Surrey Rest Homes Limited

Avens Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 January 2017 and was unannounced.

Avens Court Nursing Home is registered to provide accommodation and personal care for up to 60 people. At the time of our inspection there were 39 people living at the service, some of whom were living with dementia.

At the time of our visit a registered manager was not 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. There was a new manager in post who was in the process of applying to become the registered manager. The new manager was present during our inspection.

We carried out inspections of this service between 19 November and 1 December 2015 and 13 July 2016 where we identified a number of breaches of regulations of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. These were in relation to poor infection control, unsuitable premises, treating people with a lack of respect, not providing person-centred care, a failure to follow the legal requirements of the Mental Capacity Act and not carrying out quality checks. Following that inspection the provider submitted an action plan to us detailing how they would address these concerns. This inspection took place to check whether or not the provider had taken action in line with what they told us in their action plan.

Systems to monitor the service had been introduced and the registered provider had recruited a senior member of staff who had overall responsibility for addressing any concerns identified and taking action to support staff to improve the service. However, we found a continued failure by the registered provider to drive improvement at the service. Many of the improvements we saw during this inspection were in response to concerns we had identified, rather than from a proactive approach of registered provider.

We found continued poor infection control processes being carried out in the home and a poorly maintained environment.

People may be at risk of unsafe care as although risk assessments had been written, some were contradictory and others did not provide sufficient guidance for staff to tell them what steps to take to reduce the risk. Staff were not always following the legal requirements in relation to consent and restrictions of people's liberty.

People were not always treated in a way by staff that showed that they mattered. Some actions by staff did not display an approach that showed people were treated with respect. However, we did observe some good, kind interactions between staff and people.

There was a lack of stimulation in the home for people and the registered provider had not taken robust action to address our previous concerns in relation to activities. People's care plans were not written in a person-centred way and did not always include enough information for staff which meant that some people may not receive the care in line with their needs. People's records were not well maintained and often held conflicting information. They were also not always stored securely.

There was a sufficient number of staff on duty, however deployment of staff could have been better organised to allow staff time to socialise with people. Although staff had gone through a recruitment process before commencing work, the registered provider had failed to ensure that all paperwork relating to their recruitment was in place.

People's medicines were stored safely and people received the medicines they needed. We saw evidence that people received the care of health care professionals when required, although we did find that referrals to health care professionals for some people could have been made more quickly by staff.

Staff were aware of their responsibilities in relation to safeguarding and the registered provider had a contingency plan and fire processes in place in the event of an emergency. Staff had undergone induction and training when commencing in their role and although they had not previously received regular supervision, this had been identified and steps were being taken to ensure this was addressed.

People and their relatives were happy with the food they received and we found the lunch time experience for people was a pleasant one with people receiving their food and support when they required it.

The provider had a complaints system in place. Staff and relative's told us they were happy with the new manager, felt supported by her and could approach her with any concerns, issues or suggestions.

During the inspection we found the provider was in continued breach of six Regulations of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. We have also made some recommendations to the provider. You can see what action we told the provider to take at the back of the full version of the report.

At this and our previous inspections the service has had a rating of 'Inadequate' within the Safe domain. We have also rated the service following this inspection as 'Inadequate' in Responsive. As there have now been repeated ratings of 'Inadequate' the service has been placed 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.

The service was poorly maintained and people were at risk because of poor infection control practices.

Robust recruitment processes had not been followed because some staff files had paperwork missing.

Staffing levels were sufficient and people's medicines were managed safely.

Staff were aware of their responsibilities in relation to safeguarding.

In the event of an emergency people's care would continue in the least disruptive way possible.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always following the legal requirements in relation to the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards.

People were provided with nutritious food and drink.

There was a training programme in place to support staff to develop the skills they needed to carry out their role. Supervisions had commenced to enable staff to meet with their line manager on a one to one basis.

People had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always make people feel as though they mattered or treat them with respect.

People told us that staff were caring towards them and they talked to them in a caring manner. We observed some kind, caring interactions between staff and people.

Visitors were made to feel welcome at any time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always experience person centred care. The registered provider had not taken sufficient action to improve activities for people.

People had care plans in place however these did not always provide guidance for staff which meant some people may not receive care in line with their needs.

Information about how to make a complaint was available for people and their relatives.

Is the service well-led?

Inadequate

The service was not well-led.

There was a systemic failure of the registered provider to improve the service.

