Avon Lea Weymouth 2015 Limited

Avon Lea Nursing Home

Inspection report

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17 October 2017
20 October 2017
24 October 2017
25 October 2017
26 October 2017
30 October 2017
31 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 17, 20, 24,25,26,30 and 31 October 2017 and was unannounced. .

The service is registered to provide accommodation and residential or nursing care for up to 40 older people. At the time of our inspection the service was providing care to 23 older people some of whom were living with a dementia.

The service did not have a registered manager at the time of our inspection. The last registered manager of the service had resigned their post in February 2016 after a period of absence that we were notified of in November 2015. The current manager informed us that they had applied to CQC to take on this role. We could not find a record of this application. 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.

We inspected Avon Lea Nursing Home in May 2017 to follow up on a warning notice that was issued at a previous inspection in February 2017 because we had found people were not receiving safe care and treatment. Requirements were also made at the February inspection concerning person centred care and good governance. At the inspection in May 2017 the requirements the warning notice were not met. We also identified a continued breach of regulation regarding good governance. We rated the home as 'Inadequate' and the service was placed into 'special measures'.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are inspected again within six months of the publication of the last report. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

We carried out this inspection to assess the actions taken following the last inspection and in response to information of concern we received alleging that people were receiving unsafe and poor care. We planned to undertake a focussed inspection to answer the key questions "Is the service safe?" and "Is the service responsive?" During our inspection we identified people continued to be at risk of unsafe care and treatment. We therefore opened this into a comprehensive inspection.

During our inspection we became concerned about the safety of people living in the home. We shared our concerns with the provider and the statutory agencies. A plan was put in place to reduce the immediate risks to people. This plan included checks on people's welfare made by Community Matrons and additional nursing oversight at nights. Health and social care professionals visited the service to monitor safety. Before the conclusion of our inspection the statutory agencies took the decision to stop funding care at the home. They worked to find people new homes and everyone moved out by 27 October 2017.

The overall rating for this service continued to be 'Inadequate' and the service, therefore, remains in 'special measures'.

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.

At this inspection, we found that improvements people's experience noted at our last inspection had not been sustained. People were not receiving care in a personalised way and risk management was not sufficient to ensure people received safe care and treatment. Systems to assess, monitor and improve the quality and safety of the care people received were still inadequate. We also found additional areas of concern.

There was poor risk management. Risks related to skin damage were not being managed effectively and staff did not always have accurate information about these risks. People were not always able to make staff aware when they needed assistance and checks were not consistently carried out to ensure safety and comfort.

Staff did not always follow safe administration of medicines procedures and this put people at risk of not receiving their medicines safely.

Auditing systems were in place but they had not always recognised areas that needed improvement. When areas had been identified the cause of the issue was not always addressed and this meant the service people received did not improve as a result.

People were supported by staff who felt supported in their roles. However they did not always understand people's needs or follow safe practice. This meant some people had been put at risk of unsafe support in relation to moving and handling, skin care and drinking, when for people needed thickened drinks. Staff were not deployed in a way that meant they were available when people needed them.

Allegations of abuse had not been appropriately responded to when they had been brought to the attention of a manager. People were left at risk of harm as a result of this.

People's privacy and dignity were not always respected with people being spoken about in front of others.

Information received from professionals was not always used effectively to reduce the risks people faced and requests made by health professionals were not always followed without unnecessary delay People had not always been supported appropriately to maintain their health. Monitoring was not always effective.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

People and staff described the manager and staff as approachable. They knew how to make a complaint and felt they would be listened to and any actions needed would be taken. Complaints were not investigated in a way that ensured individual learning and where they included allegations of abuse these were not addressed appropriately.

Notifications had not been made to the Care Quality Commission where required due to allegations of abuse and people developing pressure areas. The providers were not displaying their rating published by the Care Quality Commission following the inspection of May 2017 inspection.

As in previous inspections, care staff were kind, patient and friendly throughout.

People enjoyed the activities available to them. New activities coordinators had been employed to meet people's needs for meaningful activity.

Staff had been recruited safely.

The menu offered a variety of main meals and snacks and catered for individual likes, dislikes, allergies and special diets.

We had concerns about risk management, person centred care, the condition of the home, the application of the Mental Capacity Act 2005, staffing deployment and staff understanding of their training, the management of safeguarding and complaints, failure to comply with statutory responsibilities and quality assurance in the home. We took action and cancelled the provider's registration.

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.

People's identified risks were not consistently managed.

People's medicines were not administered safely.

People were not supported by enough staff.

People were not protected from abuse by robust systems.

People lived in an environment that did not promote their safety.

Is the service effective?

Inadequate

The service was not effective because staff training had not been effective in ensuring staff had the skills they needed to work safely.

Staff supported people's choices about their day to day care but this was sometimes impacted by time constraints.

People at risk of dehydration did not receive appropriate support.

People were not supported appropriately to maintain their health.

