Athena Care Homes (Monmouth) Limited

Avocet Court

Inspection report

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Date of inspection visit:
23 August 2021
24 August 2021

Date of publication:
30 September 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Avocet Court is a residential care home providing personal and nursing care for up to 153 adults. At the time of our inspection there were 87 people living in the service, some were living with dementia.

The service accommodates people across three separate units, each of which has adapted facilities. These were, Cilgerran House and Powys House, which provided personal and nursing care, and Harlech House which provided personal and nursing care for people living with dementia. There was a separate unit, where the management team, reception and administration, kitchen, coffee shop and laundry were located.

People's experience of using this service and what we found
People and relatives praised staff for being kind and caring. We observed that staff were attentive and interacted with people in a respectful way.

Risks were not always assessed or effectively managed to keep people safe. People were using shared mobilising equipment which were not laundered between uses which presented a risk to people of acquiring infections. Risk assessments were not always adequately detailed. We have made a recommendation about the use of moving and handling slings and the risk assessment for hot water pipes and radiators.

Accidents and incidents were investigated to identify the cause and the actions needed. We received conflicting information about how falls were managed, but we observed that crash mats and call bells were in place. However, some call bell cords presented trip hazards and the manager agreed to ensure that staff were clearer about the use of portable alarms.

The manager used a dependency tool to establish the staffing levels to ensure there were enough staff on each shift to meet people's needs. Dependency levels were regularly reviewed. The manager told us that admissions in one part of the service had recently been halted on a temporary basis because of increased levels of dependency.

Staff knew how to safeguard people from the risk of abuse. They had a good understanding of how to recognise and report abuse and were confident the provider would take action in line with local safeguarding procedures.

People were supported by staff who had been recruited and employed after recruitment checks had been completed.

The home was clean and visits by relatives had been facilitated to the service in line with the government guidance which was welcomed by staff and people using the service.

Medicines were administered by staff who had been trained and we received positive feedback about how

people received their medicines. Further work is needed on ensuring that people receive their topical medicines as prescribed.

A new manager had started work at the service in January 2021 and staff told us they were helpful and approachable. The new manager assured us that they were in the process of applying to register with the Care Quality Commission (CQC).

There were governance systems in place to monitor and assess the care provided. Audits on quality and safety had been completed but those in place had not identified the shortfalls we found in areas such as risk management and medicines.

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 good (published 14 December 2020).

Why we inspected
The inspection was prompted in part due to concerns received about how risks to people were managed. A decision was made for us to inspect and examine those risks in one part of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led in Harlech House.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 good to requires improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Avocet Court on our website at www.cqc.org.uk.

Follow up
We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Avocet 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector 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. The Expert by Experience spoke with people's relatives on 24 August 2021 over the telephone.

Service and service type
Avocet 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 ten relatives about their experience of the care provided. We also spoke with six members of staff and members of the management team including the manager.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included three people's care records and medication records. We looked at a variety of records relating to the management of the service, staff recruitment records and quality assurance records.

After the inspection
We continued to seek clarification from the provider to validate evidence found and spoke with two visiting professionals about their views of the care delivery.

Requires Improvement

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 deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• We were not assured that risks were consistently identified and effectively managed.
• Pipes and radiators were uncovered and there was no risk assessment in place. No one had been harmed but people living in the service were at high risks of falls and we were concerned that people could fall against an unguarded surface which could burn or scald them. The provider assured us that they were following the appropriate health and safety guidance with temperature restrictions and temperature checks. In response to our findings a risk assessment was subsequently produced but this was not detailed. The manager told us eight radiators were checked each month, which given the size of the service meant that some parts of the service would not be checked for a significant period.

We recommend that the risk assessment for the management of the risks associated with unguarded surfaces is reviewed and more specific details provided as to how effective oversight be maintained.

• A recent incident had occurred where a person using the service had sustained a significant burn from a hot drink. Following the incident, the provider had provided assurances that specific actions would be undertaken to reduce the risk of another incident. Reminders had been given to staff, and while efforts were being made to obtain cups, which did not spill so readily, this had not been undertaken in a timely way. The manager told us that no one required this type of cup at the time of the inspection however we observed a number of people in bed with hot drinks nearby. We also saw that two further scalding incidents had occurred, although there had been no serious injury.
• Some people required assistance to mobilise and we observed staff assisting people to transfer. This was undertaken in a safe way using the moving and handling equipment. However, staff used shared hoist slings which were not laundered between each person. This presented a risk of cross infection.

We recommend that the provider seeks advice from a reputable source on its infection control procedures and its use of slings.

• We received conflicting information from families about how well, falls were managed. One told us, "The home is doing all they can. (My relatives) bed has been lowered and there is a pull-out crash mat." Another said '(My relative) has fallen over several times…. A pressure mat was put down, but they sometimes step round it. I think they are generally looked after well, but they need to try a little harder."
• Equipment such as crash mats and alarms were in place for those individuals who had been identified as being at risk of a fall. However, we observed that call bell leads presented a falls risk as they stretched out across the floor. We were assured by the manager that pendant alarms were available, and they would

review people's needs and ensure that those who required them had access to them.
• The manager told us that they worked closely with visiting professionals and sought specialist advice where required. Visiting professionals confirmed that the service contacted them appropriately and followed their guidance.
• Specialist mattresses were in place to reduce the likelihood of skin damage and people were repositioned at regular intervals.
• Accidents and incidents were investigated to identify the cause and the actions needed.

