Heathfield Care Homes Limited

Croft Manor Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 1 and 4 July 2016. Croft Manor Residential Home provides accommodation for up to 28 people who require personal care. During the inspection 26 people were being accommodated. On the second day of our inspection one person arrived for a short stay.

The service had 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 and associated Regulations about how the service is run.

Staff understood the principle of keeping people safe and were aware of the associated policies and procedures regarding safeguarding. People's risk assessments were not competed or detailed to ensure staff were aware of all the risks associated with people's care. Staffing levels met the needs of people, with the home having a long standing static staff group. Staff received supervision and there was a training programme in place to ensure staff were supported in their roles. Recruitment checks had been completed before staff started work to ensure the safety of people. Medicines were administered and stored safely.

There was a lack of understanding regarding the Mental Capacity Act and people's records did not show people's capacity to make specific decisions had been assessed. This meant people did not have their mental capacity assessed and restrictions may have been placed on people without their agreement and may not have been in their best interests. People enjoyed their meals and were offered a choice of refreshments around the clock. People were supported to access a range of health professionals.

People did not always have their needs planned in a personalised way, which reflected their choices and preferences had been considered. This meant staff may not always have the best information on how to meet an individual's needs and preferences. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations of these concerns, however the outcome of complaints had not been recorded.

People felt the staff were caring, kind and compassionate. The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the registered manager and providers and were clear about their roles and the values of the home. Records were not always accurately maintained and this was not an effective part of the quality audit process. Notifications were being submitted as required.

We found breaches in four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff had an understanding of how to safeguard people.

Risks regarding people's care had not always been identified and risk assessments were not always in place to mitigate the risk.

Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staffing levels were planned to ensure the needs of people could be met.

Medicines were safely stored, administered and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a good knowledge of the Mental Capacity Act 2005, restraint and of the need for best interests decisions.

Staff received training and supervision to ensure they had the knowledge and support to meet people's needs.

People received support to ensure they ate a balanced diet.

People were supported to access a range of health care professionals.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who respected their

privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care which was in line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and provider operated an open door policy and staff were encouraged to share concerns and make suggestions.

The quality assurance process did not identify or address all the issues needed.

Croft Manor Residential Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 1 and 4 July 2016 and was unannounced. One inspector and a specialist advisor in nursing and the care of frail older people, especially those living with dementia, carried out the inspection.

Before the inspection, we reviewed previous inspection reports, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.
The service was last inspected in June 2014 and at this the service was found to be compliant with the regulations looked at.

Before the inspection, the provider completed a Provider Information Return (PIR). 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.

During the inspection we spent time talking to ten people, two visitors, seven members of care staff, the registered manager and the nominated individual of the provider. We looked at the care records of seven people and staffing records of four members of staff. We saw minutes of staff briefings, policies and procedures, compliments and the complaints log and records. Policies requested were sent to us following the inspection. We were given copies of the duty rota for a month, which included the week of the inspection, and a copy of the training plan.

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 observed interactions between people and staff. We received written feedback from two health and one social care professionals.

Requires Improvement

Is the service safe?

Our findings

Staff had knowledge of safeguarding people at risk and had received training to support this. When asked, staff were aware of the policies regarding safeguarding and where to locate these. They were aware of which agencies should be informed if they had any safeguarding concerns. People felt safe and were confident staff would raise any concerns if they reported they did not feel safe. One person told us, "I feel safe here. They have strict rules for who can come in".

Risks relating to people's care had not always been identified, which meant people did not have appropriate risk assessments in place to ensure staff knew how to care for people safely. For example one care plan recorded that the person may want to go home and could get, "Very cross and upset when they are told they could not live in their home anymore." During the inspection we witnessed this person become distressed and asking to go home. The care plan did not include a risk assessment and gave no clear guidance to staff on how they should approach this situation to minimise the risks for the person.

For another person we noted they had lost a considerable amount of weight, but his had not been identified as a risk. There was no risk assessment in place to identify this weight loss and ensure staff were aware of the risks associated with this for this person and how they could take steps to minimise these risks.

