Surrey Rest Homes Limited

Avens Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 July 2016 and was unannounced.

Avens Court Nursing Home is registered to provide accommodation and personal care for up to 60 people. At the time of our inspection there were 49 people living at the service, some of whom were living with dementia.

At the time of our visit a registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager in post who was in the process of applying to become the registered manager. The new manager was present during our inspection.

We carried out an inspection of this service on 19 November 2015 where we identified a number of breaches of regulations of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. Following that inspection the provider submitted an action plan to us detailing how they would address these concerns. This inspection took place to check whether or not the provider had taken action in line with what they told us in their action plan.

We found the systems to assess, prevent and control the risk of infections were inadequate and further action was required in relation to the environment in order to make it a suitable place for people to live.

There was a sufficient number of staff on duty, however deployment of staff could have been better organised. Although people and their relatives were complimentary about the food we identified concerns in relation to the lack of choice of meals and the time people had to wait before being served with their meal. This was in part due to the insufficient deployment of staff at the service.

People's privacy and dignity was not always promoted by staff. Activities were not person-centred or meaningful and had not taken into account people's interests. Although people had care plans which recorded individualised care requirements, some information was missing and people's daily notes were not written in a person centred way by staff.

Systems to monitor the service were not robust and the registered provider had failed to take action on our previous concerns. Action plans had not been put in place to address the issues that had been identified in the provider's monthly reports. Some audits had not taken place, such as an infection control audit.

The provider had a new fire alarm system and some new fire doors fitted at the service and regular testing of fire alarms and emergency lighting were carried out.

People told us they felt safe with staff who looked after them, and this was echoed by their relatives. Staff had received training that would help them to keep people safe and were able to describe the types of abuse and the processes to be followed when reporting suspected or actual abuse. Staff received supervision and appraisal to support them in their roles.

People received their medicines as and when they required them and people told us they could see the GP whenever they needed to. People were looked after by staff who had been appropriately vetted by the provider before they commenced employment.

Care plans were in place for each person. They included information to guide staff on how people would like their needs to be met. People's preferences, likes and dislikes were recorded and staff were knowledgeable about the care needs of people.

The provider had a complaints system in place and people and their relatives told us they knew how to make a complaint.

People and their relatives told us they thought the home was well run by the new manager and they were able to have open discussions with staff.

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

At this and our previous inspection the service has had a rating of 'Inadequate' within the Safe domain. As there have been two repeated ratings of 'Inadequate' the service has been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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

Staffing levels were sufficient but the deployment of staff did not always meet the needs of people.

People's medicines were managed safely.

The provider only employed staff who had been appropriately checked to ensure staff were safe to work at the service.

Staff were aware of their responsibilities in relation to safeguarding.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always following the legal requirements in relation to the Mental Capacity Act (2005).

People were provided with nutritious food and drink.

There was a training programme in place to support staff to develop the skills they needed to carry out their role.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always treat people with respect and dignity.

People were unable to have privacy if they wished it and staff did

not take the time to engage or interact with people.

People told us that staff were caring towards them and they talked to them in a caring manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always experience person centred care. There was a lack of meaningful activities or one to one sessions for people who remained in their room.

People had care plans in place and these were discussed with people and their relatives. However, some information was missing and daily records were not written in a person-centred way.

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

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems in place to assess and monitor the service were not robust or effective. The registered provider had failed to take action on previous concerns.

People and relatives had confidence in the new manager and they were involved in the running of the service.

Staff felt supported by the new manager.

Avens Court Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 13 July 2016. The inspection team consisted of two inspectors, one specialist advisor who is a specialist nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector carried out the second day of the inspection, which was announced.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion as this inspection was carried out to follow up on concerns we had identified at our last inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we had discussions with six people, four relatives, ten members of staff and the manager. We observed how staff cared for people and worked together. We read care plans for six people, looked at medicine administration records and mental capacity assessments and Deprivation of Liberty Safeguards applications. We looked at five staff recruitment files and supervision and training records. We saw audits undertaken by the manager, minutes of resident and relatives and staff meetings, and a selection of policies and procedures.

