HC-One No.1 Limited

Amerind Grove Care Home

Inspection report

124-132 Raleigh Road
Bristol
Avon
BS3 1QN

Tel: 01179533323

Date of inspection visit:
08 November 2022

Date of publication:
12 January 2023

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

Amerind Grove Care Home provides personal and nursing care for up to 169 people. At the time of the inspection, 45 people were living at the home.

People's experience of using this service and what we found
The provider had announced before this inspection that they would be closing. People and their relatives were being supported to find other homes that could meet people's needs. Some people had already started to move to other homes.

People living at Amerind Grove Care Home told us they received safe care.
People's care records specified whether people needed staff to support them to change their position regularly. However, the positional change charts in place did not always show that people had their position changed in line with the guidance recorded in care records. The care records for a person with a pressure sore contained a photograph of their wound. However, there was nothing documented on the photo to confirm it was the person, or the date the photograph was taken. Additionally, there was no measuring tool in the photograph. This meant it was difficult to assess the actual dimensions of the wound which would help the staff to monitor healing.

People were protected from abuse by staff who understood how to identify and report any concerns. Medicines were managed safely, and people received their medicines as prescribed. There were enough staff on duty and staff were recruited safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Quality assurance systems were in place to monitor the quality and safety of the home. However, we did identify some shortfalls with record keeping which we feedback at the inspection. This was in relation to medicines records, positional charts and wound care records.

The home was led by a registered manager, clinical lead and a wider management team. There was a clear management structure in place with some long-standing staff in post. The staff told us that morale at the home was low, since the provider had announced the closure of the home. It was evident the staff were committed to providing good care to people despite the challenges they faced. We were told by the provider that they were working closely with staff at the home to ensure that they were being supported during this difficult time.

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 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.

Amerind Grove Care Home

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 Health and Social Care Act 2008.

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
The inspection was carried out by two Inspectors 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.

Service and service type
Amerind Grove Care Home is a nursing 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.

Registered manager
The home had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
Before the inspection we reviewed all of the information available to us, including any information of concern, notifications and the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We spoke with the registered manager, regional quality improvement lead, clinical lead, six staff, nine people who lived at the home and one relative. We observed how staff interacted with people. We considered all this information to help us to make a judgement about the home. We looked at a range of records. This included people's care records, risk assessments, maintenance records, meeting minutes and quality assurance records.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- People's care records specified whether people needed staff to support them to change their position regularly. However, we identified some shortfalls with the completion of records which increased the risk that people could be harmed.
- Positional change charts did not always show that people had their position changed in line with the guidance recorded in care records. For example, the plan for one person was for staff to support them to change position every two hours. However, on some days the records showed periods of up to six and a half hours when the person had stayed in the same position.
- On another occasion, records showed staff had supported another person to move at 10:25 hrs. The next entry was at 21:10 hrs, which meant the person had not been moved for 10 hours. We were told people had been turned but the staff had not updated people's records.
- We were told one person had a pressure sore. We looked at the person's care records. There was a photograph of their wound. However, there was nothing documented on the photo to confirm it was the person, or the date the photograph was taken. Additionally, there was no measuring tool in the photograph. This meant it was difficult to assess the actual dimensions of the wound. The provider's wound plan guidance was, "Photographs should be updated weekly as a minimum. All wounds should be photographed alongside a measure for scale."
- We discussed this with the clinical lead and registered manager during the inspection. They told us they would address this with the staff and nurses. Whilst people had not come to any harm, improvements were needed.

Improvements were required to ensure risks were monitored to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- Risks had been assessed. People's care records provided guidance for staff on how to manage the risks of harm to people. For example, they gave instructions for staff on any equipment that was needed to support people to transfer safely; this included hoist and sling details.
- Some people had been assessed as being at risk of choking. Referrals had been made to the speech and language therapist (SALT) and guidance was available within people's care records. They recorded step by step guidance for staff on how to reduce the risk of choking, such as specialist diet information and information on what to do if somebody did choke.
- People had been assessed for the risk of falls and plans provided guidance for staff on how to reduce the

risk of this happening. For example, the details of any walking aids which people used and whether they needed staff support to move around the environment.
● Some people had been assessed as being at risk of pressure sores. Air mattresses were used to prevent skin breakdown. All the air mattresses we looked at were set correctly.
● Routine safety checks of the building were carried out. We noted some gaps in recorded checks, but we were told this was because the home had been without a maintenance manager for two months. Outside contractors had stepped in to carry out the checks during this time.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to protect people from the risk of abuse. Staff received safeguarding training. They told us what actions they would take if they suspected someone was at risk of harm or abuse.
● Safeguarding alerts were raised externally when required to the local authority and the CQC.
● People appeared comfortable around staff. People confirmed they felt safe. One person for example told us, "I have never felt not safe. I am good, warm and I feel safe."
● The registered manager investigated safeguarding concerns and ensured risk assessments and management plans were in place to keep people safe.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the home was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. The registered manager had a spreadsheet in place. This helped them to manage the different stages of people's applications.

