will need to consider that some relaxing gentle background music is provided; staff to ensure quiet tones with an even calm voice is used'.

The quality assurance and service development lead showed us a quality of life and wellbeing document they had developed to support staff on induction in understanding a person centred approach to care. This included question prompts such as 'how did you sleep', 'how was your day' and, 'what would you like to do today'. This was not yet in use but planned for forthcoming inductions.

Inadequate

Is the service responsive?

Our findings

The care and support people received was not responsive. A member of staff told us, "Residents are sometimes not happy because we can't help them or are rushed". A person confirmed this saying, "I'm not being looked after and if I ask for something I don't get it".

People's care plans were personalised and gave staff details of how to care for and support people. However, due to staff shortages staff did not have the time to be able to care for and support people as described in their care plans. One staff member said, "The level of care [people need] is really, really high and it is a struggle".

For example, one person, who was living with dementia, had a clear and sensitive plan as to how staff were to support the person when they were anxious, upset or distressed. This included that staff needed to approach the person slowly, give the person plenty of reassurance and to give them time to express their feelings. During our observations the person was visibly distressed and they were recalling an upsetting event from their past to themselves and to the other people, who were also living with dementia, that were sat with them. The person became so distressed they began to cry and we offered them comfort as there were not any staff available. We then asked a member of staff to sit with the person as they were upset. The staff member stopped and briefly offered them some comfort and then offered and went to get the person a drink. Another staff member then noticed the person was upset and offered them a drink. Neither of the staff sat with the person as detailed in their plan to reassure the person and understand why they were so upset.

People did not consistently receive care and support that was responsive to their needs. For example, one person was in bed with dried faeces on their hands, sheets, call bell and wall. Their call bed was out of their reach behind their head. Their urine catheter bag was also full. The person was not aware they needed support with personal care when we spoke with them. Staff arrived at 9:40 am to provide the person with personal care and to make them comfortable. According to the care records the person had last been checked by night staff at 7 am where they recorded they were asleep. This meant potentially the person had not been checked for over two hours particularly as the faeces had dried out.

Another person, who was living with dementia and did not communicate with words, had a healthy skin care plan in place. This was because they had been assessed as at high risk of developing pressure sores. Their care plan included they needed to be repositioned every two to three hours during the day and every four hours during the night. In addition, their continence plan included they needed to have their continence wear changed and be washed every four hours to maintain their dignity and keep their skin healthy. On the first day of inspection the person was hoisted into a lounge chair at 8:30 am and was not repositioned or moved until 12:45 pm when they were transferred into a wheelchair for their lunch. They were taken to their bedroom at 1:54 pm to lie on their bed and have their continence wear changed. This meant the person was not repositioned for four hours and their continence wear was not changed for five and half hours. We reviewed the person's records for the previous two days and 10 days during February 2017 and saw the person was not consistently repositioned as set out in their healthy skin and continence plan.

This person's care plan did not include that they remained seated in their hoist sling. Staff confirmed the person's sling was breathable and suitable for them to remain seated in. However, the person's healthy skin care plan detailed that the person should not have any foreign objects or tight clothing that could cause pressure damage. On the first day of the inspection the person was sat in their hoist sling with the hoist straps under and between their legs from 9 am until they were moved at 12:45 pm. This meant that some people's care plans did not included sufficient detail to make sure staff had all the information they needed or had contradictory information.

One person, who was not able to independently move their wheelchair, was taken to dining room by staff at 12 pm. Staff put an apron on the person but lunch was not served until after 12:45 pm. The person was still sat at the dining table at 1:40 pm and they told staff they were waiting for their pudding. Staff got the person their pudding and the person remained in the dining area. At 4:20 pm the person was still sat in their wheelchair with three other people in the dining room. There were not any staff in the lounge or dining area. At 4:30 pm the person used their feet to move themselves from the dining area to the lounge. A staff member came through the lounge and the person asked to sit in a comfy chair. The staff supported the person to a comfy chair. The person had not been offered the opportunity to go to the toilet and subsequently had an accident a few minutes after sitting in the armchair. We immediately found the registered manager to assist the person.

One person had a skin integrity care plan in place and was identified as at high risk of pressure care issues. Their care plan said they would usually get up at around 8 am. However they remained in bed for an extended period of time on the first day of the inspection. They had discoloured areas on their feet. Their feet were pressed against the bottom of the bed because the bed was not long enough. We raised our concerns about this with the registered manager. Following the inspection the quality assurance and service development lead wrote to us and told us, 'Residents who require extra leg length beds now have extensions in place'.

Another person had skin integrity needs. Their care plan said they needed support to reposition themselves every three to four hours. They were sat in a wheelchair on the first day of the inspection from 12 pm until 5 pm where they were supported to return to their bedroom. We asked a member of staff why this person had not been supported in accordance with their care plan and they told us it was due to, "Lack of staff".

One person was a risk of choking. They had a safe swallow plan which described how there drinks needed to be thickened to ensure they didn't choke. However, their risk assessment did not reflect this information. This meant staff had contradictory information about how this person needed to be supported to ensure their safety.

Four people did not have their call bells with easy reach of them. They were able to use their call bell. We gave the call bells to the people so they could summon for help. One of these people who was cared for in bed had both their legs hanging over the bedrails. They were able to move one of their legs but not the other. We gave the person their call bell so they could summon staff assistance. The provider's internal quality assurance audit carried out in January 2017 also identified people not having their call bells within reach as an issue.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive appropriate person centred care based on their needs and preferences.

