Care Quality Commission

Surrey Rest Homes Limited

Avens Court Nursing Home

Inspection report

Broomcroft Drive
Pyrford
Woking
Surrey
GU22 8NS
Tel: 01932 346237
Website: www.surreyresthomesltd.co.uk

Date of inspection visit: 19 November 2015, 24 November 2015 & 1 December 2015
Date of publication: 26/01/2016

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**

Overall summary

Avens Court Nursing Home is a care home providing accommodation with nursing care for up to 60 people. There were 53 people living at the service when we commenced our inspection. The service is a large detached property laid out over three floors.

The inspection took place over three days, the first of which was unannounced on 19 November 2015. Due to serious concerns about the safety of the service, we returned on 24 November 2015, with a fire safety officer from the local fire service. We then returned again on 1 December 2015 to meet with the provider.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008

Summary of findings

and associated Regulations about how the service is run. The current manager had been working in the service since August 2015 and was in the process of applying to be registered.

The inspection was carried out over three days because on the first day we identified serious failings with regard to the health and safety of the premises. In particular, we had significant concerns about the way fire safety was being managed. For example, we found that fire escapes were blocked, not enough staff were trained in fire safety and actions from the fire risk assessment were outstanding. We therefore spoke with the local fire service and requested that they visit the service with us. The conclusion of the fire inspection was that there were multiple failings in the prevention, detection and evacuation systems at the service. As a result, emergency work had to be carried out that day in order to allow people to remain living in the service. The fire safety officer issued an enforcement notice under The Regulatory Reform (Fire Safety) Order 2005.

In addition to fire safety we also highlighted concerns in respect of the maintenance of the service which compromised the safety of people. For example, window restrictors were not robust enough to protect the people living in the service from the risk of falling out of them. This had been highlighted to the provider in 2014, but no action had been taken to address the risk.

The service was in a poor state of repair and in need of significant refurbishment in some areas. One relative told us, "The home needs a good old paint and overhaul." We saw that paintwork was damaged, windows cracked and several ceilings had holes in them. One of the lifts was out of order and carpets and other soft furnishings were stained and damaged. In one person's bedroom we saw that a broken fan was stored by the side of their bed and the privacy curtain between them and another person was soiled. Whilst it was clear that renovation was ongoing, there was no refurbishment which ensured that all areas had been identified and scheduled for improvement.

The cleanliness of the service required improvement. We found that floors in communal areas were stained and unclean underfoot. The surfaces in bedrooms were thick with dust and there was no plan to clean hard to reach areas such as skirtings and covings. Whilst cleaners were employed to work in the service, there was no clear plan for what they were expected to clean and when.

The previous registered manager had left in May 2015 and the provider had failed to ensure that the service had been effectively managed. The monitoring visits on behalf of the provider were infrequent and had not identified the improvements that were needed. Where concerns regarding the health and safety of the service had been highlighted to the provider by other agencies, they had not taken steps to ensure these issues were addressed. Audits had either not been undertaken or were incomplete. This had resulted in no action being taken when there had been a rise in falls and infections.

Staffing levels were not sufficient to meet people's needs. The people living at Avens Court had complex support needs and the lack of experienced staff at key times meant that people had to wait too long for their care. One staff member told us, "It's hard to provide good care if you're short staffed a lot". We saw that people had to wait for support with their personal care and at mealtimes some people sat at dining tables for 20 minutes before being assisted to eat.

We also observed that people spend large periods of the time without engagement in activities. Whilst there were some activities taking place in the main lounge, there was no alternative for those people who were either unable or did not want to take part in a group activity.

Whilst staff were caring and compassionate to people, especially those receiving end of life care, people's privacy and dignity were not always adequately promoted. For example, staff did not always take appropriate steps to ensure the privacy of those people sharing a bedroom. Similarly, when staff forgot to shut the door when supporting one person to use the toilet.

Medicines were managed safely, but they were sometimes delivered later than planned due to staff shortages and not all people had appropriate guidelines in place to inform staff about when occasional medicines should be given.

