Avante Care and Support Limited

Amherst Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Amherst Court is a residential care home providing personal care to 60 older people at the time of the inspection. This included people living with dementia. The service can support up to 71 people. The accommodation was provided in four care suites spread over two floors. A lift was available to take people between floors.

People's experience of using this service and what we found

People and their relatives said they felt safe living at Amherst Court. Staff understood how to recognise abuse and poor practice and how to report it.

We observed staff acting according to the aims of the service to provide person-centred care. They made sure people were able to understand what they were saying and reassured people who were anxious.

Staff were checked to make sure they were suitable for their role. The majority of feedback was that there were enough staff to support people's needs.

People at high risk of falling had been identified and actions taken to minimise the recurrence. We have made a recommendation to reinstate detailed monthly falls audits.

People were supported to take their medicines as prescribed by their doctor.

There were effective systems to prevent and control infections. Additional measures were in place during the pandemic.

There had not been a manager in post for six months which had affected staff morale. A new manager had been appointed and was introducing themselves to the staff team.

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

Rating at last inspection
The last rating for this service was Outstanding (published 15 August 2018).

Why we inspected
We received concerns in relation to the management of falls and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Outstanding to Good. This is based on the findings at this inspection.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the relevant sections of this full report.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Amherst Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by three inspectors.

We spoke with two people who used the service and telephoned four relatives to gain their experience of the care provided. We spoke with eight members of staff including, the two deputy managers, two senior carers, two carers, an activity organiser and a housekeeper. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment. We also reviewed a variety of records relating to the management of the service, quality monitoring and the deployment of staff.

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

The service did not have a manager registered with the Care Quality Commission. The service was being managed by two deputy managers. A manager had been appointed to commence management of the 21 September 2020. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was to establish the safest and most appropriate way of carrying out our inspection visit during the covid-19 pandemic.

What we did before the inspection
We sought and received feedback from the local authority. We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and telephoned four relatives about their experience of the care provided. We spoke with eight members of staff including the two deputy managers, two senior carers, two carers, an activity coordinator and a housekeeper. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We also reviewed a variety of records relating to the management of the service, quality monitoring and staff deployment.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

● Feedback from the majority of people and relatives was there were enough staff to meet people's needs. In the service's 2019/2020 survey 72% of people, family and friends responded there were enough staff. One person told us, "I think they have done very well during the pandemic, but yes I think they could do with more staff. The staff are very kind and they really care and are very lovely to me." A relative said, "There were enough staff when I visited last."

● Staffing numbers were assessed according to the number of people living at the service with a ratio of one person to four care staff/senior staff during the day. Staff were then divided between each of the four units, dependent on the number of people residing there. There was flexibility in moving staff between units to meet people's changing needs. We received feedback from some staff that this was not always the most effective way to deploy staff. This was because when staff moved to another unit, it reduced the number of staff on the original unit and hence the staffing ratio. The deputy managers said they would consult the staff team to help ensure the effective deployment of staff.

● Contingency plans were in place to ensure there were staff available to cover staff vacancies, staff sickness, annual leave and significant staff shortfalls as a result of the pandemic. The service was in the process of recruiting new staff at the time of the inspection. Agency staff from the provider's bank of staff were used when existing staff were not able to cover any staff shortfalls. These were usually regular agency staff who therefore had time to get to know people.

● Checks on new staff included obtaining a person's work references, identity, employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

Assessing risk, safety monitoring and management

● Potential risks to people's health and well-being continued to be assessed and reviewed. This included the risk of falling, developing pressure areas and presenting behaviours that may challenge themselves or others.

● Guidance was available to staff, so they knew the areas of high risk for each person and how to support the people in the right way. For people at high risk of falling, a falls diary was used to identify any specific areas of the home or any situations in which the person was a higher risk of falling. Personalised control measures were in place to help reduce these risks. For example, one person was supported to wear hip protectors, to use their walking frame and was regularly checked by staff. Another person sat in an armchair at lunchtime as they were at risk of falling if they sat at the dining room table . Staff were aware of which people were at risk of falling and we observed staff following written guidance during the inspection.

● Staff understood guidance about how to support people who could present behaviours due to anxiety. A record was kept of any incident and behavioural charts were used to help identify any triggers. These were

shared with relevant health care professionals as required. We observed staff talking to people in a calm and patient manner to reassure people.
● Regular checks were made on the environment and electrical and gas appliances were maintained. This was to make sure the service was safe for people and staff. Staff participated in fire drills to assess they knew how to take action quickly to keep people safe in the event of a fire.

Learning lessons when things go wrong
● A record was made of any accident, incidents and near misses, together with any action taken to minimise the reoccurrence. These significant events were reported to the management team to assess if any further actions needed to be taken to reduce the chance of the same thing happening again.
● For example, one person had fallen four times in a month. Their falls risk assessment had been updated and falls diary kept up to date. A referral had been made to the falls team who had given the person hip protectors. As sensor mat was in their bedroom to alert staff when they were mobilising.
● A daily meeting was held with senior staff and the management team. At these meetings current risks to people's health and well-being were discussed and any lessons learned shared.
● Incidents were communicated to people's relatives, so they were kept up to date with their loved ones' well-being. One relative told us, "They informed me every time he has a fall and involvement of GP". Another relative said, "In majority of times they do inform me, yes. Before lockdown yes, but it has been difficult because of Covid-19".