Records held for people were contradictory, not contemporaneous and not held securely.

Auditing of the quality of the service was now taking place and the new clinical consultant had already started to take action to identify shortfalls in the service.

Staff felt supported by the new manager and relatives gave us positive feedback in relation to her.

People and their relatives had been given the opportunity to give their views on the home and the care provided.

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 17 January 2017. The inspection team consisted of three inspectors and one specialist nurse advisor.

Before the inspection we gathered information about the service by contacting the local authority quality team. In addition, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law. Prior to and following our inspection we obtained feedback from the local authority quality team.

We asked the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR as part of our overall inspection.

During our inspection we had discussions with two people, four relatives, 11 members of staff, the manager, a clinical consultant who had been newly appointed to the home and two social care professionals. We observed how staff cared for people. We read care plans for seven people, looked at medicine administration records and mental capacity assessments. We looked at five staff recruitment files and supervision and training records. We saw audits undertaken by the manager, minutes of resident and relatives and staff meetings, and a selection of policies and procedures.

The last inspection to Avens Court took place on 13 July 2016 where we identified a number of breaches of the regulations.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe living in the home. One person told us, "I feel safe living here, all staff are lovely."

Relatives told us that they believed their family member was safe living at Avens Court. One relative told us, "I don't worry about his safety. It's the way the carers look out for him. They let him be and only stop him if there is danger." Another said, "I feel he is safe here. Dad has really settled down since moving in here."

At our inspection in July 2016 we identified concerns relating to infection control and the premises. We found at this inspection the registered provider had failed to take sufficient action in both of these areas and there continued to be concerns.

During our inspection in July 2016 we found the provider had failed to ensure that effective systems were in place to monitor and control the spread of infection. At this inspection, although we found some improvements had been made, for example in relation to the cleanliness of the home and the cleanliness of the kitchen, we again found concerns in relation to infection control processes.

People were at risk of infection due to poor infection control processes being carried out. We asked a new member of staff to demonstrate to us the cleaning process for commodes and they showed us these would be cleaned in the bath using a spray and wipes. The staff member was unaware there was a sluice room next door to the bathroom (a room for cleaning and disinfecting continence products) saying, "I haven't been shown the sluice room" although they were able to show us they knew how to use the sluice machine. We noted however that staff would be unable to wash their hands in that particular sluice room as there was not enough room to do so. This was confirmed by a member of staff who told us they could not wash their hands in that sluice room because of the lack of room (and had to do so at another sink). There was no soap in that sluice room or a bin which meant clinical waste or gloves could not be disposed of. Following our inspection the local authority said that during their visit they had spoken with a selection of staff about cleaning commodes and they were able to describe proper processes in relation to how they would do this.

We found six people's rooms did not have soap and commodes and toilets in some people's rooms were stained. In a communal toilet there were buckets with water in them. The mops were positioned on top of these buckets with the head of the mops facing downwards meaning they could harbour germs. This was something we had also identified at our last inspection. A recent visit from the local quality assurance team had also identified concerns in some areas of cleanliness. A staff member told us, "We take it (infection control) very seriously, but I am new so I do not know if we have a lead." We noted that although guidance for staff on infection control had been made available to staff, it was clear staff were not following this.

The failure to prevent, detect and control the risk of infections was a continued breach of Regulation 12 of the Health and Social Care (Regulated Activities) Regulations 2014.

At our last inspection in July 2016 concerns had been identified in relation to the environment. Although we

saw some improvements the environment people lived in was still not properly maintained. We saw at this inspection refurbishments works had commenced and some people's bedrooms had been repainted and curtains that had previously been hanging down had been re-hung. A relative told us, "The décor is better but it's still ongoing. They are slowly doing the bedrooms." However, we found other people lived in rooms that were not properly maintained. This included six rooms which had either no hot water at all or only tepid water. A staff member told us they often reported there was not enough hot water in people's rooms and said it was a constant problem. The local authority quality team identified similar concerns during an unannounced inspection they carried out two days after our inspection. We found laminate floor in people's rooms was ill-fitting and torn in places stains under radiators (some as a result of the refurbishment) and on window sills which had not been cleaned up. The emergency cords in people's room were long and some twisted around lamp shades above people's beds which meant they could not be used or posed a choking risk. Some rooms contained old metal hospital beds which posed a risk of entrapment and there were no plugs in people's sinks which meant plastic bowls had to be used. People's commodes had no lids with seats placed on the top of open bowls and the temperature in some rooms was extremely hot. One person's room had the sink coming away from the wall and another person had a radiator lead across their room which would have been a trip hazard.