People's rights were not protected by the framework of the Mental Capacity Act and the conditions of a person's Deprivation of Liberty Safeguard were not met.

People had a choice of food and drinks available that reflected their likes and dislikes, allergies and specialist diets.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff acted with kindness and compassion throughout our inspection. However, people were cared for by some staff who

acted in ways that did not promote their dignity and privacy.

People's opportunities to direct their own care were restricted by staff availability and systems.

Is the service responsive?

Inadequate

The service was not responsive because people did not always receive care as outlined in their care plans.

Most people had individual care and support plans that detailed how they should be supported. Staff told us they had not had time to read these plans.

Professionals told us that the staff did not always carry out tasks requested.

Complaints were not fully investigated and did not address individual learning needs

People had the opportunity to participate in activities.

Is the service well-led?

Inadequate

Auditing systems were not effective in identifying areas that required improvements.

Breaches of regulation and concerns raised by the Care Quality Commission had not been addressed.

Statutory notifications had not been made and the rating had not been displayed in accordance with legal requirements.

Avon Lea 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.

We carried out this unannounced inspection on the 17, 20, 24, 25, 26, 30 and 31 October 2017, with two inspectors visiting each day and a further two inspectors copying documents. The inspection was planned as a focussed inspection to look at how people received safe and responsive care and treatment. This was carried out to assess the action taken since the last inspection and in response to information of concern relating to people's experience of care in Avon Lea Nursing Home. This was extended to a comprehensive inspection as additional risks were identified.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with social care commissioners and health and safeguarding professionals to get information on their experience of the service. We also looked at information we received in the provider information return. This 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. The provider had completed this in January 2017. We were able to get up to date information during our inspection.

During our inspection we spoke with eight people who used the service and a visiting relative. Some of the people living in Avon Lea Nursing Home no longer used words to communicate, we spent time in communal areas and observed how staff supported and spoke with them. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the two owners; the manager who was a nurse, two nurses, and nine staff. We gathered feedback from the GP who visits the home and health professionals who

visited during the course of our inspection. We reviewed records related to 19 people's care. We also looked at records related to the running of the home including: three staff files, management audits, accident and incident records, training records, staff meeting records and records relating to compliments and complaints.

During our inspection the statutory agencies took the decision to stop funding care at the home. They worked to find people new homes and everyone moved out by 27 October 2017. The inspection plan was altered to ensure we did not cause additional stress on staff or people whilst they were supporting people to move to new homes. This meant we were not able to speak with care staff, the manager and the providers and people as much as we had planned, as this may have impacted on the care people received

We asked for further information to be provided to us following our inspection. This included information about care plans, training and policy information. We also asked for evidence that the manager had applied to be registered. We received most of this information as requested.

Inadequate

Our findings

When we last inspected the service in May 2017 we found that the provider had not met the requirements of a warning notice for a continued breach in regulation in relation to safe care and treatment and the records related to risks. We took action in accordance with our enforcement policy. Full information about CQC's regulatory response to any concerns or continued shortfalls is added to reports after any representations and appeals have been concluded. At this inspection the provider had not taken sufficient action and people continued to receive unsafe care and treatment.

People were assessed regarding their ability to use a call bell to seek assistance from staff. At our inspection in May 2017 we found that people who were able to use their call bells did not have access to them. There were continued incidences of people not having access to call bells. We raised this as a concern on the first day of our inspection. People remained unable to reach their bell on subsequent days. Eight people did not have access to their call bells over the course of our inspection. We raised this with the manager on the first day of our inspection and with the provider on the second and third days. People were put at risk because they could not seek staff support when they needed it. One person had slipped in their bed and could not reach their bell. When given their bell they immediately called for assistance and asked to be made comfortable. Another person called and asked for assistance to get up when given their call bell. A further person told us, and records showed, they had to phone a friend as they could not access their call bell.

Where people could not use their bells to seek staff support, the hourly system of recorded checks of people was meant to ensure they received help when they needed it. At our inspection in May 2017 we found that people did not always receive these checks. At this inspection people continued to go for more than an hour without checks. One person did not have access to their call bell and was not checked for three hours. Another person was not checked for three and a half hours. People were put at risk because systems in place to ensure safe supervision were not being followed effectively.

When we visited in May 2017 skincare risk management was not sufficient to reduce the risk of people developing pressure sores. There were continued shortfalls in skin care management. People who had been identified as being at high risk of developing skin damage had their fluid intake monitored to ensure they had enough fluid to support their skin integrity. We looked at 12 people's fluid intake records and noted that their intake was not always monitored or shared with staff. This meant appropriate action was not always followed, such as, increased offers of fluids if a person was not achieving their target intake.