Staffing and recruitment
● The staff told us there were enough staff to support people safely. Their comments included, "Staffing is much better than it was going back a few months ago. Another comment was, "I would say we have enough staff as we are also closing."
● We were told the previous months had been a difficult period of time with staffing. This was due to a high number of agency staff being used to help cover shifts. The registered manager told us that as people had started to move out of the home the occupancy was lower with the staffing ratio kept at the same levels.
● People and their relatives were happy with the staffing levels at the home. Their comments included, "I sometimes need help, they are quite nice and staffing levels seem good" and "Staffing seems better. We have no complaints."
● There was a consistent staff team, many of whom had worked in the home for several years. Staff often worked within the same units with people, so they knew them well.
● Staff were recruited safely. Recruitment checks were carried out before staff were appointed. The registered manager made appropriate checks of nurse's professional registrations.

Using medicines safely
● Medicines were managed safely. Medicines were stored safely in trolleys within locked clinical rooms. The

temperatures of storage areas which included the room and fridge were monitored daily
● Controlled medicines were stored safely. We carried out a random stock check with staff which was accurate.
● Medicines were dated when opened, including topical creams and lotions. This meant staff were aware of expiry dates.
● Some people were having their medicines administered covertly. This is when medicines are disguised in food or drink. People had been assessed for their ability to consent to this and when they lacked capacity, there was documentation in place to show how best interest decisions had been reached.

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 assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider encouraged visitors to the home to reflect the latest government guidance. Visits took place in people's rooms and were no longer pre booked.

Learning lessons when things go wrong
● Incident and accident reports showed immediate action taken and any steps taken to prevent recurrence. When accidents happened, staff followed best practice guidance. For example, falls monitoring took place when people had an unwitnessed fall or suspected head injury.
● Organisational learning took place. Monthly reviews of incidents and accidents took place and lessons were shared with staff.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- Governance reports helped the registered manager, clinical lead and regional quality improvement lead to monitor the quality of care provided to people. However, the governance systems in place had not identified the shortfalls which we have found. Whilst no one had come to harm improvements were needed.
- As we mentioned in the key question safe, we found improvements were needed to some of the records, such as people's position charts, records in relation to the monitoring of pressure sores and of maintenance records.

There were gaps in records and the governance arrangements systems which potentially put people at risk of receiving unsafe care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager was knowledgeable about their responsibilities and of the types of significant events which they were required to notify CQC about. Records showed the home had submitted notifications to CQC where needed.
- An regional quality improvement lead also supported the home and maintained good oversight. They visited regularly.

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

- Staff had created books for people who were moving to their future homes due to the closure. Each person's book contained photographs of events people had been part of and personalised messages from staff.
- It was clear that staff knew people well and had a caring approach towards people. We found the staff to be caring and attentive of people.
- It was evident from speaking with the staff that morale was low. It was a challenging time for people and staff since the news was announced of the closure.
- One staff member told us, "The news of the closure has not changed the focus which is us all caring for people. We all love the residents here very much. It is a challenging time and the morale is terrible". Another staff member told us, "The staff are feeling drained, sad and worried about people moving from here".

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
● Effective systems were in place to ensure staff were kept up to date with key messages and updates. Handover meetings took place at the start of every shift and provided an opportunity to communicate important information about people's wellbeing.
● Daily heads of department meetings took place. We were told these were useful to attend and kept each department updated with key changes at the home.
● Staff meetings took place with the managements team. Recent meeting had been centred around the homes closure programme. It was clear from reading the meeting minutes that the provider had shared information with the staff.
● Some staff we spoke with felt the provider had not engaged enough with the staff team. We gave feedback to the management team about this. They told us that as much information had been shared with staff as possible. What they were not able to do was to give a firm closure date or give staff their notice period. This was to ensure the closure was not rushed and that safe staffing levels were maintained.
● The senior management team and human resources staff were also on hand to support the staff and had visited the home.
● Continuous feedback from people and their families was sought. Relative's meetings were held. In the past the meetings were an opportunity to discuss any forth coming changes planned at the home and to feedback about the care.
● Due to the home's closure it was evident that the recent meeting was centred around this. Information was shared with relatives.

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; Working in partnership with others
● Incident reports and root cause analysis reports were reviewed. We saw correspondence between the provider and family representatives which showed the provider was aware of their responsibility in relation to duty of candour.
● The home worked with a range of professionals in order to support people. For example, records showed people were reviewed by the GP, nurse practitioner, tissue viability nurse, SALT team, physiotherapists and chiropodist.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to safely monitor and manage risks. This left people at risk of receiving unsafe care and treatment.

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 provider had failed to implement a robust governance system which did not identified the shotfalls in providin safe care to people. This left people at risk of receiving unsafe care.