We noted from the registered provider's action plan that the refurbishment was due to complete in July 2017. A staff member told us, "I think the environment has improved. They are planning to change all the hospital beds. I think the corridors and floors need changing – the colours need doing."

We spoke with the manager and clinical consultant at the end of our inspection about the concerns we had identified. Following our inspection we were sent an action plan by the clinical consultant which demonstrated a response to these concerns. Maintenance had been informed about the lack of hot water; the sluice was to be relocated to make it more accessible for staff and equipment such as hoists and commodes would receive a deep clean.

The failure to ensure that the premises were properly maintained was a continued breach of Regulation 15 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

There were some areas of the home that had improved. For example, we found the dining and communal lounge on the ground floor looked cleaner and brighter. The 'library' was brighter with art on the wall and books and music (although we noted that people would have been unable to reach the books because they were on a high shelf). The kitchen had been deep cleaned and the corridors on both floors had been painted.

People were at risk of unsafe care. Risks to people had been identified but staff were not always knowledgeable about the action to take to minimise these risks. We observed a staff member pushing one person in their wheelchair without using the footplates. The staff member told us, "(Name) doesn't let us do it (use the footplates)." Although this person's care plan referred to the fact that they did not like to use the footplates, it did not provide guidance to tell staff it would be safer to pull this person when in their wheelchair rather than push them to reduce the risk of injury. Another person smoked and we observed them being accompanied by staff several times during the day into the garden to have a cigarette. We noted however there was no fire safety equipment in the garden area and although this person had a risk assessment around their smoking, it did not include the use of a fire retardant apron to help this person stay safe. A third person required a pressure relieving cushion when sitting on a chair to reduce the risk of sores. We found the cushion was not fit for purpose as it was lumpy. And a further person was not being provided with softer foods whilst they awaited new dentures which would help reduce the risk of them choking.

The failure to provide safe care to people was a breach of Regulation 12 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

The provider had not carried out appropriate recruitment checks to help ensure they employed suitable staff to work at the home. The provider had not always obtained or held in place appropriate records such as two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We read from an email that the clinical consultant had already identified these gaps in recruitment files and was working with head office to either obtain copies of paperwork held by them (as in the case of DBSs) or requesting paperwork was sought.

We recommend the registered provider ensures they are compliant with Schedule 3 of Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

During our inspection in July 2016 we found the provider had not ensured there was a sufficient number of staff deployed to meet the needs of people. This was particularly evident during lunch time when people had to wait for their lunch or wait to be supported to eat. During this inspection we found staffing levels were sufficient and on the whole people received the care they required in a timely manner. The lunchtime experience for people had greatly improved and people received their lunch promptly with those requiring support receiving it. However we did discuss with the manager at the end of our inspection that we felt deployment of staff could be better organised during certain periods of the day to help ensure that staff had the time to engage and socialise with people. One staff member said, "I think there are enough staff but it's harder when we are short." A professional told us, "There are always plenty of staff around."

We recommend the registered provider reviews the deployment of staff to meet the needs of all people at all times.

People's medicines were stored, administered and disposed of appropriately and securely. The home had a medicines policy and the policy was being adhered to. Each person had a Medicines Administration Record (MAR). We found these had been completed appropriately by staff, with no gaps which demonstrated people received the medicines they needed. Staff checked the temperatures of the storage areas for medicines to check they were stored in the correct way.
Medicines were kept safety with only appropriately trained staff having access to them. One staff member told us, "We take medication very seriously, it is a big responsibility and I am very careful." Where people had 'as required' (PRN) medicines, protocols were in place which gave appropriate guidance to staff.

People were cared for by staff who knew what action to take should they suspect abuse was taking place. Staff had received training in relation to safeguarding people and were able to give good accounts of safeguarding, the types of abuse possible and how they would report it. A staff member told us, "I know who lives here. I care for them and I treat them like my own family. If I see wrong doing I will report it."

In the event of an emergency people's care would continue with the least disruption possible. People had a personal emergency evacuation plan (PEEP) that gave clear descriptions about how to safely evacuate each individual in the case of an emergency. A recent fire inspection showed that the home was meeting adequate safety in relation to fire risks.

Requires Improvement

Is the service effective?

