Countrywide Care Homes Limited

Croft House Care Home

Inspection report

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20 August 2021
23 September 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Croft House Care Home is a residential care home, providing personal and nursing care for up to 68 people. There are three separate units within the home providing residential, nursing and dementia care. At the time of inspection there were 54 people living at the service.

People's experience of using this service and what we found
Infection prevent and control (IPC) risks were not always effectively managed. People were at risk of cross infection due to best practice guidelines not always being followed.

Risks to people's health and safety were not always safely assessed, monitored and managed. People were at increased risk of harm as a result of dietary needs not being effectively managed and errors being made when utilising skin integrity equipment.

There were not always enough staff safely deployed within the service to meet people's needs. Staff did not feel supported within their role.

Systems and processes to monitor the service had not been effective in assessing, identifying and addressing areas requiring improvement. Feedback was not always obtained and lessons learned from accidents and incidents were not consistently identified and used to make improvements to the service.

People's privacy and dignity was not consistently maintained. We made a recommendation that the provider monitors practice in this area.

People were safeguarded from the risk of abuse. The provider reported incidents to the relevant authorities.

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

Rating at last inspection (and update)
The last rating for this service was inadequate (published 23 February 2021). The service remains inadequate for the second consecutive inspection.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 18 December 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing, privacy and dignity and good

governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains inadequate. 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 Croft House Care Home on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing and good governance at this inspection.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Croft House 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 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
Three inspectors and an Expert by Experience carried out this inspection. 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
Croft House Care Home 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 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. Inspection activity started on 20 August 2021 and concluded on 23 September 2021. We visited the service on 20 August 2021.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who use the service and fifteen relatives about their experience of the care provided. We spoke with eleven staff members including the regional director, nurses, carers and housekeeping staff.

We reviewed a range of records. This included three people's care records, multiple medication records and health and safety records. We looked at three staff files in relation to recruitment, induction and supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed a range of records relating to the management of the service, including policies, procedures, training and supervision data and quality assurance records. The evidence review was concluded on 23 September 2021.

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last inspection the provider had failed to prevent and control the spread of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risks in relation to infection prevention and control (IPC) were not always effectively managed. This placed people at increased risk of cross infection.
- Staff did not always wear face masks in line with guidance. Some staff wore masks under their nose and were observed to be touching their masks.
- Personal protective equipment (PPE) was not always stored appropriately, for example, masks and gloves were left open to airborne particles.
- Best practice in relation to entry to the service was not always followed. Neither inspector was asked to complete a visitors screening questionnaire in relation to COVID-19 upon arrival. This was against the providers policy.
- Aspects of cleanliness required improvement. There was an odour of urine in one part of the service and equipment was not always clean, for example, one person had a dirty falls mat.
- Relatives expressed concerns regarding cleanliness of the service. Feedback included; "I feel [name's] room is often untidy as I find dirty cups and plates left around," "There were dirty cups and a very bad smell in [name's] room," and "In one cup I found dried milk."

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess risk and monitor people's safety. They had failed to ensure people's dignity was maintained. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had made some improvement in relation to privacy and dignity and was no longer in breach of regulation 10 however they remained in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

- The provider did not always ensure risks to people's health and safety were effectively assessed,

monitored and managed. This placed people at increased risk of harm.
● At the previous inspection airflow mattresses, used for people with skin integrity needs, were not set correctly. This remained the case at this inspection. Three people had their mattresses set for the incorrect weight, against the requirements set out in their individual charts. This placed people at risk of developing and/or deteriorating pressure sores.
● People's dietary needs were not safely monitored or managed. The service had a whiteboard in place which identified six people needing thickener in their drinks. There was no information regarding the thickener dilution. This increased the risk of errors being made and placed people at increased risk of choking.
● Environmental disrepair placed people at increased risk of falls. For example, there were gaps in the flooring on the residential dementia unit. Two people on the unit were walking around with no footwear.
● One person had a call bell attached to the wall however there was no lead attached for them to press in an emergency. This meant that there was an increased risk to their safety if an incident occurred.

The provider had failed to assess, monitor and mitigate risks to people's health and safety at the service. This placed people at increased 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.

The provider responded immediately during and after the inspection. They confirmed actions had been implemented to address the highlighted risks.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

The provider remained in breach of regulation 12 for preventing and controlling infection and assessing risk, safety monitoring and management, however enough improvement had been made at this inspection and the provider was no longer in breach for management of medicines.

● Overall, medicines were managed, administered and stored safely. Records showed people received their medication as prescribed.
● Stock checks were completed. There were two minor errors found regarding stock counts however there was no impact to people, and these were rectified immediately.
● Staff were knowledgeable about medicines process and procedures. Regular competency checks were completed to ensure safe medicines management.