People had care plans that told staff how often they needed to be supported to move in order to protect

their skin. One person's care plan stated that they should be helped to move every two hours and the position they required was stipulated. Records showed that this person, who had damaged skin at the time of our inspection, was not receiving this care. Records also did not always reflect the position they had been supported into and so staff would be unable to determine how to assist them appropriately. Another person's care plan stated that they should be helped to move every three hours because of skin damage. Records indicated that this person was not receiving this care. Another person who had pressure damage on their feet had their feet pressed up against the end of their bed for an hour and complained of pain. We asked the manager to ensure they were made safe and comfortable. They did so. Another person who's records indicated they were at risk of skin damage had been in same position for five hours. We fetched staff who made them comfortable. Another person's care plan stated they needed an air mattress to protect their skin and they did not have one in place. We asked the manager about this and they told us they had never needed one. They had an air mattress when we inspected in May 2017. They were not receiving the care outlined within their care plan.

In May 2017 we found gaps of 24 hours in the records relating to creams prescribed to protect people's skin. This meant people may not have had creams applied for the treatment of their skin. At this inspection we found that whilst those cream records that had been archived were complete those still in use continued to have gaps of up to 24 hours. This indicated that people's creams were not being applied as prescribed.

Recording of medicines was also incomplete and did not support safe administration. Gaps in the antibiotics register did not match the Medicine Administration Record that showed all antibiotics had been administered. A nurse told us they had changed a person's dressing. However this person's wound dressings not been signed as administered on their MAR for eight days. Another nurse confirmed that they would sign that they had administered a dressing. These errors indicated that the procedures in place were not being adhered to. In July 2017 specialist medicines had been found to be missing from the home. This also indicated that appropriate procedures were not always followed. During the inspection prescribed thickening powder was found open in a communal area upstairs. We identified this to a nurse and asked for this to be moved. We found it open in the same place on our return visit. The container details that it should be stored closed and there are risks associated with consumption.

People did not always get pain relief appropriately. One person was calling out and saying they were in pain repeatedly. A nurse asked them once if they wanted pain relief and they said no and they did not administer this. The person who was assessed as being confused due to their health continued to call out about pain. The nurse did not return. We spoke with the nurse who told us they would return and offer again.

People did not receive care designed to reduce the risks they faced when moving and using equipment to support their mobility. In May 2017 we highlighted that a person's care plan to reduce the risks associated with moving safely was not being followed. At this inspection we found people remained at risk when being supported to move. We observed four people being helped to transfer from wheelchairs without the brakes being applied. This was unsafe and put them at risk. Another person was known to be at risk of falling from their wheelchair and had been identified as requiring supervision when in their chair as a result of a previous fall and communication from a family member. Prior to our inspection, they fell from their chair and sustained injury in a communal area. Records indicated that another person living in the home made staff aware that this had happened. The person experienced harm because plans designed to reduce risks were not followed.

Another person's had been put at risk because their needs had changed and their moving and handling assessment and care plan had not been updated to reflect this. Consequently some staff were using a hoist and other staff using equipment designed for more able people to assist the person to move. Community

matrons identified this and requested a physiotherapist review the person's needs. The physiotherapist found the person needed a hoist to transfer safely.

This person had risk assessments in place detailing that they were at risk of falls from their wheelchair and should be checked regularly when in their room. Staff told us the person did not face any risks requiring checks when in their room telling us: "he is all right when he is in his room". Records indicated that they did not have these checks. This meant the person was put at risk because staff did not understand their care plan. There was no reference in their care plan to additional checks when not in their room. Records stated that this person had fallen from their wheel chair when unsupervised in the garden. There was no change to their risk assessment and they then fell down stairs when unsupervised. The person experienced harm because their environment had not been assessed to ensure their safety based on known risks.

A sign indicating that oxygen was stored in a room was covered up. This meant the risks associated with oxygen were increased. For example it would not be considered by staff or fire professionals in the event of a fire. We spoke with the provider about this and they assured us they would make the sign visible. They told us they had removed the sign as the person no longer used oxygen. We found the oxygen still in the person's room. The oxygen had not been removed leaving people, staff and visitors in the building at an unnecessary risk.

Incidents involving distress were not monitored appropriately. We observed two people hit staff when staff did not act on what they were requesting. These incidents were not shared with senior staff or recorded. This meant people were at risk of continued exposure to situations that distressed them and staff were at an increased risk of experiencing violence.

There was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not deployed in a way that met people's needs. Feedback from health professionals, who provided oversight and assistance at night following the identification of concerns, was that it was not possible to provide appropriate and safe care to people with the staffing allocated. They found that people could not be assisted to move or receive personal care appropriately. One person told us that they often were not able to get up at the time they wanted as the staff were not able to do this and the manager explained that a person could not have personal care at the time of their choosing as there were not staff available at this time. On one occasion the records reflected that the person requested personal care and was told the staff were busy. They did not receive this support for a further four hours.

We observed people trying to get staff attention when in a communal area and not being able to do so as there were no staff available and they did not have a means of calling them. We fetched the manager who ensured staff were made available to provide this personal care.