Our findings

At our inspection in July 2016 we found that decisions were not always made in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found at this inspection the registered provider had failed to take sufficient action to address our concerns. The MCA protects people who may lack capacity and ensures that their best interests are considered when decisions that affect them are made. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS ensure that people receive the care and treatment they need in the least restrictive manner and only in their best interests.

The manager told us at the beginning of the inspection that, "We've started mental capacity assessment reviews and you should see improvements." However, we did not find this to be the case.

One person had capacity and their care plan stated, 'I am able to make my own decisions' however, we found that this person was being restricted on how many cigarette's they could have each day. Their care plan recorded, 'his cigarette should be controlled by staff by giving him one at a time and staff to keep his cigarette. Leave at least 4 hours. He should be weaned from smoking until he is completely clean. Divert him'. This meant this person was being deprived of their right to make choices in relation to their care and support. Another person's care plan stated, 'she can make every-day decisions' but later on the care plan recorded, 'she has a learning disability she cannot make every-day decisions'. There was no clear information on whether this person had capacity to make decisions. One person's DNAR (do not attempt resuscitation) was agreed with their sister. However this relative had passed away some time ago and staff had not asked the GP to review the DNAR with them or the person's advocate to ensure that this was still the right decision. Another person had a DoLS application for the locked front door but no MCA had been carried out prior to this to ascertain whether they had capacity. There were also bed rails in place for people but there were no MCA or best interest discussions in relation to these.

The failure to follow the legal requirements of the Mental Capacity Act 2005 was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a mixed understanding from staff of the MCA. One staff member told us, "If they (people) cannot make choices we supervise them." However, another said, "People were assumed to be able to make decisions unless proven otherwise." This staff member was able to describe to us best interest meetings and why they were important for people. Following our inspection we were told by the clinical consultant that funding for MCA training had been agreed.

Staff were familiar with covert medicines (medicines disguised in food or drink). One staff member told us, "Some residents might not understand the consequences of refusing to take medicines. In these situations, it may be necessary for us to act in the best interests of the patient. The GP has to agree if we covert any medicines." Mental capacity assessments had been undertaken for people who were on covert medicines.

People and their relatives were complimentary about the food. One person told us, "The food is good. I get all the food I ask for." A relative said, "The food here is fantastic. Dad eats everything and has two puddings. He also gets a snack and a drink whenever he wants." They told us their family member could have anything they wanted even if it was not on the menu. Another relative said, "Nothing wrong with the food. It's really, really good."

Dietary requirements in relation to people were known by staff which helped ensure they were provided with appropriate foods. The chef had a list of people's likes, dislikes and dietary needs which included any allergies they had. All meals were freshly cooked and lunch time was seen to be relaxed with people who required one to one support receiving it.

We did find however that not everyone was given a choice of meals in a way they would understand. In the dining room downstairs people on a normal diet were offered a visual choice of meals. However, for those on a pureed diet or who had meals in their rooms they were not provided with a visual choice. We spoke with a staff member about this who told us that people on a pureed diet chose their meals the day before. We spoke with the manager about this at the end of our inspection and received an action plan from them the following day to demonstrate they had taken action to address this.

People were supported by staff who received an induction and had access to a range of training. This included topics such as moving and handling, first aid, dementia awareness and health and safety. A staff member told us, "I think new staff have enough training. The training is good." Another staff member told us they had attended an induction programme, followed by shadow working with a senior care staff for two weeks. A third member of staff told us they had an induction and training which included infection control, dementia, safeguarding and fire safety. They said they were shadowed by a senior member of staff for a week. Nursing staff confirmed their training was comprehensive and up to date. One nurse told us, "I had a handover; the induction here is the same as anywhere. It is a very nice team and I like working here." We observed staff demonstrating skilled moving and handling techniques when transferring people. One staff member told us, "We transfer any resident that needs to be moved in pairs." The staff in charge assumed their roles with ease and confidence. We observed them work methodically and prioritise as required, whilst coordinating and offering support to care staff.

Staff were not always provided the opportunity to review and discuss their performance, as regular supervisions had not taken place. However, we found the clinical consultant had identified this shortfall and had already started to lead supervisions for care and nursing staff. A matrix was in place to help ensure that all staff received supervision in a timely manner.