One person had a plan relating to catheter care. This provided staff with detailed and accurate guidance on

how to clean and empty the catheter.

Some people had care plans relating to specific medical conditions such as diabetes. Some of the guidance for staff provided was clear and helpful. For example, one person's plan provided guidance on how staff should take blood sugar readings. However, other aspects of the plans were not clear. This meant there was a risk staff may not respond appropriately in the event of the person becoming unwell.

There was one fulltime and one part time activity worker. We chatted with them and they told us they provided group activities and also supported individuals who spent most of their time in their bedroom. They said they were supported to attend activities meetings with other providers and that the provider had purchased new activity equipment. Relatives told us about their family member who enjoyed books and having their nails painted. They described the activity workers as, "Good" and told us about how they undertook activities their relative enjoyed such as looking at dog books.

People's care plans explored what they liked to do. One person's plan said, 'I love TV, particularly Home and Away, Neighbours and Judge Judy. I love reading the bible and bible stories'. When we visited this person they were watching the television. An activity worker told us about what they had done to support this person with their faith. They said, "I have tried and tried with this, because [the person] likes their bible stories and it is important to them. I have found a lady who is very interested and devout, who is happy to attend to read bible stories".

There was a complaints policy in place. The complaints received by the service in the past 12 months had been investigated and there had been contact with the complainant to explain the findings. Three of the five complaints received by the service related to concerns about the quality of care provided to people at the home. The provider's internal quality assurance audit identified two further complaints that the registered manager had not told us about. The complaints system was not organised in a way that would enable the registered manager to easily monitor complaints for trends such as the trend we identified relating to poor quality of care.

Inadequate

Is the service well-led?

Our findings

The home was not well-led. This was because the governance at the home was not effective.

The registered manager submitted weekly and monthly reports to the provider. These included information about medicines management, pressure care, staffing and accidents.

The quality assurance and service development lead for the organisation told us they felt there had been a steady improvement in the care people received. They completed a range of quality audits and said they visited the home twice a month to support the registered manager to make improvements. A recent monitoring visit covered audits of areas such as people, staffing, health and safety, training and care plans. Other audits such as 'full home reviews', and quarterly external quality assurance audits were also completed. These led to actions plans in specific areas. We saw action plans and areas to focus on were clearly displayed on a board in the registered manager's office.

However, these quality assurance systems were not effective. For example, the auditing of staffing, medicines, people's care plans and the accident and incident analysis had not identified the issues found during this inspection.

Staff had carried out a health and safety audit. This was reviewed in internal provider audits in January 2017 and February 2017. These stated that a number of issues needed to be rectified to ensure the environment was safe. Following the inspection we wrote to the registered manager to request a copy of this audit. The registered manager was not able to find the health and safety audit.

The provider's internal audits were not able to fully assess and monitor the service. The February 2017 internal audit stated 'Could not locate all internal quality audits for February 2017' and, 'Whilst there is evidence action plans are now being completed following audits the consistency in completing the 7 main internal audits is sporadic.' This meant the provider could not be assured that the quality assurance audits directly carried out by Avonwood Manor staff protected people from the risk of harm.

Part of the provider's assurances of the quality of the service were determined by them reviewing the registered manager's 'walk-arounds' of the home. The provider's internal quality assurance stated 'Ideally 3 per week to be carried out to give a full overview in the detail of how the home is being managed day to day at ground roots'. The registered manager told us they tried to walk around the home every day including observing care practice and chatting with people. However, they acknowledged that a great deal of their time was spent situated in a third floor office where they were not easily accessible to either people or staff and were not able to hear or see what was happening in the home. The provider's internal quality audit in January 2017 stated there were two recorded 'walk-arounds' with the document stating the registered manager had a number of these records to type up. In February 2017 the provider's internal audit did not record any 'walk-arounds' but stated it was repeating the January findings and advising the registered manager to take action. This meant that trends or concerns noted by the registered manager may not have been detected or acted upon because the system in place was not effective.

In addition, the registered manager's lack of knowledge in areas such as the Mental Capacity Act 2005 including DoLS had led to people being unlawfully deprived of their liberty and the systems in place to protect people's rights under the MCA were not effective.

The local authority contract monitoring visited in September 2016 and identified shortfalls. The registered manager developed an action plan. The local authority monitoring team visited again in January 2017. Some actions from the registered manager's plan had been completed however; other action points remained unmet or partially met. The registered provider and manager had not acted fully on the feedback provided by the local authority to improve the quality of care at the home.

Some staff felt listened to by the management team. Other staff felt less supported and told us that issues they raised were not always addressed. We received a range of comments which included, "There are times when I feel like I can't talk to them. I am wary. I don't always feel like I have done well" and, "I don't like the style of management. Sometimes nice, but then you are shouted at".

These shortfalls in the governance were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality assurance and service development lead told us that people's views were sought on an individual basis about their enjoyment of meals and activities. However, they acknowledged there was not a systematic approach to establishing people's views of the overall quality of care they received; or a system for detecting themes or trends to act on any concerns or issues people may have had. They explained that they planned to implement a system that enabled them to seek people's views and recognise and act upon emerging trends or issues by July 2017.

Relative feedback was sought through a survey in February 2017. The results had been analysed and fed into a development plan.

The quality assurance and service development lead told us about some of the development work that was taking place in relation to recruitment and retention of staff. They said, "If we get the staffing right, everything else will be right".

The quality assurance and service development lead told us the registered manager was dedicated to making improvements and the registered manager told us, "The support is amazing" and, "I love the home and I know we can improve".