The last inspection to Avens Court took place on 19 November 2015 where we identified a number of breaches of the regulations.

Inadequate

Is the service safe?

Our findings

People felt safe living at the service. One person told us, "Yes this is a safe place to live. The people here are nice." Another person told us, "It feels good to be here. It must be safe because I have no worries at all."

Relatives told us that they believed their family member was safe living at Avens Court because the new manager had their trust and had had an impact on the service. One relative told us, "I feel that my family member is in safe hands. I think it is a wonderful safe place." Another relative told us, "I feel my family member if very safe here. They are washed, clean and well looked after, excellent."

Despite these comments we found that people may not always be protected from the potential risk of harm at Avens Court.

People were not protected from the risk of the spread of infection as staff did not have good infection control procedures in place.

During our last inspection the service had failed to ensure that effective systems were in place to monitor and control the spread of infection. At this inspection we again found concerns in relation to malodours and the cleanliness of the service. Continence aids were out of their wrapper and exposed to airborne germs. In a communal toilet there were buckets with dirty water in them. One was used to clean up body fluids, urine, faeces and blood. Mops were positioned on top of these buckets with the head of the mops facing downwards meaning they could harbour germs. Wet room non-slip mats had not been lifted for some time or thoroughly cleaned. In communal shower rooms we found a clinical bin with no lid on it and another that was full to the brim. The manager told us after the inspection that the clinical bin without the lid had been replaced.

We identified concerns from our observations of the kitchen in relation to its cleanliness and referred these to the Environmental Health Office who have assured us they will visit the service

We asked the manager on several occasions for the cleanliness and infection control audits that had been undertaken at the service but were not provided with these. We looked at the daily cleaning schedules for the previous five weeks. These showed that a cleaning regime had been undertaken by staff but there was no evidence to show that this had been monitored by the manager.

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

The environment posed risks to people's safety. At the last inspection issues had been identified in relation to the environment. There were inadequate window restrictors in place and the temperatures in parts of the service were high. During this inspection we found that all windows had new restrictors in place and the temperature at the service was comfortable. However, we identified other issues in relation to the environment.

The action plan from our last visit informed us that the carpets and vinyl flooring would be replaced along the corridors and in bedrooms and that the service would be redecorated with dementia-friendly colour schemes. The manager provided us with an updated action plan that recorded that these actions had not been completed, although refurbishment work had commenced.

We noticed that carpets in the corridors were clean and that re-decoration had started. The bedrooms on the second floor had been painted and these felt more homely. However, other parts of the environment were in need of repair. Some paintwork was still chipped and there was a vent cover missing from the library wall, exposing open brickwork.

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

People would be kept safe in the event of a fire. Serious issues in relation to fire safety at the service were identified during our last inspection and the local fire and rescue service had placed an enforcement notice on the service. The fire service visited again in July 2016 and reported that the fire safety systems were now adequate. We saw that regular checks had been undertaken on the fire safety equipment which included the testing of the alarms and emergency lighting system. During the day one person accidentally set off the fire alarm. Staff were quickly in position, on each floor, ready to follow planned evacuation procedures and the fire marshal checked that all visitors were accounted for.

The effects on people in the event of an emergency would be minimised as staff would know how to respond. People had a personal emergency evacuation plan (PEEP) that gave clear descriptions about how to safely evacuate each individual in the case of an emergency. Regular fire drills took place and there were emergency contingency plans in place that gave clear guidance to staff on what to do in the case of emergencies, for example gas leak or floods.

During our last inspection the service was found to have insufficient staffing numbers to meet the needs of people. During this inspection the staffing levels for the service had been reviewed using a dependency level tool. There were three registered nurses (RN), eight health care assistants, a chef, cook, kitchen assistant and a domestic team of four people. The manager, who was also an RN, was supernumerary to the duty rota. They told us they worked at the service every week day from 07:30. The waking night staff consisted of one RN and five health care assistants.