The new manager had inherited the service in a poor state, but had been effective in implementing a number of changes within the time he had been employed. Staff and most relatives felt confident in his leadership and felt

Summary of findings

included in the decisions being made to improve the quality of care. The work undertaken in the service over the course of this inspection demonstrated a commitment to driving the service forward and improving the service provided to people.

Recent improvements to care planning meant that people were better involved in discussions about their care and treatment. It was clear that steps were being taken to provide a more personalised approach to care. Specialist needs such as wound care or weight loss were managed effectively and people were supported to maintain good health and access external professionals such as the GP, dietician or tissue viability nurse as needed.

There was a training programme in place and staff were encouraged to access additional specialist training such as dementia awareness to enable them to develop the skills and experience to deliver their roles. Staff demonstrated that they were able to support people safely when they mobilised and had a good understanding of their responsibilities in respect of safeguarding and mental capacity.

We found a number of breaches of regulations. You can see what action we asked the provider to take at the back of this report.

Summary of findings

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 were placed at risk because the management of fire safety in the service was inadequate.

The service was poorly maintained and potential environmental and infection control hazards had not been appropriately assessed or mitigated.

Staffing levels were not sufficient to meet people's complex needs and as such some people had to wait for support. Appropriate checks were undertaken when new staff were employed.

Medicines were managed safely, but were not always administered in a timely way due to the shortage of staff. Not all people had appropriate guidelines in place to inform staff about when occasional medicines should be given.

Staff had a good understanding about their safeguarding responsibilities and took proactive steps to keep people safe from the risk of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

People were not always appropriately supported at mealtimes. There was ongoing improvement to the quality of meals and this was necessary as the dining experience was not always positive for people.

The design and layout of the service was not wholly appropriate for people living with dementia.

There was a training programme in place and it was evident that staff had recently been better supported to develop the skills and experience needed to undertake their roles.

People's legal rights were protected because staff had a good understanding about how to effectively support people who lacked capacity.

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 always caring.

Staff did not always take adequate steps to protect people's privacy and dignity.

Whilst we saw some good examples of compassionate care, we also observed some situations where staff were task focussed and did not fully consider the impact that their actions had on people.

Summary of findings

Recent improvements had been made in the way people and their representatives were involved in making decisions about their care and treatment.

End of life care was managed well and people and their families were treated with compassion and kindness at this time.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not always adequately supported to engage in activities that were meaningful to them.

Most people and their relatives felt able to raise concerns and had confidence that they would be listened to.

Recent improvements to care planning meant that people were better involved in discussions about their care and treatment.

Specialist needs such as wound care or weight loss were managed effectively.

Is the service well-led?

Requires improvement

The service had not been well-led.

The provider had failed to have adequate oversight of the service.

The lack of robust auditing and monitoring by the provider meant that the failings identified in this report had been allowed to continue over an unacceptable period of time.

Records were effectively maintained, but documents containing people's confidential information were not always stored securely.

The new manager had been effective in implementing a large number of changes to improve the quality of service and staff felt well supported by his leadership.

The work undertaken in the service over the course of this inspection demonstrated a commitment to driving the service forward and improving the quality of care provided to people.

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 was 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 inspection took place on 19 and 24 November 2015 & 1 December 2015. The first inspection date was unannounced and consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On the second inspection date, one inspector was accompanied by a fire safety officer from the local fire service and on the third date, two inspectors visited the service to discuss their concerns with the provider.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. 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. This was because our inspection was brought forward in response to concerns raised with us.

As part of our inspection we spoke with seven people who lived at the service, ten relatives, eight staff, the manager, provider and four other professionals, including the local fire officer, two social workers and a commissioner from the Local Authority. We also reviewed a variety of documents which included the care plans for six people, five staff files, medicines records and various other documentation relevant to the management of the service.

The service was last inspected in September 2014 where we found no concerns.

Inadequate

Is the service safe?

Our findings

Most people and their relatives said that they felt the service was a safe place for people to be.