People were supported to access appropriate health professionals should they need to. However, we found that referrals may not always done in a timely manner. This was in the case of one person who had not been referred to the dentist when they lost their upper denture. A staff member told us some referrals were not made as quickly as they would like. One member of staff told us, "Nurses take too long to refer people to the continence nurse." They said that often people had to wait a long time to be provided with the correct continence aids. Following our inspection the clinical consultant confirmed that a referral had been made to the dentist for the person who required new dentures.

We did see in some people's care plans however that they had received involvement from a wide range of external health and social care professionals. This included palliative care nurses, dieticians, speech and language therapists and physiotherapists. One person's health had deteriorated and staff had asked for the GP to visit them and another person had been observed to not have been eating and again staff had contacted the GP.

Requires Improvement

Is the service caring?

Our findings

People told us they were looked after by kind staff. One person said, "I'm really happy."

Relatives were also happy with the care provided to their family member. One relative told us, "The care he gets I cannot dispute. He looks clean. His room is clean. The carers are fantastic." Another said, "Dad's bedroom is always clean and tidy. People are always dressed in clean clothes. Staff respect people all the time." A third told us, "They (staff) look after her well. I'm pleased that she's here."

At our inspection in July 2016 we found that people were not always treated with dignity and respect by staff. At this inspection we found some improvement had been made, however we found that staff did not always consider people when providing care.

People were not always treated with respect by staff. During the morning the television was on in the upstairs lounge but it was positioned so it could not be seen by everyone. At one point a staff member came into the lounge and changed the television programme without asking anyone what they wanted to watch. The television remained on this channel all day and people were not watching it. On another occasion a staff member came into the lounge to speak to a colleague. They did so without acknowledging anyone else in the room. The manager came into the entrance of room and said to staff, "Can you bring residents down, why are you keeping them here?" This was said out loud and did not account for whether people actually wanted to go downstairs or not. At lunch time we observed staff put clothes protectors on people without asking them first. This included putting one on one person was whilst they were asleep.

People were not always made to feel as though they mattered. In the dining room downstairs we saw one person ate their lunch sitting on a lounge chair as there were no spare chairs around the tables. This was despite staff telling us that this person liked to sit at the table. We also saw a member of staff who had supported someone to eat stand up, remove the person's clothes protector and walk away before the person had finished their last mouthful. We saw one staff member giving one person some fruit but not giving them the chance to fully swallow their mouthful before trying to put some more in their mouth. One person at a table was trying to reach a wooden puzzle in front of them. Rather than move the puzzle to within the person's reach, staff took it away. We read a note in the staff diary which stated, 'Could you please celebrate (name) birthday. It was on (date).' We asked the manager why this person's birthday was not celebrated on the day and were told, "Staff must have forgotten it."

We observed one person in particular for the majority of the day. We saw that during the morning they were asleep in a chair in the lounge. They were not woken up by staff when tea was being offered to people. At lunch time, staff woke this person up and they had their lunch. However, when we saw this person again during the afternoon we found they remained asleep and only on one occasion between did a member of staff try and rouse the person to engage with them. This lasted for about 30 seconds and the staff member gave up and walked away.

People's environment was not made to feel like their home. We found the lounge upstairs was very un-

homely with nothing of interest for people in it. The chairs and side tables looked worn and in need of repair. In one corner of the lounge there was a large office desk and filing shelves where staff stored people's care plans. In another corner there was a kitchen area with microwave. It was cluttered and untidy looking. A sink was attached to one wall which staff used regularly throughout the day. People's chairs sat around the walls of the room, some in positions that did not enable people to see the television. There was nothing about the room that made it feel like someone's lounge.

Failure to always treat people with dignity and respect was a continued breach of Regulation 10 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

We did see some good examples of kind, attentive care however during our inspection. At lunch time we saw a staff member start to feed one person and then encourage them to do it for themselves which they did. Another person was asleep when their meal was brought to them. The staff member gentle woke the person, explaining it was lunch time and told them what they had chosen for lunch. The staff member provided one to one support to this person throughout their meal.

We did see occasions when staff approached people they smiled at them and staff communication with people was warm and friendly, showing a caring attitude. One person asked if they could have a drink and a staff member said, "Of course, take a seat and I will get one for you" which they did. This same staff member went around to each person to encourage them to drink or to check if they needed anything. A second staff member called out to one person using their nickname. When we checked this person's care plan we found that this was their preferred name. And a third staff member sat chatting to one person and said to them, "You look pretty." When one person was being transferred, staff reassured them by saying, "We are going up my lovely." A relative told us, "Staff are always talking to him (their family member) and he responds to some staff in particular." We observed one staff member talk to people in their own language which they clearly appreciated.