People were cared for by a sufficient number of staff, however deployment of staff could have been better organised to ensure people received their lunch within an appropriate time. Throughout the day we did not see people having to wait to be supported. Staff were seen in all parts of the service attending to people when they needed it, however we found the deployment of staff on the first floor during the lunch time was insufficient. Some people had to wait more than 30 minutes to be served their meals and some people who required support to eat did not receive it because there were not enough staff. The action plan submitted to us by the previous registered manager told us that kitchen and domestic staff had undergone training so they could help with feeding people. However we did not see this happen. We spoke with the manager about this at the end of our inspection who told us they would address this.

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

People benefitted from a service where staff understood their safeguarding responsibilities. Staff records confirmed they had received training in relation to safeguarding people which included whistle blowing.

Staff knew the different types of abuse and what to do if they suspected or witnessed abuse. One member of staff told us, "I would not hesitate to tell the manager or one of the nurses if I saw anything that was wrong or someone being mistreated." Staff knew the reporting procedures to be followed which also included how to contact the local authority. Staff understood and were confident about using the whistleblowing procedure. They said they would not hesitate to report any member of staff they witnessed providing inappropriate care to people. A staff member told us, "These people are my friends. I make sure that they are looked after and I keep them safe."

Risks to people had been identified and staff were knowledgeable about the action to take to minimise these risks however written guidance or information was not always completed by staff. Assessments of the potential risks of injury to people had been completed. These were based on daily living activities for example, moving and handling, medicines, falls and skin care. However we found in one person's care plan that they had body charts indicating grazes or bruises on four separate occasions but no cause or outcomes were recorded. Guidance about the action staff needed to take to minimise risk was not always recorded although risk assessments were reviewed on a regular basis. Staff followed good safe practice whilst supporting people with limited mobility and transferring people between chairs and wheelchairs.

The provider carried out appropriate recruitment checks which helped to ensure they employed suitable staff to work at the service. The provider had obtained appropriate records as required to check prospective staff were of good character. These included two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's medicines were stored, administered and disposed of appropriately and securely. We observed staff administering medicines to people. This was undertaken in a sensitive manner and safe procedures were followed by the RN. The Medicine Administration Records were correctly recorded. Systems were in place for the ordering and safe disposal of medicines.

Where people had 'as required' (PRN) medicines, protocols were in place which contained information on the PRN medicines they required, what may trigger the need for it and the maximum dosage they could take.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were complimentary about the food. One person told us, "Good food here, I like it very much." Another person told us, "I like the food here; there is plenty to eat, usually too much." A relative told us, "I eat here quite a bit; the food is very good indeed. My relative eats very well and enjoys their food."

People were provided with adequate quantities of food and drink to maintain their health. There was a choice of a hot or cold meal at lunch time and people were seen to be provided with drinks and snacks throughout the day.

The lunch time experience for people eating in the main dining room was a pleasant experience for people. The dining room tables were covered with cloths and flowers were on most tables. People could choose where they wanted to sit and who to sit with. The meal was well presented and staff explained what the meal was to people.

Where people required it, staff supported them to eat. People were supported by care staff who asked them if they would like more food before offering another mouthful. We saw and heard good social interaction between residents and carers during the mealtime on the ground floor.

Decisions were not always in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We checked whether staff were working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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 called the Deprivation of Liberty Safeguards.

Mental capacity assessments had been undertaken for people but they were not always for specific decisions, such as whether a person had the capacity to know they should take their medicines. The MCAs were generic assessments in relation to people living at the service. We noted that two people were being administered their medicines covertly (disguised in their food) but there was no evidence that a best interest discussion had taken place or any input from the GP to decide whether or not this was what was best for the person. We found people's bedrooms doors on the ground floor were locked during the day meaning they were restricted from returning to their room. However, although DoLS applications had been submitted for people these were in relation to the locked front door only.

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

Staff told us they had received training in relation to the MCA and DoLS and we confirmed this from the staff training records. Staff told us people made choices about everything they wanted to do. One member of staff told us, "We always offer choices to people. For example, they can choose their bedtimes and the clothes they want to wear."