In another example the care plan referred to a person being unable to use the alarm call bell system. Whilst this posed a clear risk for this person there was no risk assessment and no detail of how the risks were to be mitigated and managed. During this inspection we found this person on the floor and had to alert staff as they were unaware the person had fallen. Staff responded appropriately but there was no risk assessment in place to explain the risks and say how these would be reduced.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people and staff we spoke with told us there was sufficient staff on duty to meet the needs of people. One person told us their needs were met but said about the staff, "They are always so busy they don't have time to talk". We witnessed staff respond to people in a timely fashion, and alarmed pressure mats and call bells were answered quickly. There was evidence of regular dialogue between the registered manager and provider regarding the safe staffing levels. The registered manager told us they could increase the staffing levels if people's needs changed. The duty rota's demonstrated there was a regular staff pattern followed. The shift patterns were staggered to ensure there was always enough staff to meet people's needs. There were six care staff on duty in the morning, four in the afternoon and three at night.

Recruitment records showed relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded.

Medicines were managed safely. Medicines were kept in a locked trolley secured to the wall inside a locked room. Spare stock was held securely in locked cupboards and the provider had a good stock control. The recording of medicines was safe, except for a small error regarding the pages of the controlled medication, but this was resolved whilst we were still inspecting. Medicines were stored appropriately in a locked refrigerator, the temperature of which was recorded daily and was within the required limits. Topical medicines in people's rooms all had an 'opened date' on them which was good practice. Two senior carers told us they had received medicines training within the previous twelve months and they both said they had competency assessments with the manager on an annual basis.

Requires Improvement

Is the service effective?

Our findings

Staff had a basic knowledge about mental capacity and how it affected people who lived at the home. 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.

There was a lack of understanding regarding the application of the MCA. People's records contained a mental capacity assessment but there was no individual decision specific mental capacity assessments. For example where people had sensor mats or bed rails in place these had not been considered a restraint. People's capacity to agree or disagree to these decisions had not been considered. The home used several stair gates, which are a form of restriction, but capacity assessments had not been considered as this equipment had not been considered a potential form of restraint. Some people's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were signed by relatives; however their records showed they did not have Lasting Power of Attorney for Health. This meant they may not have had the legal authority to sign these forms on behalf of other people.

The lack of assessment of people's capacity and having regard of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had an understanding of the Deprivation of Liberty Safeguards and some staff had received training to support their understanding. Applications to deprive people of their liberty had been made to the local authority responsible for making these decisions; however these had not been chased to ensure people were not being deprived of their liberty illegally. The provider has confirmed following the inspection they have chased up these applications.

The provider had a training programme and all staff were expected to complete all identified training. A training matrix was available which showed which staff had completed which training. The registered manager told us if there was any training outstanding for staff members this would be discussed with them at their supervision. Staff told us they found the training good and equipped them to do their jobs. Staff told us if they wanted to do any specific training which was not currently available they would be supported to find and attend this training. A staff member told us, "I have had such a lot of training it is difficult to remember it all but I do feel well trained and competent and professional and proud of my standard of care".

People thought staff looked after them well and had the necessary skills. Staff told us they felt supported in

their roles. Staff supervision had started on a regular basis and all staff had an appraisal booked within the next two months. A staff member told us, "Supervision is my time, and I can talk about the things that are important to me, it is not just a manager's list of what I have done wrong or could do better". Another staff member said, "The manager is really supportive and so supervision is conducted in the same way, to help me give the residents the best care I can and be happy at the same time".

Staff had an induction period where they would be paired with more experienced staff for their first shifts to ensure they got to know the people they would be supporting. The Registered manager informed us new staff worked towards gaining 'The Care Certificate'. This is the standard employees working in adult social care should meet before they can safely work unsupervised. It gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

We observed people having meals at breakfast, lunch time and during the evening meal. The breakfast meal was particularly unhurried and people had a choice about the time they ate and whether it was in the dining area. The dining tables were laid attractively and people chatted with one another and engaged warmly with staff. We saw most of the meals were presented attractively and the staff took care to offer people choices about what they wanted to eat. This applied even when people chose to eat in the lounge.

Staff offered people a range of cold drinks and hot beverages during and after the meals. They were attentive and created a pleasant atmosphere chatting to people and assisting those who required it. We noted that the people who were supported to eat were helped in a respectful manner with staff sitting next to them and taking sufficient time for people to eat their meals in an unhurried way.

There appeared to be plentiful amounts of food available. There was a drinks trolley which also had a selection of snacks which was available during the day and the night. The chef told us about the different types of food available for people with special dietary requirements and how these were prepared. They told us all food was prepared using fresh ingredients and if people did not like what they had ordered they could have any other meal cooked freshly for them. The chef showed us the vision cards they used which included pictures of different types of meals from which people could make a choice.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records. A relative told us if they wanted a GP to visit that was arranged that day, they also told us their relative saw a chiropodist regularly.

Good

Is the service caring?