We saw staff speaking to people in a polite way, making eye contact and waiting for people to respond to their questions. Staff also asked permission before doing anything for people. One person had a continence issue and a member of staff discreetly asked if they could take them to their bedroom so they could get changed, explaining the reason why. People had been supported to look smart and to dress in co-ordinating clothes. One staff member said, "I always ask what they want to wear." A professional told us, "I've always seen staff engaging with people."

People were given the independence to move freely around the home. One relative told us, "The environment is good as there are lots of places he can walk instead of one long corridor." We regularly saw people walking around the ground or first floor of the home with no restrictions in relation to accessing communal areas and returning to their bedrooms as they wished. At our previous inspection we found that bedrooms on the ground floor had been locked, but we noted at this inspection everyone had access to their room whenever they wished as they remained open.

Relatives were made to feel welcome. Relatives spoke of being made to feel welcome whenever they visited. One told us, "I always feel welcome here. As soon as staff see you they say hello. I see staff giving residents a cuddle and speak to them nicely." Another relative said, "They (staff) always make me feel welcome." A third said, "I am told to come along at any time and they make me feel welcome."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found a lack of a person-centred approach for people. During this inspection we found sufficient improvements had not been made.

We asked people and relatives about activities within the home. One person told us, "I join in with the activities. They are good." A relative told us, "I feel motivation is needed. More activities are needed. More energy is needed. They could do with music and exercise especially for those that sit there." A third told us, "He does not communicate, but he gets lots of stimulation with all the voices around him." We noted in the most recent satisfaction survey that four out of the 11 respondents had rated social activities and events as, 'adequate' or, 'poor'.

At our inspection in July 2016 we found that people did not have access to a range of activities they could be involved in and the registered provider had not taken action to improve activities for people to make them personalised and meaningful. At this inspection we found little improvement. The lack of activities were also identified by a local authority quality visit which took place after our inspection.

People did not have the opportunity to participate in activities that were meaningful. We spoke with staff about activities that took place. They told us they would go through the 'Daily Sparkle' (reminiscence newspaper) with people each day, carry out aromatherapy and pampering for people and take a portable music player to people's rooms for them to listen to. Although we were shown a full activities schedule for the day, we did not see any of these activities happen in the upstairs lounge and only saw attempted activities take place downstairs for a short period of time during the morning. We found the activities lead was acting as care staff for the majority of the day. We asked to see information regarding previous activities and one to one sessions for people who remained in their rooms but staff were unable to provide us with any evidence of this. A staff member told us, "There are no activities. Today there are two new staff which is why there is a lack of activities. There should be more than one activities co-ordinators because we are too busy." Another staff member said, "We sometimes play board games and have light music." A third staff member told us that activities took place on the ground floor only and people upstairs watched television, read magazines or talked to staff. They said, "We sometimes play ball games in the evening." We were told that external activities did not take place and although one had been planned for December this had not happened.

The manager told us at the beginning of the inspection that we would find, "A more friendly dementia environment" but we did not find this to be the case. There was an overall lack of understanding of appropriateness of activities and surroundings for people who may be living with dementia. The lounge on the ground floor had a large notice board which contained health and safety information and dementia posters which were directed at staff. In another area there was an 'infection control corner' which again consisted of a noticeboard with information for staff. There was a washing line attached to the wall of the corridor on the first floor which had children's clothes pegged to it. It was hung so it was not accessible to people and in an area in which the majority of people did not pass and had no meaning for the people that lived there.

People had care plans which had been developed from the pre-admission assessment carried out prior to them moving into the home. However, we found that care plans were not written in a person-centred way which may mean that people would not receive care specific to their needs or preferences. We had made a recommendation to the registered provider about care plans at our last inspection. Following our last inspection the registered provider had employed a clinical consultant who had started work on reviewing the care plans, although this had only just commenced and the clinical consultant told us this was one of their first tasks since starting at the home. There was a lack of personal history in people's care records which is important in that it helps staff get to know people. One person had very little information other than their family member's names and that they liked music, hymns and musicals. Care plans regularly referred to 'the resident' rather than using the person's name.

Care plans contained information about a person's care needs, for example, washing, dressing, grooming and oral healthcare, their social and wellbeing, privacy and dignity. There was information recorded, such as, 'I would like you to provide me with a protective towel during my personal care'. Although care plans were written in a language that suggested it was the person who had written it there was a comment that stated the care plan was developed from information obtained from relatives. This demonstrated a lack of a person centred approach to care planning.