Despite what people told us, we identified serious concerns about the safety of the service. On the first day of the inspection we found that fire safety had not been well managed. We noticed that the main stairways had been secured by combination locks to prevent people from accessing them independently and an external fire exit was also locked. The fire risk assessment which had been carried out in March 2015, had highlighted that these locks should be linked to the fire alarm to allow escape routes to be accessible in an emergency. There was no evidence that this had been considered. We also found that numerous fire doors were either propped open or did not close tightly to provide adequate protection in the event of a fire. We read an incident report from May 2015 which stated that the fire alarm had sounded and staff had been unable to identify the cause or reset it and as such had called the fire brigade for assistance. It was not possible to see what action had been taken to ensure the alarm was functioning properly. We saw in training records that less than half of the staff employed had completed up to date fire safety training. As a result of these findings, we contacted the local fire service and arranged for a fire safety officer to join us on the second day of the inspection.

The fire safety officer confirmed our concerns and also highlighted other failings with regard to the fire precautions at the service. In particular, a report from the service's own fire maintenance company identified in both June and August 2015 that parts of the fire detection system were not functioning properly. No action had been taken to remedy these issues. The conclusion of the fire inspection was that there were multiple failings in the prevention, detection and evacuation systems at the service. As a result, emergency work had to be carried out that day in order to allow people to remain living in the service. The fire safety officer issued an enforcement notice under The Regulatory Reform (Fire Safety) Order 2005.

In addition to the fire safety concerns, we also found that the environment posed risks to people's safety. For example, in October 2014, the Quality Monitoring Team for Surrey County Council had raised concerns about the inadequacy of the window restrictors in place throughout the service. An action plan from the previous registered manager had confirmed that these would be replaced by the end of October 2014. We found that this had not happened. The people who lived at Avens Court Nursing Home were older people, many of whom were not stable on their feet. The window restrictors in place were not deemed safe in accordance with the guidance issued by the Health and Safety Executive.

On the first day of the inspection, we also found that temperatures in parts of the service were high. This included some people's bedrooms, where we found that people were uncomfortably hot. The manager informed us that there was a problem with the boiler and that engineers had been called on numerous occasions to reduce the temperature. Whilst we could see that this was the case, the level of heat was having a negative effect on the well-being of some of the people in the service and was also a difficult environment for staff to work in. We raised these concerns with the manager who told us that they were actively seeking a solution and in the meantime they were monitoring the temperatures and ensuring people had additional fluids and had ventilation in their rooms.

Failure to assess and where possible, mitigate risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was in a poor state of repair and in need of significant refurbishment in some areas. One relative told us, "The home needs a good old paint and overhaul" and another commented "The building needs refurbishment." We saw that paintwork was damaged, windows cracked and several ceilings had holes in them. One of the lifts was out of order and carpets and other soft furnishings were stained and damaged. In one person's bedroom curtains had come apart from the curtain pole and were hanging down across the window. A broken fan was stored by the side of their bed and the privacy curtain between them and another person was soiled. The surfaces in some bedrooms were thick with dust and there was no plan to clean hard to reach areas such as skirtings and covings. Floors in some communal areas such as the ground floor lounge and dining room were sticky underfoot.

We saw that people had been employed to make environmental improvements to the service and that some areas had recently been upgraded. For example, the flooring in the downstairs dining area had recently been replaced. During the three days of the inspection work was

being undertaken to rectify this. The manager was clear about the work that had been commissioned and the ongoing plans to renovate the service, but it was evident that the property had not been effectively maintained.

The provider had failed to take adequate steps to ensure that the service was clean, properly maintained and fit for purpose in some areas. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place to manage infection control were inadequate. In addition to the poor cleanliness of some areas, we found that the environment also presented risks associated with poor infection control. On the first day of the inspection we found that the paintwork on most doorways and handrails was significantly chipped which meant that these surfaces could not be appropriately cleaned. We highlighted this to the manager who arranged for all these areas to be repainted before we returned for the second inspection day.