Our findings

People only had good things to say about the caring nature of the staff. One person told us, "They make you feel at ease. Staff are kind and you can do as you like. The staff work very well together, they take it very seriously". Staff spoke to each person by their first name and had a good understanding of the importance of supporting people as individuals. One member of staff told us, "This is the resident's home, it is not our place of work, we just come here to support people who live here just as much as if we were community carers going into their homes. We treat this as their home because it is, so we have to ask their permission to go into their rooms and every carer does". Another member of staff said, "I love working here with these residents, they are all very special people, all different and I have great respect for them all. This is a wonderful place to work with a great team".

People told us they were encouraged to be as independent as possible, for example, to dress themselves as far as they could. One person told us they preferred to spend a lot of time in their room but staff would always knock on their door before entering. We observed staff knocking on people's doors and waiting for a response before entering a bedroom. When they entered a room they asked permission from the person before undertaking any tasks such as cleaning or any care or support function. This showed the staff respected people's space and their rights to regard their bedrooms as their own and not just part of a workplace.

We observed respectful and caring interactions between staff and people. Staff took great care to ensure people received the care and support they required and went out of their way to spend time with people. They made great efforts to ensure people had the food they enjoyed and supported them in ways that at times were exceptional. The staff were clearly dedicated and very skilled in the care they provided. However, this high standard was not quite maintained throughout the two days of our visit although the care remained on the whole at a very good standard of kindness. This was more to do with a lack of skills of the staff on duty rather than a lack of a caring nature, when we observed an interaction with one person which was not reflective of other interactions we had observed.

Overall staff showed an interest in people as individuals and asked their opinions about events in the news and other topical issues. They also asked them about important events in their lives and family events that may be in the future. Staff were quick to respond to people's needs and most staff had a gentle and pleasant manner. They smiled at people a great deal and were affectionate in a professional way towards them.

Requires Improvement

Is the service responsive?

Our findings

People were assessed before they moved into the home and were encouraged to look around the home before moving in.. From these assessments people had care plans developed. It was not possible, from the way care plans had been written, to establish whether people had been involved in the development of their care plans. Care plans had the same format and tended to include information in the same areas, rather than being individual to each person's needs and preferences. There was some information in people's care plans about their lives and their preferences but these were stand-alone documents and were not widely used throughout the care plans. As a consequence care plans were not significantly personalised.

We found people's records did not include important information and whilst being reviewed on a regular basis the reviews did not include relevant updated information regarding people's current needs. For example, one person's care plan had three care summaries each of which provided different information about the person's care needs. Their vision was recorded on one summary as 'partially sighted', 'wears glasses' and another referred to them as 'blind'. The lack of clear information meant it was difficult for staff to know how to meet the person's needs in a responsive way.

We observed one person becoming distressed and trying to leave the home. This person's care plan gave very little information on how staff should support the person when they became distressed. Staff told us and records showed this behaviour happened on a regular basis. No consideration had been given to identifying the triggers for this behaviour which would have been essential in order to meet the needs of the person. As a consequence the person became more distressed and staff did not know how to support the person.

In another example we saw the person's care records identified they lived with diabetes. Records showed they had lost a significant amount of weight. In six months they had lost 7.15 kg, with their last weight recorded in June 2016. The person's MUST (Malnutrition Universal Screening Tool) which is a five step screening tool to identify adults who are at risk of malnutrition, had not been updated since the end of December 2015. The person's care plan and reviews gave no indicators of the weight loss or of how staff should support the person with this. This placed the person at risk of increased effects from the diabetes or of any other condition associated with their weight gain

Two people were being treated for urinary tract infections (UTI'S) and a third person had a history of repeated UTI's. Only one of these people had a fluid balance chart. (Several factors are linked to the development of UTI's in older people, one of these is dehydration. For this reasons a preventive care plan is essential and one that includes attention to regular and maximum fluid intake based on each person's unique needs). For the one fluid balance chart there was no daily target intake and the daily amounts were not totalled. This meant it was not possible for staff to monitor people's intake and understand if people were having sufficient fluid especially in the light of their infection. There was no guidance for staff about what fluid amount would be beneficial for people. This meant people were not receiving personalised care in terms of meeting their needs when they had a UTI.