People and their relatives spoke positively about staff and told us they felt staff were well trained. One relative told us, "Yes, I feel they are well trained and know what they are about."

People were supported by staff who had access to a range of training to develop the skills and knowledge. Staff told us that they had received all the mandatory training which included medicines, safeguarding, moving and handling, fire awareness, first aid, food hygiene, health and safety and infection control. Other training included dementia, palliative care and diabetes. We noted from the training records that some mandatory training for staff had expired. The manager was able to provide us with evidence that refresher training had been booked. Staff had undertaken induction training. One staff member told us, "My induction included all the mandatory training and it helped to do my work."

Staff were provided with the opportunity to review and discuss their performance. Staff told us supervisions were carried out regularly to help ensure staff were transferring their training into good practice. Staff also had annual appraisals which was an opportunity for them to discuss any aspect of their role, including training requirements or concerns with their line manager.

People were supported to maintain good health and we saw the provider involved a wide range of external health and social care professionals in the care of people. These included palliative care nurses, dieticians, speech and language therapists and physiotherapy. People told us that they see the optician, chiropodist and dentist when they need to.

Requires Improvement

Is the service caring?

Our findings

People were complimentary about the caring nature of staff. One person told us, "I love it here because everyone is caring, kind and knows what I like." Another person told us, "There are nice people here who look after me."

Relatives were also complimentary about the care provided to their family members. One relative told us, "I am very satisfied and happy for my family member to be here. I find staff are very good. I come in most days so I would know if my family member was not being cared for properly." Another said, "Carers care. They make time to ensure that my husband is well cared for."

Despite these comments at our last inspection we found that people were not always being treated with dignity and respect. During this inspection we found some improvements had been made, however, there was a continued lack of respect shown towards people.

People's rooms were not always personalised or decorated to an appropriate standard. Some curtains in bedrooms were not hung properly as they had come adrift from the curtain rail. The plaster on some bedroom walls was rippled and looked as if it had suffered from water damage. Some of the bedroom vinyl flooring had stains and holes. Three bedrooms had malodours, two of which were very strong. Five bedrooms had stained bed linen.

There was a lack of photographs or homely furnishings to make people's bedrooms individualised. It was difficult at times to tell whether or not a room was being used because they were so depersonalised. Sometimes people choose not to bring personal items with them or they may have no family to help supply items that matter to the person. However, in these circumstances a provider should make efforts to assist the person to make the room as personal and comfortable as possible or record when people have refused assistance to do so.

People were not always treated in a respectful way. A member of staff walked up to a person who was asleep leaning to one side with their arm over the side of the chair. Without waking the person the member of staff 'pushed' the person back over trying to sit them up straight. Another staff member went into a person's bedroom to carry out some personal care. Although they knocked on the door and said, "Hello" when entering, we did not hear them make any conversation with the person whilst they were in their room. A third person was constantly trying to open the door to the garden, clearly expressing a wish to go out. However a staff member said, "You can't go out it is too near lunch."

People may not receive food based on their individual needs and personal preferences and they were not always offered alternative meals if they did not wish the menu choices. The main meal on the day was a choice of chicken with vegetables. The alternative was a tuna sandwich. We saw people making their choice, however, one person did not want either but nothing else was offered to them by staff. We noted the day's menu was written on the noticeboard in the dining room however it was written in a way that people would not be able to understand. The chef was unable to name people with medical conditions/allergies, such as

someone who had diabetes which meant these people may not receive food suitable for their needs.

People were not shown respect as they did not always receive their food in a timely manner or at a suitable temperature. People on the first floor had to wait some time before they were served their meal. The food was brought up at 13:15. However, by 13:40 only five of the nine people sitting in the lounge had been served their lunch. Some people did not receive their meals until almost 13:50. During this time the chicken dish sat on an unheated trolley and we observed one staff member plate up a meal and take it to one person (who was eating in their room) without reheating it. Two people required pureed food. Although one staff member reheated one of these meals another staff member took the second plate of pureed food to a person after it had been sitting on the trolley for half an hour which meant it would have been cold.