We were told the person in charge was the infection control lead.. We spoke with the manager and looked at documentation related to training. We found no evidence that the manager had undertaken any recent or specialist training in infection control. The infection control manual and policy were not up to date and had not been reviewed for four years.. This demonstrated that staff did not have access to current legistlation or best practice guidelines.

The latest internal infection control audit was on the 1 June 2015 and was conducted by two staff members. This was the first audit since April 2014 and had highlighted 22 separate major issues. These included issues around kitchen cleanliness, the state of fixtures and furnishings and the management of waste. The audit contained no action points to remedy these issues and no dates for follow up. There was no subsequent audit. In addition, some areas showed a marked deterioration from the results of the June 2015 audit. For example, it stated that chairs and furniture were clean. This was not the case on our visit as several chairs in communal areas were badly stained and lacked seat cushions.

There was a strong smell of urine in the downstairs communal area and in the 'reminiscence room'. In the first floor communal bathroom, we found a thick layer of dust lining the bath with ladies' nightwear in it. The last audit had stated that 'baths had been cleaned following use'. In the second floor toilet we found faecal matter lining the toilet bowl. The last audit had stated that toilets were 'clean and free from extraneous items'. The audit had also stated waste bags were never more than two thirds full before sealing. We observed full, sealed bags on two occasions during our visit. As such people were not appropriately protected from the risk of infection.

The June 2015 infection control audit also contained a 'monthly infection audit' which listed people requiring antibiotic therapy for infections such as chest infections, cellulitis and urinary tract infections. There had been 41 cases of antibiotic use from January to August 2015. There were no subsequent entries from August onwards. The audit did not contain any information or enquiry concerning possible links or trends with these infections. Each case was either 'resolved 'or 'ongoing'. There were ten people requiring antibiotics for infections in August 2015 alone. We found no evidence of an attempt to discover the cause of this and as such could not be assured whether people were being adequately protected from the risk of infection.

Some staff wore personal protective equipment, such as aprons and gloves whilst giving care, but most did not. This contravened the provider's policy. We observed that staff regularly washing their hands.

The failure to appropriately assess, prevent and control the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not sufficient to meet people's needs which had a negative impact on the level of care provided. Some relatives queried whether there were enough staff working in the service and two said that a lot of experienced staff had recently left. One relative told us "The number of staff has gone down substantially since [my family member] entered the home." The people living at the service had complex physical and emotional needs and whilst we observed that staff spent time to support people safely and at their own pace, this meant that others had to wait significant amounts of time before they received support. At both breakfast and lunch on the first inspection day, we saw that some people were sat at tables for between 20 and 30 minutes before being supported to eat. Some people were sat in the same position for so long that they slept at the table whilst waiting for assistance. When we arrived on the first morning, one person was sat at a

Inadequate

Is the service safe?

dining table waiting for a cup of tea and was there for half an hour before they received it. Another person took food from someone else's plate and no staff were around to notice. Two relatives said they frequently visited at mealtimes in order to assist their family member to eat because they knew staff were busy.

People living on the first floor of the service were delayed in receiving support with their personal care because staff were busy supporting others. It was nearly lunchtime before staff had the time to support one person to get dressed. In the morning medicines were still being given out 10:45am because the nurse on duty was repeatedly called away to provide support to other staff.

Two staff members told us, "We can be short staffed at times but other staff, like kitchen staff, will come to help sometimes. We don't use agency staff." Another staff member told us, "Quite a few staff have left recently and sometimes shifts just aren't covered. On nights there should be six staff but there can sometimes only be four. Tempers can get shortened when that happens."

The failure to deploy sufficient staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate checks were undertaken before staff began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and character references, job descriptions, evidence of up to date registration with the Nursing and Midwifery Council and Home Office Indefinite Leave to Remain forms in staff files to show that staff were suitable to work in the service.

