Alma Care Homes Avens 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Avens Court Nursing Home is a care home providing personal and nursing care to 51 people aged 65 and over, many of whom may be living with dementia. The home, which is in a converted house and is set over two floors, each floor having its own lounge area. At the time of our inspection, there were 29 people living at Avens Court.

People's experience of using this service and what we found
People were not safe living at Avens Court. There was a lack of staff to meet their needs and instances of potential abuse were ignored by staff or not raised as such. People had accidents and incidents and staff did not take steps to help ensure future accidents or incidents were reduced.

Although risks to people were identified, staff did not follow guidance to help keep people free from harm. People were left at risk of pressure sores, malnutrition and falling due to staff not having sufficient time to supervise people or taking the time to care for people in the way they needed.

People's medicines were not handled safely. There were numerous gaps in medicines records which meant the registered provider could not guarantee people received the medicines they should have. People also lived in an environment which put them at risk of infection. There was a lack of effort by staff to regularly bathe people and people were left in wet bedding due to staff shortages and the inability to meet people's needs in a timely manner.

The management and leadership of the service was ineffective. The registered provider had failed to act in a transparent and open manner and also failed to address previous concerns. Despite staff and relatives raising concerns, the registered provider had not listened and made changes to improve the care for people and the service they received. Although the registered provider had engaged a management service for Avens Court they demonstrated a lack of candour as they had not informed people, relatives or staff.

Despite audits being carried out at the service, shortfalls were not identified or addressed. Organisation of staff was inadequate in that there was a lack of senior management at the service. This left inexperienced staff, who did not know people, running the service.

The registered provider did not meet their requirements of registration in that there had been a lack of registered manager in the service for nine months. They had also failed to report potential safeguarding concerns to CQC.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 4 December 2019).

Why we inspected
Since our last inspection we received numerous concerns in relation to the management of the service, staffing levels, people's needs not being met and a poor living environment in relation to cleanliness. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report. We found continued breaches of regulation in Regulations 12, 17 and 18 of the Health and Social Care Act 2008.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Avens Court Nursing Home on our website at www.cqc.org.uk.

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of Inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Avens Court Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Avens Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This meant that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received from the service, such as statutory notifications of accidents and incidents and any safeguarding concerns. This included concerns raised by the emergency services, tissue viability nurse and the local authority. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and two relatives about their experience of the care provided. We spoke with six members of staff.

We reviewed a range of records. This included three people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We liaised with the local authority and the management service who had been engaged to take over oversight of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staffing and recruitment

At our last inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient staff deployed.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

- There were not enough staff on duty to meet people's needs. A relative told us, "I am not happy. There is no consistency of staff. He (my relative) wasn't shaved on Saturday, his hands and nails were dirty." A second relative told us, "Things are difficult here at the moment. They (agency staff) don't know what they need to do."
- When we arrived, we found one nurse and three care staff on night duty, to meet the needs of 29 people many who had high dependency. The nurse told us, "These agency staff don't listen and don't know people's needs. My PIN is at risk. There is not enough of us."
- At 10:30am we heard one person call out for help saying, "You're not doing your job properly, please help." Staff did not acknowledge the person so we went to speak with them. They told us, "I need help, I'm sitting in a puddle." We alerted a member of staff who told us, "I know, I heard her but my colleagues are busy with personal care elsewhere." They told us they would let someone know. However, despite two staff coming into the lounge area the staff member did not inform them. It was only at 10:36am that two staff assisted the person out of the lounge to get changed.
- People were not given the support they needed to eat and drink due to a lack of staff. We observed two people sitting at a dining table for their breakfast. No staff were available to assist them and as a consequence their breakfast got cold. We checked one person's care plan which stated, 'needs supervision with meals' which they had not had.
- Staff told us there was an insufficient number of them to meet people's needs and provide people's care in a timely way. No activity staff were employed, there was one housekeeper for the whole building and the chef was without a kitchen assistant. The chef told us, "It happened very suddenly." However, we were told that the shortage of kitchen staff had occurred the previous day but no action had been taken by management to resolve this.
- We observed people still being given their breakfast at 10:00am. They were being given tea and food that had been sitting on the breakfast trolley for at least an hour. We felt the jug of tea and it was lukewarm. We also felt the underneath of the bowls of porridge which again were lukewarm. We did not see staff reheat breakfasts before giving them to people.