People's dignity was not always promoted or respected by staff. Relatives told us that staff paid attention to their family members' cleanliness and their appearance was always clean. However, we noticed at times throughout the day that people's clothes were stained or dirty.

People could not have privacy when they wished it. People's rooms on the ground floor were locked during the day. We spoke with the manager about this who told us this was in order to prevent people going into rooms which were not theirs. However this meant people were unable to return to their room to have time on their own if they wished to.

People were not always engaged with by staff. Six people were sitting in one area of the lounge and although a staff member was present they were not taking the time to interact with people. Four other people were sat in the dining area on chairs along one wall. All four of them were asleep and staff were not seen attempting to rouse or interact with them. On another occasion a member of staff came into the lounge on the first floor and sat down beside one person. Rather than speaking to the person, they just sat watching television.

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

We did witness frequent kind, caring interaction from staff. We heard some members of staff talk to people in a caring manner. For example, one person was sitting in a chair. A member of staff went to the person with a glass of apple juice and sat down beside them carefully helping the person to drink and chatting to them all the time about how nice the drink was. One person had reverted back to speaking in their native Italian and they were supported by an Italian speaking carer who also acted as a translator for other staff to ensure that this person's needs were met. People were referred to by name by staff. There was a good balance between light-hearted banter and respectful conversation.

Some staff were careful to ensure that people's dignity was not compromised because they listened to what people wanted and talked to people as individuals. One member of staff supported a person who was having difficulty making themselves understood. The member of staff knelt on the floor, established eye contact and spent time to find out what the person wanted. They went away and returned with what the person had requested.

People were enabled to be independent. We saw people walking around all parts of the home and there were no restrictions in relation to accessing communal areas. When people became 'lost' staff supported them with kind words and reassurance in an unobtrusive way. Staff encouraged people to get up from their chairs only offering support if the person was struggling or was at risk from falling. Where support was offered it was discrete and followed good moving and handling practice. One person gestured to a staff

member that they wanted to get out of their chair. The person was encouraged to stand by themselves and move independently.

People and their relatives were involved in making decisions about their care. Staff told us the previous manager had instigated a key worker system where staff are allocated have an overall responsibility for a number of people to ensure their people's holistic needs are met. We saw in some bedrooms that information and photographs of people's key workers were displayed. Staff told us that they regularly discussed the care plans with the person and their relatives and they could make changes at any time. One person told us, "I can go to bed when I like and get up when I feel like it. Always a breakfast when I want one."

People were cared for by staff who were aware of their needs and past histories. Staff were able to describe how people's assessed needs were to be met as well as people's like and dislikes.

Relatives told us they were involved in making decisions about their family member's care. One relative told us, "I come to the care plan reviews, one is due in August. I know about my family members' care package and I have made a few little suggestions which have been followed." Another relative told us, "I have had input into the care plan and everything is in it."

People were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. End of life care was manged and recorded in care plans. There was a section in the care plans that included advance decision making. This section was completed in conjunction with people and their families. This included whether individuals wished to be resuscitated in the event of cardiac arrest.

Relatives were made to feel welcome. Relatives spoke about the warm, caring atmosphere in the building and the fact that they were made to feel welcome when they arrived. They said they had a good relationship with the staff which made communication easy. They told us that staff knew people well and knew how they liked to be treated. We heard, "They know that X is worried about showers but she likes having a bath and likes staff to wait with her" and, "Know that she likes to be clean and tidy, very important to her."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found a lack of a person-centred approach for people. During this inspection we found insufficient improvements had been made.

People did not have a range of activities they could be involved in and the provider had not taken action to improve activities for people to make them personalised and meaningful. There was a programme of daily activities displayed in the service; however these were dated May 2016. We observed an art and craft activity took place in which only three people took part in. Some people took part in group activities however, we saw many other people were mainly sitting in chairs dozing. On the first floor, in the afternoon, people were sitting in the same chairs they had been in during the morning which indicated to us that no-one had moved all day. The television was on but some people were sitting in a place where they could not see it. One person was sat in their wheelchair by a table all day. They spent the majority of the day wiping the table with their hands. We did not see any interaction or activity take place with this person other than during lunch time. In one person's care plan it was recorded that they liked the garden, however, we did not see staff support the person to go outside. We did not see any one to one activities taking place with people and the activity coordinator was unable to confirm whether or not this happened. A member of staff told us that activities for people in their rooms was, "They have a television and a CD player."