Whilst some people did not always receive their medicines in a timely way, there were systems in place to manage medicines safely. The registered nurse on duty was aware which medicines needed to be given at specific times and had ensured these were prioritised. Medication Administration Records (MAR charts) were found to have been completed and the registered nurse demonstrated how medicines were administered in a safe and personalised way. Where people required medicines to be given covertly, we found appropriate best interests decision making protocols had been followed. Covert medication is when medicines are concealed in food or drink.

Guidelines for the use of people's occasional medicines or when required (PRN), such as those used to treat pain relief or anxiety were not always in place. As such, the registered person could not be assured that staff administered these medicines appropriately and consistently. We observed that one person was repeatedly calling out in pain, but had to wait for two hours before being offered their prescribed pain relief. There were no guidelines in place to indicate what pain this person may experience and when they should be offered their PRN medicines.

Failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding about their safeguarding responsibilities and took proactive steps to keep people safe from the risk of abuse. Relatives told us that staff treated their family members with respect and kindness at all times and had no concerns about them being safeguarded. Staff were confident about their role in keeping people safe and demonstrated that they knew what to do if they thought someone as risk of abuse. Policies and procedures were in place for staff to follow if they suspected harm and the nurses in charge were clear about how to correctly report abuse to the outside agencies.

Requires improvement

Is the service effective?

Our findings

Feedback from people and their relatives indicated that the quality of food at the service was variable, but had recently improved. One relative told us that they used to avoid visiting at supper time because they didn't like the look of the food that was served. Two relatives felt that their family's specialist diet needs could be better managed. For example, one told us that their relative was a vegetarian and they didn't feel that they got enough nutrition and variety. Another said that their relative was assisted to eat in their room and they felt chilled desserts would often sit for too long in the warm.

The manager told us that meals needed to be improved and was in the process of reviewing all the menus. He had arranged for a local farm shop to supply fresh vegetables because there had been a reliance on frozen food which people didn't enjoy as much. We saw fresh vegetables being prepared at the time of our visit. One relative said, "The food has improved, I have tasted it and it seems fine now."

People did have some choice over their meals, but this was not always made clear to them. We read in care plans that people had been asked about their dietary preferences, but this information had not been shared with kitchen staff. We observed that at breakfast there was a limited choice of food, with most people eating porridge that had been mass prepared. This did not look appetising and we noticed that many people did not finish their servings. The new menus showed that people could have a cooked breakfast if they chose and the manager acknowledged that staff needed to make choices clearer and more meaningful to people living with dementia.

At lunchtime, we saw that people were given a choice of two main meals, one of which was a vegetarian option. The side orders served with each meal choice were the same however and as such those selecting beef curry, had this with mash potato and mixed vegetables. We saw that people were given appropriate portion sizes and offered more if they finished. People commented that the food tasted nice. The provision of food for people on a soft diet was good with each food group being separately blended to allow people the opportunity to distinguish different tastes. We read in care records that people were weighed regularly and appropriate action taken if their weight altered. For example, where one person had lost weight, their food intake was being monitored and a GP appointment had been requested.

As previously highlighted, there were not sufficient staff to support people at mealtimes which resulted in many people waiting for help with their food sat in front of them. As such, some people ate food that was either cold or luke warm because most staff did not reheat the meal before assisting people. Staff ability to support people to eat was variable; some provided very good assistance at an appropriate pace, whilst others were seen to provide support in a task based way and with limited interaction. We read in one person's care plan that they required supervision and prompting during mealtimes and this was not seen to be provided.

The design and layout of the service was not wholly appropriate for people living with dementia. Relatives highlighted the need for the decoration of the service to be improved. It was evident that refurbishment was ongoing, but at the time of the inspection the environment was not fully suitable for the needs of the people supported. For example, many walls were painted in very bright colours and carpets, including those on stairways were heavily patterned which would be confusing for people living with dementia. Similarly, in order to operate the lift, the movement button had to be depressed continuously and as such was difficult for people to use independently. The manager said that he had got agreement from the provider to refurbish the service in dementia friendly colours and we have requested that timescales for the completion of this work are included in their action plan.