Staffing and recruitment
● There were not always enough staff effectively deployed to meet people's needs, particularly on the residential dementia unit.
● Buzzers to alert staff were sounding frequently. We observed that staff looked stretched and continually completing care tasks with minimal time for meaningful interaction.
● There was one activity staff member on for the whole service. There was no time for the staff member to provide meaningful engagement in activities.
● The service used a high number of agency staff to cover vacancies and absence. Staff told us; "There are too many agency staff they don't have the same level of commitment," and "We have a lot of agency staff. They don't always turn up or arrive on time."
● People, relatives and staff felt there were not enough staff to meet people's needs. One person told us, "At

the moment the staff are working flat out." Relative feedback included; "I do not think there are enough staff to look after [name]. Care staff are run ragged," and "I have concerns over the staffing levels." Staff feedback included; "We are always understaffed all the time," and "We do our best, but we can't be in two places at once. It wouldn't be good enough for my family because there aren't enough staff."

The provider had failed to ensure there were sufficient staff deployed to meet people's needs effectively and in a timely manner. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse;

At our last inspection the provider had failed to ensure systems and processes at the service were effective in safeguarding people. The safeguarding systems in place did not recognise where people's dignity and respect was not maintained. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

● The service had policies and procedures in place to safeguard people from abuse and protect them from harm. Safeguarding incidents were being reported to the relevant authorities.
● Staff were trained and had good knowledge regarding safeguarding procedures and how to protect people.

Learning lessons when things go wrong
● Accidents and incidents were not always monitored to learn lessons. A breach was identified in this area, details are documented within the well-led section of this report.

Inadequate

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 inadequate. At this inspection this key question remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection the provider had failed obtain feedback from people and learn lessons to improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Thirteen relatives told us that they had not been asked for feedback on the service.
- There was no evidence meetings were taking place with people living at the service prior to the inspection.

- Some people and relatives had given feedback via a survey in September 2020. There was no evidence of action planning or improvements being made following this.
- Lessons learned from accidents and incidents were not consistently identified and used to improve the service.
- Lessons learned were not shared with staff during supervision or staff meetings.

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

- Governance systems and processes were not effective in assessing, monitoring and improving the service.
- The service was rated inadequate at the previous inspection. At this inspection repeated concerns were identified regarding infection prevention and control (IPC), airflow mattress settings, monitoring and management of people's dietary needs, environmental risks, service improvement and management oversight. The systems in place had failed to identify these concerns.
- Audits in place were not always robust and lacked detail regarding action plans, progress and completion. There was no evidence of management oversight of these.

This is further evidence of a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● Staff did not consistently receive supervision and appraisals. There was limited evidence of staff meetings taking place. One staff member told us, "I can't remember the last time I had supervision."

● Staff did not feel supported in their role and did not feel supported by the registered manager. Feedback included; "No one asks how we are," and "I feel supported by colleagues. Not by management."

● Relatives did not always know who the registered manager was. They felt the registered manager was not engaging. Feedback included; "Since the new [registered] manager started I feel the service has extensively deteriorated," "I don't know who the registered manager is," and "I have never met [the registered manager]. They haven't introduced themselves on any of my visits. I don't even know their name."

● The service did not always work effectively in partnership with other services to make improvements to the service, for example, the local authority IPC team.

This is further evidence of a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

● People's privacy and dignity was not always maintained and attended to in a timely manner. One person was encouraged to sit in the dining area, by a staff member, although the person did not have appropriate clothing in place to maintain her dignity. This was highlighted to the staff member who took action to address this. There was a delay of 30 minutes before the person had their needs met and were able to return to their meal.

We recommend the provider monitors practice at the service in relation to maintaining privacy and dignity of people.

● Staff were kind and caring towards people. One person told us, "Staff here are so lovely and kind." One relative told us, "The carers look after [name] well."

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 service was open and honest with people and relatives when things went wrong. Information was appropriately shared with the local authority safeguarding team and CQC.

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's needs effectively and in a timely manner. 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 ensure risks to people's health and safety were effectively assessed, monitored and managed. The provider had failed to ensure that equipment used was being used in a safe way to meet people's needs. The provider had failed to effectively manage risks in relation to infection prevention and control (IPC). 12 (1) (2) (a) (b) (d) (e) (h)

The enforcement action we took:

Issue warning notice.

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 Governance systems and processes were not effective in assessing, monitoring and improving the service. The provider had failed to assess monitor and mitigate risks relating to the health and safety of service users. The provider had failed to obtain and utilise feedback and learn lessons to improve the service. Regulation 17 (1) (2) (a) (b) (e)

The enforcement action we took:

Issue warning notice.