

Queensland Care Limited

Homecroft Residential

Home

Inspection report

27 Victoria Avenue
Ilkley
West Yorkshire
LS29 9BW

Tel: 01943608062
Website: www.queenslandcare.co.uk

Date of inspection visit:
25 October 2018

Date of publication:
29 November 2018

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

Homecroft Residential is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home houses up to 26 people in one adapted building with a garden to the front of the property.

The inspection took place on 25 October 2018 and was unannounced. At the last inspection in November 2016 we rated the service Good. At this inspection we found the quality of the service had deteriorated. We found medicines were not consistently managed in a safe way and the quality and format of care plan documents and risk assessments needed improving. The service had had three managers in the last 12 months and needed stable management to ensure consistent policies, procedures and systems were established.

A registered manager was not in place. 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. A new manager had been in post for two weeks. We found the new manager to be open and honest with us. They had recognised many of the issues we found during the inspection and were in the early stages of improving the service. We felt assured that they would continue to improve the service over the coming months.

People and relatives said they felt people received good care and were safe. Systems were in place to protect people from abuse. Most risks to people's health and safety were appropriately assessed although this was not consistently the case. The new manager was in the process of reviewing the risks each person was exposed to, to further improve the service. Medicines were not consistently managed in a safe way as all medicines were not robustly accounted for.

There were enough staff deployed to ensure safe and appropriate care, although improvements were needed to the availability of ancillary staff such as cleaners, cooks and activities staff to optimise the function of these roles. Some staff training was out of date although a plan was in place to address this.

Overall, people's nutritional needs were met by the service. People had access to a choice of food and people told us it was tasty. Where the service was reviewing people's fluid input, this needed reviewing on a daily basis to ensure people were getting enough to drink.

Overall, the service was compliant with the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was sought before care and support was offered.

Staff were kind and caring and treated people well. Staff knew people well and engaged them in

conversation. People's views and choices were listened to.

People said they received appropriate care that met their needs. People's healthcare needs were assessed and the service worked with a range of professionals to meet those needs. The quality and accessibility of care plans needed improving to fully evidence people had an up-to-date assessment of their needs. Some activities were provided but more interaction and stimulation was needed at times.

We made a recommendation relating to ensuring the service reviewed how accessible information was to people who used the service.

People said the management team listened to them. People's complaints were responded to, but there was a lack of evidence that lessons were always learnt from complaints.

People and staff praised the new management team and said they were approachable and supportive. The new manager was aware of the areas that needed improving and had a plan in place to address. Audits and checks were undertaken, these needed further developing to ensure they were consistent and thorough.

We found one breach of regulation. You can see what action we asked the provider to take at the back of the full version of this 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 consistently safe.

Medicines were not managed in a safe way as not all medicines could be accounted for and guidance to support the safe administration of "as required" medicines was not in place.

Most risks to people's health and safety were assessed and appropriately managed, although this was not consistently the case.

There were enough staff to ensure safe care and support. Some improvements were needed to ancillary staff availability such as cleaning and activities staff.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Some staff training and supervision needed bringing up-to-date. Policies and procedures needed updating.

People praised the food on offer and there was suitable choice. Better oversight of people's fluid input was needed.

People had access to a range of health professionals and their advice was incorporated into plans of care.

Is the service caring?

Good ●

The service was caring.

Staff were kind and caring and treated people well. The staff team had developed good relationships with people and knew them well.

People were treated with dignity and respect by staff.

People's views and opinions were listened to and acted on.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People said care needs were met by the service. Care plans needed reviewing to improve their quality and make them more accessible to people.

Some improvements were needed to ensure people had access to a good range of activities and social opportunities.

The service needed to consistently log all complaints and use these as an opportunity to improve the service.

Is the service well-led?

The service was not consistently well led.

Improvements were needed in a number of areas for example to medicine management and care planning. The service would need to ensure a consistent management team to help drive the required improvements.

People, relatives and staff praised the new manager and said they were approachable and were improving the service.

Audits and checks were undertaken and these were being further developed to improve governance systems.

People's feedback and experiences were important to the new manager and were being used to improve the service.

Requires Improvement 

Homecroft 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 inspection took place on 25 October 2018 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed information available to us about this service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also spoke with the local authority commissioning and safeguarding teams to gain their feedback about the service. We also received feedback from a healthcare professional who worked with the service.

During the inspection we spoke with eight people who used the service, two relatives and four care workers including senior carers. We also spoke with the new manager, deputy manager and cook/activities co-ordinator. We reviewed three care plans, medicine records, and other records relating to the management of the service such as training records, audits and checks. 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 the mealtime experiences, activities and how staff interacted with people throughout the day.

Is the service safe?

Our findings

Medicines were not consistently managed in a safe manner. Stock control processes were not in place to ensure all medicines were accounted for and to verify people had received their medicines as prescribed. We completed a random check of boxed and 'as required' medicines and found these did not always tally up with what had been carried over from the previous month. For example, one person was prescribed a medicine every three months. The person's records indicated two doses were in place. We found the medicines box contained three doses. Another person was prescribed several doses of warfarin to be taken at different times of the day. However, there was no record of amounts carried over from the previous month. This meant there was no way we could reconcile if the amount contained in each medicines box was correct. Although the MAR had been signed, we could not be confident the person had consistently received the correct medicine dose. We spoke with the manager who had already identified the same concerns. We saw they had printed off medicines stock count sheets ready to be implemented.