Staff were being supported to develop the necessary skills and experience to undertake their roles effectively. Relatives highlighted some concerns about the initial turnover of staff following the management changes within the service. Two relatives told us that a number of experienced staff had stopped working at the service and been replaced with new staff who were still getting to know people. The manager showed us the support systems that had been put in place to develop staff. Staff told us that they felt well supported through regular one to one meetings with their line manager and nursing staff received clinical supervision and mentoring support from one of the senior nurses and the manager.

Requires improvement

Is the service effective?

Training records showed that there was a good programme of training in place with all staff undertaking relevant training in areas such as moving and handling, dementia awareness, safeguarding and mental capacity. Staff told us that they thought the access to training was good and equipped them to deliver their roles effectively. We saw staff providing some safe care in the way they supported people to mobilise.

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 found that people's legal rights were protected because staff had a good understanding about how to effectively support people who lacked capacity. One relative raised concerns with us regarding the stair locks and the restriction this placed on their family member's freedom.

This person was unable to access the stairs safely on their own and as such staff did not believe this restricted them. We have referred this individual case to the Local Authority to investigate.

We observed that when other people asked to use the stairs they were supported by staff without delay.

We asked staff about issues of consent and about their understanding of the MCA. Most of the staff we spoke with had undertaken recent training in this area. They had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Some staff could tell us the implications of DoLS for the people they were supporting. One staff member told us, "The Mental Capacity Act is there to protect people from having their rights taken away." Another staff member told us, "It's important here as there are people who can't make big decisions for themselves. We help them, along with their families." Staff acted swiftly and appropriately when they recognised that a person had signed for something that they lacked capacity to consent to, thereby safeguarding them.

People were supported to maintain good health and we saw that the provider involved a wide range of external health and social care professionals in the care of people. These included NHS Tissue Viability Nurses, GP's, dieticians and local authority social workers, one of whom visited the service during our inspection. We noted advice and guidance given by these professionals was being followed.

Requires improvement

Is the service caring?

Our findings

Relatives told us that staff treated their family members with, “Kindness” and “Compassion.” Relatives made comments such as, “Staff are quite genuine, they care” and “His care worker is great and he responds to her.”

We saw lots of examples of good care, for example we saw a staff member go and find a person’s own blanket when they mentioned they were feeling cold in the lounge and we watched another member of staff dance with a person to their favourite song. We also, observed some situations which compromised good care. In some cases we saw that staff were so absorbed in completing their tasks that they didn’t notice the impact of things on people. For example, the CD playing music in the lounge became stuck and played repetitively for 45 minutes before being switched off. For those people in the lounge and unable to move independently, they were left listening to the same short extract of music over and over again. In the upstairs lounge, there was a plastic pouch which contained numerous pairs of glasses, therefore indicating that the importance of returning them to their owner had not been considered.

Whilst staff knocked on people’s doors before entering, attention had not always been paid to making people’s rooms a pleasant space for them to spend time in. Some bedrooms had not been personalised in any way. We noticed that one person was sleeping on their bed with just a duvet cover over them. Another person’s room smelt strongly of urine and several people had soft furnishings in their bedrooms that were stained or damaged. This was not indicative of a caring environment.

People’s privacy and dignity were not always adequately protected. We saw that some people shared bedrooms and in one case no attempt had been made to maintain the person’s privacy whilst they were in bed. We also witnessed a staff member guide someone to use the toilet without ensuring the door was closed behind them.

Not all staff gave sufficient thought to how people were presented. For example, we saw that some people had food spilt down their clothes which they had not been supported to change and another person was wandering around the service after lunch still wearing a clothes protector. Some of the language used by staff was not always appropriate or respectful. We overheard staff say to people, “You are a good boy” or, “Girly”. Similarly, some staff described people to us as, “Walkers” or, “Feeders” which indicated that they were focussing on the need rather than the person.