Staffing and recruitment
• The manager used a dependency tool to establish the staffing levels to ensure there were enough staff on each shift to meet people's needs. Dependency levels were regularly reviewed, and the manager told us that admissions in one part of the service had recently been halted on a temporary basis because of increased levels of dependency.
• Contingency arrangements were in place to cover events such as staff sickness to ensure that the service had enough staff to provide safe care.
• Staff told us there was enough staff, unless there was an unplanned staff absence or people's needs changed suddenly. One member of staff told us, "You can always find the spare minute to do things right."
• We observed there was a number of people who were at high risks of falls in the communal area. Staff were observed coming and going and there were short periods were there were no staff available. We discussed our concerns with the manager who told us that that they would ensure that a member of staff would remain in the communal areas at all times.
• People were supported by staff who had been employed after recruitment checks had been completed. The manager told us that they were introducing a checklist to strengthen the processes further.

Systems and processes to safeguard people from the risk of abuse
• People and relatives spoke positively about the service. One relative told us, "My family member has been fantastic. I am confident they are safe; they always look clean, tidy and content. I have no safety concerns." Another said, "My relative is really safe. I have no doubt they care for them. There has been a massive improvement in them since they have been there. They encourage them and I get weekly update calls. They love my (relative)."
• Body maps were in place to record changes to people's skin and the manager had clear processes in place to record concerns and update records to identify learning.
• Staff told us that they knew how to raise safeguarding concerns and expressed confidence in the process.

Using medicines safely
• We received positive feedback about how staff supported people with their medicines. One relative told us, "Medication is managed well. (My relative) was in pain and I mentioned it to the home and they referred them to the GP to try and relieve the pain."
• We observed staff administering people's medicines and this was undertaken in a safe way.
• We reviewed the arrangements in place for the storage of controlled drugs and found that the amounts of stock tallied with the records.
• Shortfalls were identified in the recording and oversight of topical medicines. The manager told us that they had recently changed the system but amended their audits to ensure that the effectiveness of the new system would be monitored more closely.
• Audits showed that medicines were regularly checked to reduce the risks with medicine management

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were only somewhat assured that the provider was making sure infection outbreaks can be effectively prevented . The infection risks to people from acquiring infections including COVID-19 had not been thoroughly assessed and managed because as previously outlined people were using shared slings.

● We were assured that the provider had an infection prevention and control policy in place. The provider told us that they had 30 policies in relation to COVID 19

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Quality assurance processes were in place including a significant number of audits, but these were not always effective in identifying and addressing areas for improvement.

• We identified shortfalls in the identification and management of risk in relation to a number of areas including both environmental and individual risks. While the manager responded in a positive way when the issues were drawn to their attention, there were gaps in the audits.

• Checks were undertaken on call bells to monitor call bell response times, but the findings were not reviewed in a systematic way to identify patterns. The manager agreed to immediately address this and showed us new documentation which they were intending to implement.

• Medicine audits were undertaken but had not resolved shortfalls in the application of prescribed topical creams. We found significant gaps in recording and could not be assured that people were receiving these as prescribed. The manager agreed to amend the documentation and told us that their new recording system needed time to embed.

• The provider told us that their new digital auditing systems were being constantly reviewed and refreshed to reflect any identified shortfalls in line with their cycle of quality improvement. The provider had a development plan in place dated 2020, but this would benefit from further updating and expansion to take account of the findings of more recent audits.

The shortfalls in governance are a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• There were systems in place to handover information, but they were not working effectively on the day of the inspection, but we were assured that this was due to a computer glitch. Daily meetings were held with heads of department and nursing staff to review the care and ensure good communication.

• The manager was aware of the need to make notifications to CQC as required. We saw that one notification had not been made as required and this was immediately rectified by the manager.

• The manager had taken up post in January 2021 and told us that they had started the registration process but had not yet submitted their application to CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

• People had individual care plans were set out their preferences for person centred care. Most relatives we spoke to were happy with the service and told us that the service was open and helpful, one relative told us, "The home is really good with information, emails and letters with updates." Another said, "The home responded promptly, and I have felt better since new plans have been put into place."
• Staff understood their roles and responsibilities and expressed confidence in the management. They told us they felt well supported. Supervision sessions were carried out regularly with staff.
• Regular staff meetings were held to shape the delivery of care and gave staff an opportunity to express their views and raise any concerns.
• We saw that throughout the visit people were treated with dignity and respect. People were offered choice and they were encouraged to get involved in activities. Staff spoke warmly about the people they supported and could tell us about them and things that were important to them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager was aware of their responsibilities and gave us examples of the actions that they had taken when issues were identified.
• Relatives told us that the management team were open and responsive. One relative told us that they had raised some concerns about their family member and the service had responded positively and addressed the issues. They said, "They listened to me and this is the best outcome I could have had."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider had ensured that there were a variety of different visiting or contact options available for relatives to meet individuals during the pandemic.
• Staff worked with health and social care professionals for the benefit of people using the service, seeking specialist help to support people as required. Visiting professionals spoke positively about how staff engaged with them to promote people's wellbeing.
• Arrangements were in place to gather the views of people who used the service and relatives about their experiences. Questionnaires were sent out at regular intervals and the results collated to identify learning. The results of the most recent survey were positive.
• The manager had ensured that all staff and people living in the service had the information they needed about vaccines to ensure that they could make informed decisions.

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 17 HSCA RA Regulations 2014 Good governance Governance systems were not always effective in identifying and addressing areas for improvement