Visitors discussed staffing levels. One commented that there appeared to be more staff working and the other replied: "Sundays are the worst they have asked me to lend a hand before." A complaint had been raised by a member of staff referring to a day being difficult due to short staffing and this had resulted in an inability to complete people's personal care. People told us there were not always enough staff. One person told us staff did not always stay when they ate, which was contrary to their care plan. They said: "It would be nice if they stayed a bit longer." Another person told us that there were not always staff where they were needed referring to things becoming "chaotic" at times in the home.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Allegations of abuse were not addressed safely. Most people told us they felt safe living in the home. One person said "I feel very safe – nothing has changed there." However, we saw that where allegations had been raised by people, relatives and staff these had been addressed as complaints. This meant the local authority and the Care Quality Commission had not been made aware of the allegations or how they had been investigated. Two allegations of abuse were made by people living in the home, and their representatives, about staff during our inspection. When we spoke with the manager about one of them and they replied: "this has been on going for ages". Complaints had been made that alleged the removal of this person's property, neglect and emotional abuse. These had not resulted in safeguarding referrals being made to the local authority.

Another allegation resulted in staff suspension and this member of staff came into work during the inspection. We highlighted this to the provider who removed them immediately from care responsibilities. An incident involving alleged verbal abuse had not been identified or resulted in a safeguarding referrals being made. We asked the manager about a complaint that involved a member of staff refusing to provide care. They acknowledged that this had not been addressed with the person. This allegation of neglect had not been identified or responded to. An allegation of assault made, and retracted, by a person about a member of staff during our inspection was not reported or recorded. This meant that people and staff were at risk from a system that did not clearly structure responses to abuse allegations. A transparent approach to safeguarding are necessary to keep people safe. People were not protected by systems designed to keep them safe.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected adequately from the risk of infection. At our inspection in February 2017 we had concerns about infection control. The home received guidance from health professionals in May 2017 highlighting actions they needed to take to reduce the risks of infection. At this inspection we saw that staff wore appropriate protective clothing. People were, however, being cared for in an environment that was difficult to keep clean. Seals on floors were not intact and paintwork was missing from walls. The bumpers on a person's bed rails and a pressure cushion in the communal lounge were cracked. This increased the risk of infection as the cracks made it difficult to clean them effectively. .

Social care professionals had been told by staff that a person who wanted a bath had one the week before we inspected. This was not the case as the bathroom was full of building materials and was inaccessible as a bathroom although it was unlocked.

The sluice door on the first floor remained open on two days of our inspection. The bin inside was overfull with soiled pads and the corridor smelled strongly. There were two clinical waste bags containing used pads left in the ground floor corridor. The unlocked doors and clinical waste being left in accessible areas put people at risk of harm.

We had received information of concern detailing that some bedrooms did not have hot water. We checked the water temperature in eight people's rooms and found that five did not have hot water. . This meant staff had to wash people in cold water or carry water from another room to provide people with personal care.

There was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three staff files and saw that the staff had been recruited safely. This included the taking up of references and checks on their suitability to work with people who need care and support.

Inadequate

Our findings

When we inspected the service in May 2017 we found that training had not always been effective in ensuring staff had the skills and knowledge to keep people safe. We made a recommendation that the provider sought appropriate training and guidance for staff to ensure their understanding of good practice in supporting people to maintain their skin integrity.

At this inspection we found that staff continued to display a lack of skill and knowledge in their practice relating to skin integrity. A nurse had carried out a clinical task no longer considered appropriate in wound management. Another nurse had recorded an open wound as healing and had not recorded the grade of the wound appropriately. Two people's pressure sores that had reached a notifiable stage had not been identified as such. Care staff were not following people's repositioning plans or recording that they had applied creams as prescribed. We spoke with two staff who were not able to tell us when a person should be helped to move.

Records indicated that staff had undertaken training deemed mandatory by the providers however this was not evident in their skills and knowledge. We observed staff utilising unsafe techniques when supporting people with their mobility on four occasions. The manager had undertaken training in safeguarding and the Mental Capacity Act 2005 but made decisions that indicated a lack of understanding: failing to identify allegations of abuse and seeking to a make best interest decision for a person with the capacity to make the decision. Staff did not understand some people's health needs, for example we spoke with two care staff who were not able to describe how they would identify hypoglycaemia. There were people with diabetes living in the home and this put them at risk of delayed medical intervention.

We looked at records relating to staff support and supervision for three staff. We found they had not received formal supervision. However, staff told us they felt supported by the colleagues and managers. They felt that their training had provided them with the knowledge they required. They also told us that handovers informed them of information they needed to ensure they could support people appropriately. This had not ensured that a member of agency staff working in the home understood a person's needs putting them at risk of inappropriate care as they were working with this person.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care certificate had been introduced and two staff who needed to undertake this training programme

had started to do so. The care certificate is a national induction programme for people working in health and social care who do not already have relevant training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

One person was assessed as having "full capacity" to make decisions about their care. We heard the manager talking to a person's friend saying: "Because of what I've said… We will do it in her best interests. I know she has capacity." "If I do a best interest now will you just sign it for me?" This demonstrated a lack of understanding of the MCA, as the Act presumes that people have capacity to make decisions, and best interest decisions would only be made when the person lacked the capacity to make that decision for themselves.