Failure to always treat people with dignity and respect and ensure their privacy was maintained was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recent improvements had been made in the way people and their representatives were involved in making decisions about their care and treatment. Relatives told us that the new manager had changed the way care planning was undertaken and introduced a keyworker system in the service. The feedback was that this allowed them to be more involved in decisions about their family member’s care.

End of life care was managed well and people and their families were treated with genuine compassion and kindness at this time. We noted, from examining care plans, that they contained a section which included advanced decision making. This section was completed in conjunction with people and their families. This included whether the individual wished to be resuscitated in the event of cardiac arrest. The care plans for those who did not wish to be resuscitated contained documentation indicating this, as required by law and was countersigned by the person’s GP. Staff displayed a good level of knowledge of advanced care planning and were aware of people’s needs in this regard. A relative of a person who had received end of life care spoke very highly of the care their family member had received.

Requires improvement

Is the service responsive?

Our findings

There were some activities for people to participate in, but these were not meaningful to everyone and people spent large parts of the day sitting unoccupied. On the morning of first inspection day, a staff member was encouraging people to play a ball game in the downstairs lounge. A relative commented to us, "I have been coming here 12 months and this is the first time I have seen this [pointed to the ball game], it is usually quiet here and people are just sitting around."

In the afternoon, we saw a popular karaoke session taking place in the downstairs lounge. Those people who were in this area of the service were engaged in the activity and the staff member was actively supporting people to participate. Two relatives confirmed that this was a regular activity and that their family members enjoyed it.

There were no alternative activities for those people who were not able or did not want to join in the group sessions in the main lounge. In the first floor lounge, there were no activities or engagement for people between 10:50am and 12:50am. For people in their rooms, the only engagement they received was when they were supported with personal care tasks.

Levels of engagement between staff and people were observed to be low, especially during the morning because staff were busy providing personal support to people in their rooms. Most people spent time sitting waiting for tasks to happen. In the upstairs lounge we saw that there were frequent periods of up to four minutes where people were sat alone without staff present and when staff did come in to the room it was only to wash their hands or complete another task.

We observed one person spent a lot of time in their room throughout the day, but their room was sparse and there was nothing in there for them to do. We repeatedly checked on them and each time they were sat or laying on their bed looking into the centre of the room. Staff said that the person enjoyed watching sport, but no attempts had been made to make this available to them on a daily basis.

The activities schedule on display in the service listed the same activities were repeated each day. Care plans identified people's likes and interests, but this had not been translated into a programme of activities that was meaningful to people.

The failure to provide person-centred care that was appropriate to meet people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most relatives felt able to raise concerns and had confidence that they would be listened to. With the exception of one relative, who felt their complaints had been ignored, all the relatives we spoke with felt able to raise their opinions and concerns with either staff or the manager. There was a complaints policy and procedure available in the service and relatives confirmed that they would feel confident to use it. Most relatives said that their concerns had only been minor and that once raised they were resolved.

Recent improvements to care planning meant that people were better involved in discussions about their care and treatment. Each person had a personalised plan of care that contained detailed information about their care needs, for example, the risks associated with poor mobility or nutrition. The care plans also included information about personal histories, including likes and dislikes and references about their care. The daily records showed that these were taken into account when people received care, for example, regarding what they had eaten or whether they had suffered pain. Care planning and individual risk assessments were reviewed monthly or more frequently if required so they were up to date. The risk assessments were varied and focused on the individual. They were relevant to the care needs of people. These included the management of pressure sores and the management of people with limited mental capacity. For example, we noted one person had a pressure sore and was at high risk of developing more. Their care was managed effectively and safely, with the help of external agencies such as NHS Tissue Viability Nurses.

Staff understood the importance of individualised care. We asked staff what they understood by the term 'person centred care'. One staff member told us, "We treat people as individuals. That's why we have the key worker system." Another staff member said, "I think it's putting the person at the centre of everything, not us (staff)." Relatives said they had recently been encouraged to be involved in care plan reviews. They said that they thought the standard of care was very good.