People may not always receive the care they were entitled to. We found one person's toothbrush bone dry and solid with dried toothpaste. We asked a member of staff if they had brushed this person's teeth that morning. They initially told us they had, but then told us the person had refused. We asked the staff member to show us the toothpaste they used, but they could not find any that indicated that the toothpaste had not been used. Another person's toothbrush was also very hard and had not been used for a while. We could not find any toothbrush in another person's room. This demonstrated to us people may not always receive the appropriate oral care from staff. One person's care plan stated that they needed two staff and a small handling belt to assist them with transfers, however later in their care plan there was a record that this person required one staff member only for transfers. We noted the handling belt was not used when staff supported this person but it was not clear from our observations whether this person was not receiving care in line with their care plan or the care plan was incorrect. This same person had, 'maintain good oral hygiene' in their care plan, however we found that this person had not had any dentures for at least one month. There had been no referral to the dentist and their care plan did not reflect the fact they were without their teeth.

One person had been put back to bed mid-morning as staff told us it was because they were uncomfortable in their chair. When we visited this person in their room we found they had a large amount of dried matter around their mouth which staff had not wiped away. They had not been left with a drink in their room and although staff told us, "We are monitoring her every 30 minutes" we did not find a monitoring chart in their room to evidence this. Another person was susceptible to pressure ulcers but did not have a care plan in place which described or assessed the contributing factors which may lead to sores. People who had catheters did not information about how to minimise infection or other side effects arising from these in their care plans. Where people were diabetic, there was little information in their care plan around this. Although staff was able to verbalise the needs of the diabetic residents, which showed they knew the problems and interventions, this was not documented in a clear plan called diabetic. We asked staff about care plans. One told us, "I can't say everything is accurate. I don't know what learning disability (name) has."

The failure to provide person-centred care was a continued breach of Regulation 9 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

There were occasions where care needs were being met for people. One person was on bedrest and we observed them to be mostly comfortable, warm and clean. There was a timely repositioning routine in place and records relating to this person's skin integrity in this person's care plan. A staff member told us, "We often screen skin during personal hygiene time and we look for any problems. Then we would work to lessen progress of complications and aim for recovery of good skin integrity." Another person had recorded in their care plan, 'to stay healthy I need to drink about eight cups of fluid every day'. We found they had a food and fluid chart in their room which staff completed. A professional told us, "Staff appear to know people's needs."

Communication information was held in people's care plans such as how would a person greet people. We noted one person's care plan recorded they would say, 'Hi mate' and this is how they greeted us when we arrived at the home. A staff member told us, "Nurses discuss the care plans with us and we can update them with changes when we need to, for example, when there is a change in a person's mobility." A third told us, "We use a keyworker system so we make sure we read people's care plans." This member of staff was able to give us clear descriptions of the needs for one person which was in line with their care plan.

People knew how to make a complaint. We saw that one complaint had been received since our last inspection and this had been dealt with appropriately by the manager who was in post at the time. Complaints information was available for people and their relatives should they wish to raise any concerns or issues. One relative told us, "I feel listened to. When I bring things up they take notes." Another said, "If I had any concerns I would ask."

Inadequate

Is the service well-led?

Our findings

Although we found some improvements at Avens Court since our inspections in December 2015 and July 2016, we found the registered provider had not taken action in a way that demonstrated their commitment to improving the level of care that people received. We found many of the concerns highlighted at this inspection related to breaches of regulation identified at our previous two inspections. We found there was a systemic failure of the registered provider to identify and put right the shortcomings in the service.

At our inspection in July 2016 we found that care records for people were not always up to date or contained the full information about people which would help staff understand what care a person needed. We found similar concerns at this inspection.

Risk assessments were in place for people, but there was often conflicting information contained in these. One person's eating and drinking risk assessment recorded a 'high risk' but a separate MUST (Malnutrition Universal Screening Tool) scored the person as being 'low risk'. This same person had four falls risks assessments in place all with conflicting information. People's assessments were not dated so it was not possible to determine when these were completed.