The failure to provide person-centred care that was appropriate to meet people's needs or preferences was a continued breach of Regulation 9 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

The service had links with the museum service who provide collections of artefacts/memorabilia. Pet therapy, exercise sessions, pampering, visits to local places of interest, fetes and events open to the local community were some of the activities that staff hoped people could take part in. Services were held at Avens Court on a regular basis to support peoples' spiritual needs. However, not all of these activities had been regularly undertaken and people's risk of isolation when they were not taking part had not been addressed.

People had care plans which had been developed from the pre-admission assessment carried out prior to them moving into the home. However, some information was missing. Care plans included information on people's past history, likes and dislikes, mobility, communication and nutritional needs. Where people were at risk of poor skin integrity regular checks were made and recorded. However guidance to staff was not always written in care plans. One person's care plan read, 'adopt distraction techniques when he is anxious' and, 'likely to be agitated, physically and verbally abusive'. Although it recorded, 'distract when gets agitated or becomes aggressive' there was no information for staff around techniques which may de-escalate an incident or what may trigger this person's anxiousness.

Daily records were completed by care staff but they were just a record of routine tasks taken. Staff had already had a recommendation from their own senior management to improve. The intention was that care staff took a more person-centred approach, however this had not been put into practice by staff when

recording how people were during the day. The main nursing care records were fully person-centred however the review files were out of date for up to two months meaning the information contained in the care records may not be the most up to date.

Staff had daily handovers in order to share information about people to help ensure staff were aware of any changes to a person's health. However, written information did not always reflect what was discussed during this handover, which may mean that a staff member might not have the full picture about how to care for a person. One person was recorded as, 'crawling around dining room floor, pulling table and being threatening to others' but the daily handover notes recorded, 'had shower, ate well, restless' – there was no mention to new staff coming on shift of the incident in the morning.

The manager told us that they had identified shortfalls in the care plans and were in the process of reviewing each individual plan. They had started work on this prior to this inspection.

We recommend the provider takes prompt action to address the recommendation from senior management with regard to care plans and daily records.

People were cared for by staff who responded appropriately. Staff used strategies to prevent behaviour which could be described as challenging, from escalating. They did this from their knowledge about each person rather than from guidance in people's care plans which should have been in place. This meant that staff who knew people may respond appropriately but there was a risk that new staff would not have the information they needed to do so. There was an incident where two people clashed physically and verbally. Members of staff moved quickly to support them, standing in between them and using de-escalation strategies such as lowering the tone of their voices, offering a hand to both people and gently moving them to different areas of the floor.

Complaints and concerns were taken seriously. The provider had a copy of their complaints procedures displayed where people could see it. People's relatives told us they had not needed to make a complaint and they had confidence in the new manager. One person said, "Lovely staff who would listen if there was a problem. Little things are sorted out if I tell them." A relative told us, "I have no complaints but I know the manager would listen and deal with things."

There was a record of complaints maintained at the service. Three complaints had been recorded in the last twelve months and these had been resolved

Requires Improvement

Is the service well-led?

Our findings

Effective senior management was not evident within the home. We found systemic failure by the registered provider to take action in response to breaches in regulation found during our previous inspections. The failure to provide suitably clean and well maintained premises was first identified in 2014. The lack of staffing and robust governance processes were highlighted in September 2015 and these were found to be continued breaches at this inspection. The registered provider, in the absence of a registered manager, had overall responsibility to take action to address our concerns, but they had failed to do so.

The manager was working from the action plan written by the previous registered manager. Although we found that progress against some of the actions and improvements had been made the manager told us she would require further time to implement all of the actions.