Relatives said the service had always reacted quickly to people's changing needs. This was reflected in care records

Requires improvement

Is the service responsive?

which showed that where people had lost weight, appropriate follow-up had been taken. For example their food and fluid intake had been monitored and they had been referred to the GP or dietician.

Requires improvement

Is the service well-led?

Our findings

With the exception of one relative, we were told that people were happy with the management of the service and the feedback about the new manager was positive. Relatives told us, "The new manager is making a positive change." Another said, "The home is generally much improved since the new manager started. We've really noticed standards coming up."

Prior to the recruitment of the new manager, the provider had failed to have adequate oversight of the service. The quality of service had been allowed to fall below an acceptable standard and the lack of robust monitoring had placed people at risk of receiving unsafe and inadequate care. The provider had not completed any audits in the period whilst there was no manager at the service, nor had that they made attempts to ensure others were doing so. As a result, the increase of falls within the service was not identified and as such no action had been taken previously to mitigate the risks.

Visits on behalf of the provider had not identified the concerns raised in this report and as such appropriate action necessary to keep people safe had not been carried out in a timely way. Similarly, where the provider had been informed by other agencies that improvements were required, for example in respect of fire safety, food safety and the inadequacy of window restrictors, the provider had failed to ensure such work had been carried out and thus placed people at unnecessary risk of harm for a prolonged period of time.

Records were effectively maintained, but documents containing people's confidential information were not always stored securely. For example, care plans which recorded sensitive information about people were kept in an unlocked cupboard within communal areas.

Failure to have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and maintain records securely was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager had proved to be effective in implementing significant changes within the service. It was evident that they had inherited a difficult situation and had worked hard to effect change. Since their employment in the they had taken action to remedy the shortfalls in food hygiene as identified by the local Environmental Health Department and as such had been responsible for the installation of new kitchen facilities. They had also recruited new staff and implemented a training and development programme to enhance staff skills. They had a clear plan which addressed the need to develop a safe and more personalised service.

The work undertaken in the service over the course of this inspection demonstrated that the manager was taking action to improve the service. For example, between the first and second inspection days, the manager had taken steps to ensure the cleanliness of the service was greatly improved and infection control risks mitigated by the repair of railings and frequently touched surfaces. He had also ordered new equipment such as more suitable nursing beds and made enquiries with the Health and Safety Executive to secure appropriate window restrictors. The provider showed their financial commitment by releasing the funds to enable large scale work to be commissioned to meet the fire safety requirements.

Staff told us that they had confidence in the leadership of the new manager and said they felt well supported by him. One member of staff said, "We are moving in one direction now and providing good care." Another staff member told us, "It's better now." We read that the manager held regular staff meetings and staff told us that communication and teamwork had improved as a result.

The manager was transparent with us about the work he was doing and has kept us informed of the progress. We have received appropriate notifications regarding notifiable incidents that have occurred at the service. Staff told us that they were empowered to complete records and said that the manager's instructions were to, "Record and report everything." This demonstrated that the culture in the service was open and honest.

Relatives told us that they were better engaged with the service since the new manager was in post and said that they had been kept informed and involved with the changes that were being made. We found that there had been relatives' meetings and the manager had engaged with one relative to create a feedback survey to be used to canvass opinions within the service. One relative told us, "The new manager seems to have some good ideas with

Requires improvement

Is the service well-led?

regard to making the residents feel Avens Court is their service." Relatives said that they felt included in the running of the service and were now better involved in the planning of the family member's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to appropriately assess and where possible mitigate risks to the health and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had failed to ensure that premises were clean, properly maintained and suitable for the purpose for which they were being used.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person had failed to take adequate steps to assess, prevent, detect and control the risk of infections.**

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 **The registered person had failed to ensure there were sufficient numbers of suitably qualified, competent and experienced staff to meet the needs of people living in the service.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had failed to have appropriate systems in place so as to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person failed to ensure that people were always treated with dignity and respect, including maintaining their privacy.

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 The registered person had failed to assess, monitor and improve the quality of services and mitigate risks relating to health, safety and welfare. The registered person had failed to maintain records securely.