Pain assessments were not routinely used for people to ensure they received adequate support regarding their pain. The provider used 'as and when necessary' (prn) protocols for most medications. We observed one person had oedematous legs, (swollen) when a staff member moved the person's other leg the person cried out and asked the staff member to stop as it was "hurting". We asked the staff member if they were on any pain control. We were told the person had been prescribed prn medication for pain but had not had any that day. When we looked in their daily records we saw the person's GP had been contacted because the person had, 'painful and swollen legs'. Staff already knew the person was in pain but there was no guidance on how this should be identified or measured and staff had not thought to offer pain relief pain until we alerted them.
People told us they did not have a bath as often as they liked. The recording of baths showed a mixed picture with some days no baths being recorded whilst on other days four people were given a bath.

The care and treatment of people was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were given the choice of joining in activities. Activities in the home were carried out by an external agency. They provided one activity five days a week and on some of these days two activities were provided. There was a timetable for the week on a notice board which showed various activities. Weekend activities were listed as 'Tea in the lounge'. People told us they could access the garden when they wanted.

We noted a few concerns over the way activities were provided. On the first day the external activities provider walked into the lounge and without asking people immediately turned the television off. Some people had been enjoying watching the tennis on the television, but they were not asked about this. The activity of music was set up with pleasant banter. One person who was able left the room as the singing started and another became restless and complained about the "noise". On the second day the entertainment was again very loud and another person told us it was too noisy for them .For this reason it is important individual preferences, abilities and impairments are considered prior to any large group activity being provided. This is part of good care of people living with dementia and some physical impairments.

The registered manager kept a log of all complaints and compliments which had been made. People and visitors told us they could tell staff if they had any concerns and they were confident staff would act on the information. When complaints were made these were investigated and a record was maintained. However from the records maintained it was difficult to establish the outcome of the complaint. The registered manager was able to tell us this information and agreed it would be best to record this in the future.

Requires Improvement

Is the service well-led?

Our findings

There was not an effective system in place to monitor the quality of care people received. Whilst there was a record of incidents and accidents we noted not all incidents had been investigated which meant some of these were missing from the overall analysis at the home. For example, accidents and incidents were sometimes recorded on the person's daily record or on a body map but had not been included in the overall analysis.

For one person, their daily record showed they were "Very agitated and disruptive". A body map for the person on the same date showed they had "Bruise noted lower arm" and two days later "Graze to head un-witnessed". During this time a professional visit and documented "? UTI". These factors together may have been important information had they been compared and used to review the care for this person. This meant there were missed opportunities to identify future risks and possibly prevent a recurrence of incidents in the future.

Pressure wounds and other skin damage are a major issue in care home environments and there is a requirement to monitor and report to the Commission skin wounds of a certain level of seriousness – known as Grade 3 and above. However, there were no skin integrity care plans in use at the home which meant it would be difficult to know the grade of people's pressure ulcers and for there to be preventative guidance for staff to follow and monitor the progress of skin injuries. Each care plan contained sheets about how to recognise pressure wounds but not the guidance to prevent them. This issue could have been identified by care plan audits.

The failure to ensure there were effective systems to monitor the service to drive improvement and ensure there was learning was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

All feedback from people staff and visitors was of a positive nature. A member of staff told us this was the best home they had worked at as relationships between staff and management was good and everyone got on well together. Staff told us the manager was supportive and they felt the service was well led. Staff had positive attitudes and these were reflected by the attitude of the registered manager.

A registered manager was in place at the time of our inspection. People and staff described the registered manager positively. The nominated individual of the provider also spent time in the home and it was clear there was a good relationship between the provider, registered manager, staff and people. The registered manager told us he often applied the 'Mum Test', which meant ensuring the care provided was good enough for one's own relatives. Staff talked about providing a 'Home to Home service', reflecting this was people's home and they were there to ensure people were provided with a homely, safe environment. There were reports from the provider showing they had spent time talking to people on a one to one basis. Where issues had been raised the provider had followed these through. For example, if someone had stated there was not an item on the menu this was discussed with the chefs at the home. Meetings for staff took place and staff told us they felt they could raise issues with the registered manager and providers. There were copies of

meetings between the provider and registered manager where there was an open agenda. The registered manager told us he found the providers very supportive. The last staff meeting was in October 2015, and minutes showed this had been a relaxed meeting with the providers. There had been lots of individual discussion with people and the providers had involved people with regards to choosing the fabric for some new furniture.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person centred. Regulation 9 (1) (a) (b) (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of assessing people's mental capacity and regard to restraint in regards of the Mental Capacity Act. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk assessments in place to ensure the safety and welfare of people. 12 (1) (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure there were effective systems to monitor the service to drive improvement and ensure there was learning. Regulation 17 (1) (a)