Although care plans included information for staff it was difficult to find this information. Overall care plans were bulky, repetitive and confusing. It was difficult to find actions that staff may have taken in response to someone's health or care needs. Information was contradictory and not easy to follow, such as, 'I am unable to use call bell, but I would like you to give me the call bell when in bed as I may recall the memory to use'. One person's care plan recorded, 'I cannot eat and drink independently' but further it was recorded, 'I can eat and drink independently'. This same care plan noted, 'I have lost weight rapidly in the past 3 months' then, 'In the past 6 months have been fairly stable'.

We found much of the information in people's care plans had been copied and pasted without staff correcting the information. For example, one gentleman's care plan recorded, 'after, with your help I take off my nightdress'. Another person had reference to them having a visual impairment in their care plan, but this had been crossed out in pen which indicated it was taken from someone else's care plan. A staff member said, "They are in a mess now as all the forms are together, but we are working on it." Another member of staff told us, "We are trying to use new formats and paperwork."

Records were also not stored in a confidential way. People's personal records were stored upstairs in an open-shelving unit just inside the doorway to the lounge which meant anyone could access them.

Failure to hold contemporaneous, secure records for people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

At our inspection in July 2016 we found a lack of good governance within the home as actions identified in audits undertaken had not been addressed and some audits had not identified the shortfalls within the service. During this inspection we found some improvement had been made however some of the

improvement had been in response to concerns we had identified at this and previous inspection, rather than the registered provider identifying shortfalls themselves and taking action.

We were told by the manager at the beginning of our inspection that quality audits were now carried out. These included audits of infection control, the laundry, care plans, medicines and catering. We noted that actions from the catering audit had been completed, such as installing a fly screen in the kitchen and arranging staff training. We also saw a complaints audit and a maintenance audit. The maintenance audit identified night staff required refresher fire training and we found this had been booked. Internal and external audits of medicines carried out in 2016 identified no actions. However, a care plan audit had identified risk assessments were not up to date and a health and safety audit in January 2017 identified staff training required. A monitoring of pressure sores carried out in December demonstrated people had been referred to the appropriate health care professional.

The registered provider had recruited a clinical consultant since our last inspection who had overall responsibility for supervising the nursing staff and overseeing and putting the necessary systems in place for health and social governance. This included ensuring care plans were person-centred, risk assessments were in place and carrying out regular high level audits to work towards improving the service. The clinical consultant told us that much of what we identified at this inspection had already been evident to them when they first started. Following our inspection they sent us their action plan to show how they planned to address our concerns. This included a complete review of care plans (which had already started), training for staff (including infection control and MCA), a re-prioritisation of the refurbishment programme and to allocate an activity co-ordinator on each floor with the responsibility of producing weekly evidence- based activity programmes. We read they had already started to take action in some areas.

The new manager was visible throughout the day and it was clear she had a good relationship with people and staff. We observed she was very hands-on. A relative told us, "She is lovely. She explains things to me. I'm so happy she is here." We asked this relative if anything had changed for the better since the new manager had started at the home and they told us, "I spoke about the hallway needing an update and its much nicer now." Another relative said, "I've met (the manager) she seems nice. I could talk to her if I needed."

Staff were also complimentary about the manager. One staff member told us, "The manager is very supportive. I feel valued." Another said she (the manager) had a hands-on approach and knew the residents individually. Staff told us the manager was, "Approachable" and they felt they could report any suggestions or complaints to her.

Staff meetings had been held however these did not take place regularly and notes from the meetings were spare. The clinical consultant told us, "They haven't been done consistently. It's a work in progress." They also told us the nursing staff did not have regular meetings. We read the minutes from the last staff meeting which was held on 5 January 2017. We read that staff discussed infection control and the introduction of the 'infection control corner' however there was limited discussion at the meeting. Following our inspection, a second staff meeting was held with good attendance and notes from this meeting demonstrated much more comprehensive discussions. The clinical consultant had now introduced a programme of fortnightly staff meetings.

Residents and relatives were involved in the service as meetings took place however attendance at these were poor. We noted the last meeting was only attended by five people. Discussions included the food and activities. The manager told us that they planned to organise these meetings at different times of the day or at weekends in order to enable as many relative's as possible to attend.

A satisfaction survey had been carried out by the registered provider in 2016 to which 11 people had responded. We found that on the whole relatives had a good overall impression of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people were always treated with dignity and respect.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to appropriately detect, prevent and control the risk of infections. The registered provider had failed to ensure people would be free from risk.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 15 HSCA RA Regulations 2014 Premises and equipment

The registered person had failed to ensure that premises were properly maintained and suitable for the purpose for which they were being used.