We looked at the best interest decisions made on behalf of three people living in the home. These decisions had been made by staff and had not included the views of representatives who were actively involved in the person's life. This did not reflect the principles of the MCA and raised the risk of care not reflecting a person's preferences and not being the least restrictive option available.

One person who had a DoLS authorised had a condition in place that they had safety equipment in place when they were in bed. This equipment was not in place at the start of our inspection. We spoke with the manager who told us they did not need or have this equipment. They were not aware of the DoLS condition. The equipment was not in place on the second day of our inspection also. We saw part of this equipment was in the person's room on our third visit.

There was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported effectively to maintain their health. Referrals had been made to appropriate health care professionals for some people and records were kept by staff to monitor people's physical well-being. However, these records were not always utilised effectively and this placed people at risk at harm. Over the course of our inspection two people's records indicated that they had not had a bowel movement for three days and eight days. We spoke with a nurse who explained that this information should be shared at handover but acknowledged they were not aware of these time frames. One of these people had a medicine prescribed to support bowel function. They did not receive this medicine during this time.

Due to concerns identified during our inspection community matrons visited the home and checked people's skin condition. They found two people with pressure wounds that had not been identified and evidence of untreated fungal infection in five people. They took action to ensure people received appropriate treatment.

Two people were identified by community matrons to have contractures that were not reflected in their care plans. A contracture is a shortening of muscles or other connective tissue brought about by a lack of movement. We spoke with a clinical specialist who advised that where contractures are at risk of causing pain or infection a referral should be made to a relevant professional to ensure appropriate positioning and treatment. This had not taken place and the people remained at risk.

When we inspected the service in May 2017 we noted an improvement in the support people received to eat and drink safely. At this inspection there had been a deterioration in this support and people were put at risk. One person, who had a safe swallow plan drawn up by a speech and language therapist, needed their drink to be thickened was left with access to un thickened drink in a jug and was seen about to drink from this. This placed them at risk as they needed fluids to be thickened for them to drink them safely. An inspector called for assistance. Another person was assessed by the speech and language therapist as needing their drink thickened to a prescribed consistency. A nurse told us that they had altered this prescribed consistency. This had not been shared with the staff team or checked with the speech and language therapist. Another person had a safe swallow plan detailing that they should use an open beaker when drinking thickened drinks. We saw that they were drinking from a beaker with a spout and this was confirmed by staff as how they provided drinks. The person's drink was too thick but available in their room to be offered. We found two other people's drinks were also thicker than their safe swallow plan detailed. When drinks are too thick people may struggle to drink them or have insufficient fluid intake. We showed a nurse one of these drinks and they acknowledged it was too thick.

Where people were identified at risk of dehydration they were placed on a fluid chart to monitor their intake. We saw that these were regularly not tallied so that their intake could be monitored. During our inspection we saw two people who were having their fluids monitored did not have drinks for five hours. If they declined a drink at the time when people were given drinks regularly they were not offered again until the next drinks round. This increased the risk of dehydration for people who needed prompting to maintain safe intake.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's weights had been monitored and information acted upon appropriately when their weight changed.

When we inspected the service in February 2017 we found that mealtimes were not promoted as an enjoyable social experience reflecting individual support needs. In May 2017 improvements had been made. At this inspection we found that there had been a deterioration in people's meal time experience.

People had mixed experiences at meal times. Two staff members smiled and chatted with the people they were supporting to eat and drink. Those people responded positively, they smiled, gave the staff members eye contact and chatted with them. These staff gently encouraged the people to eat their meals. However, other staff did not talk with people and check whether they were ready to be assisted with their food and drink. For example, one staff member who was supporting one person, put the cup to the person's mouth without saying anything or asking the person whether they wanted a drink. This was not respectful to the individual.

One person did not eat their meal and staff offered them different alternatives when they were reluctant to try the main meal. Staff gave the person some sandwiches which they did not eat. The staff did not acknowledge the person did not want to eat the food offered nor did they acknowledge the person's

physical actions. When the person pushed the table and food away the staff member ignored this and put the table back in front of the person who immediately pushed it away again.

Another person was happily occupied holding a doll and singing to themselves with their main meal in front of them. However, they only ate a small amount of their meal during our observations and staff did not prompt or remind the person their meal was there. Staff did not check whether the meal had gone cold and needed to be reheated. They removed the meal without checking whether the person had finished. After the inspection we spoke with the manager who told us the person should have been encouraged and offered alternatives.

Most people remained seated in their armchair with a table placed in front of them for their main meal. People wore faded and worn aprons to protect their clothes.