Systems and processes to safeguard people from the risk of abuse
● People and their relatives said staff made them feel safe. One relative told us, "Definitely safe at Amherst Court". This reflected the results of the service's survey for 2019 to 2020. In the survey 100% of residents, family and friends responded the service was safe and secure.
● Staff understood what constituted abuse and poor practice. Staff explained if there were any changes in people's moods, they would investigate further to find out what was the cause. Any concerns were reported to the management team.
● Safeguarding concerns had been reported to the local authority, who had the lead role in investigating allegations of abuse. The management team keep an overview of any safeguarding's and actions taken to keep people safe.
● Staff knew how to whistle-blow (tell someone if they had concerns). They also understood their role in reporting any concerns to external agencies, if they were not acted upon. The telephone numbers required to report their concerns were available to staff.

Using medicines safely
● Medicines guidance was followed so people received their medicines as intended.
● Staff followed protocols which directed them when people should be given medicines prescribed as 'only when needed'. Topical creams were dated on opening to make sure they were only used during the time period when they were effective.
● When administering medicines, staff talked with each person. This was so they understood they were being given their prescribed medicines. Staff then signed the medicines administration's record to confirm the person had taken their medicine.
● Medicines were stored safely. Medicine stocks and records were regularly checked to make sure people received all the medicines they had been prescribed.

Preventing and controlling infection
●The service had carried out infection control audits, the latest being in August 2020. This was to ensure national guidance and practice was being followed to help minimise the occurrence or spread of Covid-19. It

had been identified that some kitchen staff were not washing their hands appropriately and this had been addressed with the team.

● The service was clean and free from unpleasant odours on the day of the inspection. Cleaning schedules had been adapted to ensure more frequent cleaning of high use areas during the pandemic.

● The service had adequate supplies of personal protective equipment (PPE). Staff had been trained in the use of PPE and were following this guidance during the inspection.

● The service was participating in a national program to ensure staff and people regularly accessed testing. People newly admitted to the service or returning from hospital were kept in isolation until they had received a negative covid-19 test result. There was a procedure for visitors to follow which required them to book in advance, to reduce the number of visitors at any one time.

Good

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Outstanding. At this inspection this key question has changed to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care

- A structured programme of quality checks and audits were undertaken to identify any shortfalls in the quality of care.
- The last audit in August 2020 identified some areas which required actions to ensure people's safety. This included completing written protocol's for people prescribed medicines to be taken 'as needed'. This had been rectified at the time of the inspection. Progress with actions was monitored through the provider's improvement plan. For example, protected time was being given to senior staff to help bring people's care plans up to date.
- Monitoring of significant events had identified when there had been an increase in the numbers of people falling. Falls at night had increased in December 2019. As a result, a member of the management team had worked at night to identify improvements and a falls initiative commenced. A falls champion had been identified and each person's falls were analysed in detail monthly to identify if anything else could be done to lower the risk of any reoccurrence.
- There continued to be a significant number of falls and appropriate steps had been taken to minimise them. The provider had previously carried out more detailed falls audits which identified preventative actions. It would be beneficial if the provider reinstated these audits.

We recommend the provider reinstates monthly falls 'deep dives', to give greater assurance that the risks of falling are being addressed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Two deputy managers were managing the service in the absence of a registered manager. There had not been a registered manager present at the service for just under six months. A new manager had been appointed commencing from 21 September 2020. This manager was registered as a manager at another of the provider's services. They had started to visit the service and communicate with the existing management team.
- The deputy managers were clear about their new roles and responsibilities. They had taken over the management of the service prior to the pandemic and overcome a number of associated challenges. The deputy managers had been supported in their role by members of the provider's management team.
- There was mixed responses about the management of the service but the majority was positive. The majority of feedback was that people would recommend the service to others. Comments from relatives included, "I have been having dealings with the deputy manager and they are always ready to sort out any

problems and also know the residents very well"; and "It was well managed but not at the moment. We have been told a new manager will start this month". A staff member told us, "Both deputy managers are lovely and the new registered manager seems really good as well."

● The provider had informed us of significant events that had occurred at the service. It is important that the Care Quality Commission (CQC) has a clear overview of all incidents at the service, so we can check that the provider has taken appropriate action.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility culture and aims

● The morale of the staff team had fluctuated with the long-term absence of a registered manager. This had been discussed at staff team meetings.

● Staff and the management team were clear about the value of good team work and positive relationships with family members in providing personalised care. We observed staff acting according to the aims of the service to provide person-centred care. At lunchtime staff asked some people what they wanted to eat and for other people they showed them two plated meals to help them decide. Staff adjusted their positioning so people could understand them better.

● In the service's survey for 2019/20 100% of people, family and friends said they were treated with dignity and respect. A number of compliments had been received about the staff team. One relative commented, "Since the lockdown, whilst we have not been able to visit him, I speak to him and the staff regularly and I cannot state how much we both appreciate how much everyone at Amherst has gone above and beyond "the call of duty"." Another relative commented, "We are all happy as a family with the dedication shown to Dad from all the caring staff. It has been a relief to find such a happy home."

● The management team understood the importance of being open and honest. This had been communicated to the staff team, so that if things did not go right with people's care, this could be discussed to ensure it did not happen again.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives had been engaged in the service through meetings and survey questionnaires. One relative told us, "They have taken on board the suggestions I have made in the residents' meetings I attended". During the pandemic, relatives kept in contact with their family members through phone calls, photographs, social media and garden visits.

● Staff were supported through regular attendance at supervision sessions and staff meetings. A new staff member told us, "All the trainers have been so supportive. I can go to them if I think something doesn't look right". The provider had surveyed staff at all their care services in 2019. Staff surveys specifically for staff at Amherst Court were being completed at the time of the inspection. This was to ensure the management team were aware of the views of its staff team so they could act on them.

● The provider worked in partnership with a range of health and social care professionals such as GP's, district nurses and the community mental health team. The management team had developed a good working relationship with the falls team.