At our last inspection we found monitoring visits on behalf of the provider had not been taking place, people's confidential records had not been stored securely and we had concerns about fire safety for people.

During this inspection we found the provider had addressed most of the above, however we still identified issues that should have been addressed through these visits, such as the shortfalls in infection control.

The manager could only locate the monitoring report for June 2016. Some of the issues we identified were raised in this report and a summary of actions required were recorded such as in relation to activities and maintenance of the premises. We asked to see the action plan of how the identified issues were to be addressed. The manager told us that one had not been produced which meant they could not evidence whether they had noted the actions highlighted or planned to address them in a timely manner.

The new manager commenced their role in May 2016 and submitted their application to CQC to become the registered manager. They told us that they were making themselves aware of the day to day culture of the service and would constantly keep reviewing this. The manager said they were introducing new ways to improve how the service operates and to improve the quality of life for people living at Avens Court. They told us they were carrying out observations around the service and attending all handover and staff meetings. The manager already had a set of audits that they were to implement to monitor the improvement of the service which included auditing care plans, the environment and food and staff files. In addition the manager had undertaken monthly audits of the service from May 2016 which included an audit of falls and pressure ulcers. However there had been no recent audits in relation to infection control.

Care records for people were not always up to date or contained the full information about people which would help staff understand what care a person needed. One care plan recorded a person had behaviours that challenged, but there was no guidance for staff on how to respond to any incidents. Another person had lost weight but there were no records that they had been weighed since June 2016. We spoke with the RN who told us, "The palliative care team do not have any concerns." Some of the nursing records about people had not been reviewed for two months and the daily notes for one person had recorded, 'difficult behaviour'

but the care plan had not been updated with any further information around this.

Failure to assess, monitor and improve the quality and safety of the service or hold contemporaneous records for people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The new manager was visible throughout the day and it was clear she had a good relationship with people and staff. During discussions with the manager it was evident she was committed to improving the service and was aware of the issues that needed to be addressed.

People and their relatives were complimentary about the new manager. They told us that they were always available at the service and would, "Roll up their sleeves and get out on the floor to help if necessary." One relative told us, "The new manager is lovely, on the ball, around all the time and they are always nice to people." Another relative told us of the manager, "A nice lady who has a good knowledge of the residents." They said there was good communication between them and staff. One relative said, "Get in touch with the family straight away if there are any problems." Another told us, "Very good at keeping in touch with us."

Staff were also complimentary about the manager and told us they had confidence in her. One staff member told us, "The manager is a very nice person and they are here for the staff." Another member of staff told us, "The manager will listen to us at any time. I am enjoying the new manager very much."

Regular staff meetings had been held. We looked at the minutes for the meeting in May 2016 which was the first meeting chaired by the new manager. The manager had opened this meeting with encouraging words to staff informing that they are the backbone of Avens Court and that their suggestions would be listened to.

Residents and relatives were involved in the service as meetings took place. Topics discussed included the last CQC inspection report, introduction of key workers, menus and the environment. This showed that the provider had been open and transparent about the failings of the service with people and their relatives. Relatives said that they were informed about meetings and events at Avens Court.

Staff knew the procedures for reporting accidents and incidents. Staff told us they reported all incidents and accidents to the manager and the RNs and these would be discussed during staff meetings. They said this helped them to reduce the risk of repeated accidents. The manager told us they looked at the accident and incident records to try to identify any trends and learn lessons from them. However, there had been four recorded bruises or grazes on one person that had been recorded on a body chart but there was no evidence these had been reported and followed up to find a possible cause.

We recommend that checks are carried out to ensure that procedures for monitoring and responding to accidents and incidents are always followed.

This section is primarily information for the provider

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The registered person had failed to ensure that premises were clean, properly maintained and suitable for the purpose for which they were being used.

This section is primarily information for the provider

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 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered provider had failed to ensure people were always treated with dignity and respect.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of Regulation 10 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. We have set timescales by which time the registered provider must be compliant with this Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality and safety of the service or hold contemporaneous records for people.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. We have set timescales by which time the registered provider must be compliant with this Regulation.