People were not provided with aids such as plate guards to support them to eat themselves in a dignified way. For example, one person was using their hand to keep their food on their pate whilst they used their other hand to scoop up the food.

People told us that the food was good. One person told us: "The chef is always good. They still come to see me and check the food is ok." We saw the chef visit a person and discuss what they would like to eat next. They clearly had a familiar and positive relationship indicating that this discussion was a regular occurrence. The information held by the chef about people's dietary needs, likes and dislikes reflected what was in people's care and support plans. The information included people who were having their food fortified to support them to gain or maintain their weight.

Requires Improvement

Our findings

When we last inspected the service in May 2017 we highlighted improvements in the caring nature of staff. People had been supported to maintain their appearances and staff were consistent in their interactions with people. Whilst we highlighted that confidentiality needed further consideration, understanding and respect were evident.

During this inspection we found there had been a deterioration in people's experience of care. People were not supported in a way that promoted their dignity and privacy. People had not had their hair washed and were seen to be wearing dirty clothes. Community Matron's reported that one person was wearing urine soaked trousers over a clean pad. This meant they had been left in dirty clothes after support with personal care. A relative commented that attention to people's experience was less evident.

Some staff spoke about people's care needs in communal areas. For example, care staff called down corridors to check with each other about people's personal care. The manager spoke about the challenges they perceived a person presented to staff in front of inspectors, staff and people in the entrance of the building. Care records made by staff about people living in the home for the month of April 2017 were left unlocked in a communal corridor of the building. This meant personal information was available to visitors to the building.

We entered a room that had a sign on the door indicating the room was empty and ready to be shown to visitors. On entering the room it was clear there was a person sleeping in the bed. The person had been exposed to intrusion because their dignity had not been considered. The hoist needed to support people with personal care was stored in a person's bedroom. This meant that staff entered their room throughout the night when the hoist was needed. This potential disturbance was evidence of a disregard for the person's privacy.

Care was not always provided in a way that reflected respect and appreciation of people. For example one person was being hoisted from a chair to a wheelchair by two members of staff. The person was calling out in discomfort and a member of staff highlighted that this was not the most appropriate wheelchair. This was not acknowledged by the two staff and they continued to move the person who continued to express discomfort. The language used by staff also reflected a lack of respect or judgement indicative of a lack of empathy. We saw a person called by the wrong name and three people's records included repeated misspelling their names.

People were offered some choices that promoted their independence such as: which rooms they spent time in; whether they spent time with the activities coordinator and/ or joined in communal entertainment and what time they got up and went to bed. People told us these choices mattered to them but they also told us they were restricted by staff availability. We saw people supported to the communal lounge and not given a choice as to where they sat.

There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw staff engaged in kind, familiar and supportive interactions with people. One member of staff spent time discussing people's lives with them reflecting on their places within their communities, their loved ones and significant personal, local and national events. Another member of staff took time to help someone with their hair; an interaction that they valued. We also saw some staff smiling and offering encouragement to people. People reflected on this and made comments such as: "The staff are lovely. Good as gold."

Inadequate

Our findings

When we inspected the service in February 2017 we found that care was not designed to meet people's preferences and needs and there was a breach of regulation. When we inspected in May 2017 we found there had been an improvement. People's care plans were being reviewed and staff had read care plans and understood most of the content. At this inspection we found there had been deterioration in the responsiveness of the service and this had an impact on people's experience of their care.

One person was distressed and agitated in the entrance hall because they wanted one of their cigarettes. The system put in place required a nurse to access these for them, however, the nurse was busy administering medicines. The person waited in a state of distress for 15 minutes before a member of care staff shared one of their own cigarettes with them. They were then further delayed as a member of staff realised that their wheelchair did not have footplates. These could not be found and the person was supported outside without them. The arrangements in place were not person centred and did not reflect the person's preferences.

In another incident a person wanted to go to the toilet. They were delayed initially because their wheel chair was not available and then further delayed because a member of staff decided the person needed slippers on. The delay resulted in the person being agitated further.

Work had continued on care documentation but these had not been read by the majority of staff and staff did not have a clear understanding of people's needs as described in risk assessments and care plans. This led to care not being provided as outlined in care plans. One person was meant to be hoisted to receive personal care and support in meeting their continence needs four times per day. The person told us they received this support twice a day and sometimes once a day. We spoke with staff who told us this person received this care twice a day. Records reflected that they received this care twice a day. The person did not receive care in a way that met their needs or reflected their preferences because staff did not understand the frequency at which they should receive personal care. We spoke with the manager and provider about this person's care. They showed us that they had highlighted concerns about their ability to provide on going support for this person with their funding authority.