● A staff member told us, "Residents are still in bed, there are not enough staff. People are soaked in urine; they don't have showers (due to lack of staff)." We walked around with this staff member at 12:00pm and found 11 people in bed who had either not been washed and made comfortable for the day, or been assisted to get up and get washed and dressed. This was because of an insufficient number of staff.

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

Using medicines safely; Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to poor medicines procedures, staff not adhering to guidance in people's care plans to reduce potential risks and lack of robust infection control processes.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People's medicines were not managed safely and the registered provider could not be sure that people received the medicines they were prescribed. This put people at risk of not having received their prescribed medicines.
● We reviewed the records for everyone living at the service and found 12 people had gaps in their MARs. In addition, we found the number of tablets in the medicines trolley for two people did not match the remaining number written in their MAR.
● Where people had pain patches, staff were not completing body maps to show where it was placed on a person's body. This left people at risk of harm as pain patches should not be placed on the same area twice.
● When a staff member had completed the morning medicines round, we found a foil medicine packet on top of the medicines trolley with one tablet left in it.
● Although risks to people had been identified, these were not always addressed or responded to by staff, meaning people could be at risk of harm. One person's care plan stated, 'close monitoring is required when [name] is sitting in the lounge area' as the person (who was chair bound and at high risk of falls) tried to stand up unaided. We did not see staff observing the person and as a consequence observed them attempting to stand on several occasions unsupported
● Staff did not follow good moving and handling procedures. We saw one person being wheeled through the service with only one foot plate on their wheelchair meaning their other foot was dragging on the floor, putting them at risk of injury.
● A second person was seen being wheeled through the lobby area by staff without their feet on the wheelchair footplates. The nurse and care staff tried to encourage the person to bend their legs so their feet could rest on the footplates but they were unable to do so. This resulted in the nurse holding the person's legs up whilst the other pushed the person back to their room.
● This same person was at risk of weight loss and as such a food and fluid chart was kept for them. However, this was not robustly completed by staff and there was no oversight or monitoring to check they were maintaining a healthy intake of food. Staff recorded notes such as, 'ate full meal' or 'ate partial meal' but they did not state quantities. On three occasions during a period of 16 days, no food intake was recorded at all. There was no target amount for fluid, meaning staff could not check whether the person was drinking enough. In addition, this person was seen being given a normal diet for their breakfast and yet their care plan stated they were on a fork mashable diet. We raised this with the clinical lead who said they would follow this up immediately.

● A further person's care plan stated they should be weighed weekly as they were at risk of malnutrition. Their records showed only three weights recorded in a seven-month period. A third person was noted to have a significant weight loss of 16 kilogrammes in a five-month period, but no referral had been made to a health professional in relation to this. We spoke with the clinical lead in respect of this person who said they would address this immediately.
● Where people were at risk of pressure damage to their skin, staff were not following guidance in people's care plans. One person's care plan stated they should be repositioned hourly, however records from their care plan demonstrated this was not happening. During a period of 22 days, the records had only been completed on six occasions. Staff were unable to tell us where pressure mattress settings were recorded which meant staff could not check whether people's mattresses were set correctly.
● People could be at risk of harm in the event of an emergency. When we arrived at the service at 07:05am the staff member who came to open the door did not know the key code. A second staff member came to assist and again, they could not open the front door. Later we observed a staff member who had finished their shift waiting by the front door. We spoke with them and they told us, "I do not know the code, I am waiting for someone to let me out." We asked them what they would do in the event of a fire and how they would evacuate people if they did not know the code. They told us, "I am sorry, I would have to ask someone."
● Fire safety measures were not observed by staff. We found people's bedroom doors being propped open by chairs, meaning that in the event of the fire alarm activating they would not self-close. We have made a referral to the Surrey Fire & Rescue service.
● People lived in an environment where good infection control practices did not take place. At 07:30am we found the door to the sluice room (room where soiled items are cleaned) unlocked. We informed a staff member who told us they would lock it; however it was still unlocked at 12:10pm.
● We were told by staff that there was no facility for them to clean soiled items on the first floor of the service. A staff member showed us a toilet and said staff used this area and, "They rinse things in the toilet." The taps on the sink were not connected and the pedals for the clinical bins were broken meaning that although staff had to open the lids manually they would not be able to wash their hands.
● One person had been incontinent in a chair in the lounge area. Despite staff being aware of this they proceeded to sit two different people in this chair throughout the morning. The cushion on the chair remained uncleaned from 10:36am until we left the service at lunchtime.
● We checked the bathroom where staff had taken one person to change during the morning and found their wet clothes still on the floor two hours later.
● There were only two working showers at the service, both of which were on the ground floor. Staff told us, "People are going a month without a proper shower or bath."
● The building was large, with many long corridors and it was over two floors which meant it was difficult for one person to be able to clean it thoroughly. The housekeeper told us, "There are not enough cleaning staff. No cleaner comes in when I'm off. I see wet sheets on beds that are just left to dry by staff. I don't see anyone have a shower."