Another person could not receive personal care support in the way their care plan described due to a deterioration in their mobility. Their care plan had not been updated and they had not been asked for their views. This meant that their preferences about personal care had not been sought now that their care needed to be provided differently. This person also had a care plan that reflected their hobbies and

interests. This reflected that they liked to smoke, but there was no reference to their lifelong hobby. The person's views and preferences were not reflected in their care plan.

Whilst care plans had been updated and reviewed on a monthly basis, four staff told us they had not had time to read people's care plans before supporting them. This meant they did not know important information about people necessary to support them appropriately. We spoke with two staff about a person's care plan. They were clearly committed to supporting a person's mental health but had not had time to read the care plan and were misinformed about an important element of the person's needs and this put them at risk of inappropriate treatment.

Requests by health professionals were not always followed. A person had required a blood test in August 2017. This had been delayed by nine days and when tested had resulted in the person being admitted to hospital. This had not led to improved practice as a blood test was delayed during the period of our inspection. We received information from a GP who visited people in the home regularly. They told us there had been some difficulties in requests being carried out. They told us that in addition to delays in taking blood samples there had also been delays in getting urine and stool samples. They said these: "…seem to take quite a lot of prompting and reminding. There was a recent patient who I had to ask the staff multiple times over a few weeks to attain a urine sample." Community matrons identified that a person may need another course of antibiotics and asked that the doctor be contacted to discuss this. This was not acted on and the request was delayed by 24 hours. This meant the person experienced a delay in receiving input from their GP.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a handover each afternoon to ensure that important and emerging information about people's care needs was shared. This had been reintroduced after a staff member identified it helped staff to keep up with changes at staff meeting in October 2017. Staff told us they found the handover useful and it enabled them to understand people's needs.

Complaints were not investigated appropriately. A complaints procedure was in place. There had been complaints made about the care people received. The complaints made by relatives and professionals centred on the skills and knowledge of the staff to meet people's needs. Whilst discussions were recorded with most complainants there was not recorded evidence of investigation into specific concerns or resultant actions for individual staff learning.

Grievances had also been made by staff about failure to provide care. Where staff had complained about care provision there was no investigation or outcome evident. The manager told us they were not aware of one of these concerns. This did not reflect a learning culture. One person told us they had made complaints about their care. The manager acknowledged this in discussion with us however, there was no record kept of the person's complaint and they remained unhappy with the process. The approach to the person's complaint did not address their concerns appropriately.

There was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Social opportunities were provided through both group and one to one activities. New staff had been employed since our last inspection in May 2017 to undertake this work and they were commencing the task of getting to know people and identify how they wanted to spend this time. During our inspection we saw

people chatting to a member of staff about events that mattered to them. We also saw a small group of people enjoying a jigsaw puzzle. We also saw visitors join people in the communal area to chat. Some people who spent time in their rooms were visited by an activities worker who spent time chatting and reading.

Inadequate

Our findings

When we last inspected the service in May 2017 we found on going concerns with the governance of the service. There was a continued breach in regulation. We took action in accordance with our enforcement policy. Full information about CQC's regulatory response to any concerns or continued shortfalls is added to reports after any representations and appeals have been concluded. We met with the owners and manager in August 2017 and outlined our concerns and expectations. The owners and manager provided assurance that systems in place were ensuring that people were receiving appropriate care and treatment. However we found that the provider had not taken sufficient action and the governance of the service remained insufficient to ensure the quality and safety of the care people received. We found continued and additional breaches of regulation.

The provider organisation was made up of two directors, both of whom worked in the building. One provider took a more business development role within the organisation and the other provider who was also the nominated individual had a more active role due to their clinical experience as a registered nurse. A registered nurse had been managing the home since our inspection in May 2017. It is a condition of the registration of the home that it has a registered manager. At the time of our inspection this condition was not being met as the last registered manager of the service had resigned in February 2016 after a period of absence that we were notified started in November 2015. We were told that the manager had applied to CQC to become the registered manager. . We could not find a record of this application and asked for evidence from the provider. We did not receive this evidence.

The manager's role included the further development of quality assurance systems. Quality assurance tasks were carried out by nursing staff and the manager with oversight provided by the nominated individual. There was an on going action plan addressing the issues identified by our inspections and input from the clinical commissioning group following monitoring visits and this plan had updated in October 2017 and sent to us.

We found that this action plan did not reflect the service people received. For example the action plan details that supervisions, storage of confidential material and tissue viability monitoring were all recorded as 'achieved and on going'. This did not reflect the evidence found during the inspection.

At our inspection in May 2017 we judged that the provider had failed to recognise areas that needed improvement to ensure the best outcomes for people. At this inspection, they continued to fail to have an understanding and complete oversight of issues related to the safe care and treatment of people that had

been identified three times in previous breaches of regulation and resultant enforcement action.

The oversight process had not secured an improvement in skin care for people living in Avon Lea Nursing Home. For example audits of wound, skin tears and bruises had been undertaken by the manager in July, August and September 2017. This noted new pressure sores but did not involve any analysis of root causes or actions necessary. When community matrons checked people's skin in October 2017 they found sores that were not reflected in care plans and pressure sores that had progressed to a notifiable stage. We found care plans related to skin integrity were not being followed for these people. This was also the case at our inspection in May 2017.

The systems in place to review and audit the care and treatment people living in Avon Lea Nursing Home received had not been effective in securing improvements. The medicines audit completed in August 2017 had not identified that oxygen was being stored in the building. We found oxygen stored without a warning sign visible putting people at risk of harm. The lack of hot water was not identified in the audit overview for September 2017 although we were told this had been an on going issue in the home. The clinical governance overview for September 2017 recorded that staff were to be reminded of confidentiality due to documentation not being behind a locked door. This had not led to the locking away of all records people's confidentiality generally being respected.

The records necessary to monitor care were not meaningful because some were inaccurate. Staff were required to complete records of the care they provided to people including checks on their position, whether they had needed personal care and had access to a call bell. These checks and records were necessary to ensure safe care and treatment. Two people's records indicated they were in a position that they were not in and records did not always include the position people had been helped into. This meant staff could not determine which position they needed to assist people into to protect their skin.

We found inaccurate records during our inspection. One record completed retrospectively said the person had access to a call bell for two hours when they did not. On the second day of our inspection we arrived at 6:00 am and found that records had already been completed until between 7:00 and 8:00am for everyone living in the home. We observed that the care recorded did not occur. For example one person who had pressure sores on their sacrum was recorded as having had a bowel movement and a pad change that did not happen. Lack of accuracy of records meant that care plans designed to keep people safe were not followed.

There was a system in place designed to ensure that there was oversight of the care received by each person living in the home on a daily basis. We identified concerns regarding the effectiveness of this system at our inspection in May 2017. This system was now completed by nursing staff; we found it remained an effective oversight tool. However the records did not accurately reflect people's experience and so failed to provide the information necessary for oversight. For example it did not pick up where fluid intakes had not been tallied, nor did it make reference to incidents two people had been involved in. We also found there were days where this oversight system had not been completed. This meant that where people were not receiving safe care as outlined in their care plan this had not been picked up.

The emerging culture of the management and staff team did not support person centred care practice. A nurse referred to a person as being 'like a child' and the manager reflected on their interactions with a person using terms such as 'moaned' and 'demanded'. This expectation of appreciation and lack of understanding was also evidenced in the records of staff reflections of situations that had led to complaints. This meant that concerns had not been responded to dispassionately and appropriate action to safeguard people's rights had not been taken. For example, responses to a situation where a person had explained

their need to direct their care reflected a belief that staff should be appreciated for the care provided and that the person should fit in with the systems in place in the home.

Staff did not understand their roles and responsibilities in ensuring people received good quality care. A team meeting in October 2017 reflected the manager's disappointment at a lack of team working and they acknowledged that they understood staff had not worked effectively during the manager's recent annual leave. The nominated individual had maintained oversight of the home during this time. Requests made by management were not followed through for example messages relating to how regularly people should be helped to move and the need to be familiar with people's care plans.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not submitted notifications of allegations of abuse to the local authority or the Care Quality Commission. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We did not address this with the provider at the time of our inspection due to the activity involved in people leaving the home.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009

The providers were not displaying their rating published by the Care Quality Commission following the inspection of May 2017 inspection. Providers are required to display their rating in the premises from which they provide a regulated activity. The rating was not on display in a place where visitors and people would see them. We did not address this with the provider at the time of our inspection due to the activity involved in people leaving the home. □

There was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Statutory notifications that were required by the Commission were not made. Regulation 18 (1) (2) (a) (e) (g) of the Health and Social care Act 2008 (Registration) Regulations 2009

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive care that met their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not treated with dignity and respect and their privacy was not respected. Regulation 10 (1) (2) (a) (b) of the Health and

	Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

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 People's care and treatment was not provided in line with the principles of the MCA. Regulation 11 (1) (3) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

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 Care and treatment was not provided in a safe way because the risks people faced were not appropriately assessed and actions were not taken to mitigate these risks. Regulation 12 (1) (2) (a) (b) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected by systems and processes that identified and investigated allegations of abuse. Regulation 13 (1) (2) (3) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

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 premises and equipment used by the provider to meet people's needs was not always clean, secure suitable for it's purpose, and properly maintained and used. Regulation 15 (1) (a) (b) (c) (d) (e) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received were not appropriately investigated and did not lead to proportionate action. Regulation 16 (1) (2) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to monitor the safety and quality of care people received were not effective in identifying shortfalls or ensuring improvements. Records were not accurate and were not kept securely. Regulation 17 (1) (2) (a) (b) (c) (e) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider's rating was not displayed

	conspicuously where people living in the home could see it. Regulation 20A (1) (3) (5) (7) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of appropriately skilled staff deployed to meet people's needs. Regulation 18 (1) (2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We cancelled the provider's registration.