The lack of robust medicines processes, responding to risks to people and preventing the possibility of spreading infection was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse. Learning lessons when things go wrong
● People could be at risk of harm as staff did not respond to incidents of potential abuse. We observed two people having an altercation both verbally and physically. Although there were three staff members in the vicinity at the time, none of them responded to this only doing so when we alerted them to it. A staff member said to us, "What's the problem?"

● A relative told us, "I feel he is safe around not getting out, but I am so worried about the food situation and the carers don't know people. There isn't enough guidance."
● Although people had accidents and incidents these were not always recorded robustly. We found a mixture of records held in a folder as well as in a pile of paperwork in the nurses' station. We found 27 recorded incidents and accidents over a period of 54 days. Of those, only six had preventative measures recorded. A number of falls were unwitnessed, indicating that people were not being supervised sufficiently.
● We read of five potential safeguarding concerns relating to unexplained bruising or clashes between people that had not been raised as safeguarding concerns. We highlighted this to the clinical lead.

The lack of safeguarding services users from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of accurate records for people.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● There was a lack of robust management oversight of the service and the registered provider had not responded to the concerns found at our last inspection.
● Despite the registered provider knowing they had commissioned a management company to take over the running of the service they had failed to be honest and open with people, relatives or staff. A staff member told us "I have someone on the phone. They are saying they are a new company that are taking over." This was the first the staff member was aware of this and they were clearly shocked and upset. The registered provider also failed to tell people and their relatives. This was left for the management company to do, which they did on 7 February 2020.
● Staff told us the culture within the service was such that it was having a negative impact on people. A staff member told us, "We are at loggerheads with [senior manager] I told her I'm concerned about the agency staff's ability and her response was, 'You'll have to train them because they're the cheapest I can get.'"
● There was poor organisation of staff. The service was manned by agency staff and although they told us they had worked at Avens Court before we heard nursing staff consistently giving instructions to them because they did not know what they should be doing. Many of the agency staff had a poor understanding of English. We tried to speak with some but they were unable to answer our questions because they could not understand what was being asked of them. During handover, no written notes were given to staff and no one, apart from the clinical lead, was writing anything down. Care staff were left to allocate tasks out themselves as there was no one at the service in a position to organise this.
● A senior staff member had arrived at the service to carry out medicines competency assessments with staff, however they ended up taking on the role of clinical lead for the day in the absence of anyone else in

charge.

● Records relating to the service were incomplete. Daily clinical meetings were last recorded on 8 January 2020 and no heads of department meetings had been held since December 2019. Care plans had conflicting information. One person's care plan stated they were independently mobile, but then later that they needed the assistance of two care staff to mobilise. This same person's profile page stated they needed their food and fluid recorded, but this was not mentioned in their nutritional care plan. Staff were not completing repositioning or food and fluid records robustly.

● Audits that were carried out had not identified shortfalls. An infection control audit in November 2019 stated there were no concerns and yet we found the foot operated pedal clinical bins did not work. It also stated that laundry was segregated into clean and dirty areas, however this would not be possible due to the limited space in the laundry.

● The registered provider did not meet their regulatory requirements. We read of five potential safeguarding concerns that had not been reported to CQC. In addition, a further two notifiable incidents had not been reported.

● The registered provider failed in their responsibilities in relation to duty of candour as they were not open and honest when things went wrong. They had failed to apologise to people and their relatives for the failures at the service or take accountability for people's poor care. Despite writing to the registered provider on two occasions following our inspection to ask for assurances they would immediately address our concerns, they failed to respond to our correspondence.

● There had been no registered manager at the service since April 2019 which is a condition of the provider's registration.Two managers had been employed and left without the provider ensuring that they applied to register with CQC.

● Despite the registered provider telling relatives during resident and relatives' meetings they planned to improve the service for people, taking into account their views and feedback, this had not happened. A relative told us, "For the past six months I feel all I have done is complain. This place used to be happy." A second relative said, "The management changes all the time. Everything is up in the air."

The lack of robust management oversight of the service and the failure of the registered provider to meet their requirements of registration was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.