Protocols were not in place for 'as required' medicines to include in what circumstances medicines should be given, side effects to be aware of, what the medicines were for and how much should be given. We spoke with the manager who was aware of this and had plans in place to introduce these. This demonstrated a lack of complete records in relation to each person's care and support.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered by staff who were trained in the safe management of medicines and had their competency assessed. Medicines administration records (MARs) were in place and were completed indicating people had received medicines as prescribed, or the reasons why medicines had been omitted were documented. We observed part of the morning medicines round and saw the person administering medicines did so in a very calm and patient manner, gently explaining what the medicine was for and waiting with people to ensure they took their required medicines. Arrangements were in place to ensure people received time specific medicines at the correct time.

Most medicines were securely stored in locked cupboards in people's rooms. However, this meant the person administering medicines was required to visit the person's bedroom, remove the medicine to take to where the person was sitting, which could be downstairs in the lounge, in order to administer the medicine, then take the medicine back to lock away in the person's bedroom. This was a very time-consuming task which impacted on staff availability, particularly during the morning period. The manager told us they were planning on changing the system.

Overall, we found there were enough staff on each shift to provide people with care and support, however improvements were needed to ancillary staff availability such as cleaners, cooks and activities staff to ensure the function of these roles was optimised. People said they did not have to wait for care and support. Staff told us sufficient staff were deployed to keep people safe although one staff member told us an extra staff member would ensure people received timely care and support at peak times, such as mornings. The

manager and deputy manager told us they were already looking at how staff deployment could more effectively cover these periods. All staff we spoke with told us staff helped to cover for sickness and annual leave to keep agency staff use to a minimum, although some agency staff were used at night time. This meant people were mostly supported by consistent staff. Due to a lack of cleaning staff, care staff were having to provide cover and although the cook did a shared activities and cooking role, there had been fewer activities due to having to provide more cover in the kitchen. Recruitment was ongoing to address these shortfalls.

Safe recruitment procedures were in place which helped ensure staff were of suitable character to work with vulnerable people. This included checks on staff backgrounds and previous employment.

People were protected from abuse and improper treatment. People said they felt safe in the home. Staff had received safeguarding training and understood what actions to take if concerned about people's safety. All staff told us they would report any concerns to their line manager and were aware of other bodies they could speak with, such as the local authority safeguarding team and CQC. We saw during the inspection staff were vigilant in checking people were safe and protected from harm. Where incidents had occurred, appropriate liaison had taken place with the local authority safeguarding team and action had been taken to keep people safe.

In most cases, risks to people's health and safety were assessed and appropriate plans of care put in place however this was not consistently so. Staff knew people well and the risks they were exposed to which gave us assurance people were cared for safely. Risk assessments were in place which covered areas such as falls, mobility and skin care. However, one person had displayed recent behaviours that challenge, but their risk assessments had not been updated to provide guidance to staff. We spoke with the management team about the need to update this and involve other professionals to help in the risk assessment process.

Overall the premises was safe and suitable for its intended purpose. A maintenance worker was employed who ensured the building was kept safe and well maintained. Key safety checks took place such as to the fire, gas, electrical and water systems to ensure they were safe. We identified possible risks associated with two external fire escapes leading from people's bedrooms which had not been considered through risk assessment. Measures were taken to assess these risks and introduce new control measures immediately after the inspection. A fire risk assessment had been completed by a specialist contractor and recent improvements had been made to the building following the findings. Staff received fire training and periodic fire drills were carried out. Personal Emergency Evacuation Plans (PEEPS) were in place for people who used the service.

Staff had access to, and utilised gloves and aprons appropriately to prevent the risk of cross infection. Most areas of the building were clean and tidy. We identified an odour in one bedroom. This had already been identified by the manager with plans in place to replace the carpets in three bedrooms. Some bathrooms were also cluttered for example with incontinence pads, we raised this with the manager so it could be addressed.

Incidents and accidents were logged, investigated and analysed on a monthly basis to look for any themes or trends. We saw action had been taken following incidents to keep people safe.

Is the service effective?

Our findings

People's care needs were assessed prior to admission and then used to formulate plans of care.

We found policies and procedures needed updating in line with the latest guidance, best practice and legislation to promote effective care. For example, to ensure guidance such as National Institute for Health and Care Excellence (NICE) was followed, and policies were in place to ensure compliance with the General Data Protection Regulation (GDPR) and Accessible Information Standard (2016).

Some improvements were needed to the provision of staff training and support. Staff received an induction to the service to ensure they became familiar with the service's working practices. We saw training was up to date for new staff who had transferred to Homecroft from another provider. However, some staff training for established staff required updating. The manager showed us evidence of having enrolled these staff on a two-day 'fundamental skills for care' face to face training to ensure all staff were fully trained. Staff we spoke with were positive about the training opportunities available to them. Although some supervision and appraisals had taken place, the manager told us they were aware of the need to reintroduce these on a more regular basis.

People living at Homecroft were offered a choice of hot food at breakfast, lunch and teatime. For example, although some people preferred cereal and/or toast for breakfast, other people enjoyed choices such as poached eggs on toast or bacon and egg sandwiches. At lunchtime, two main options were available as well as choices of desserts. The cook told us they were determined to ensure those who had special diets still had a good, tasty option. For example, they ensured those who had soft diets received tasty fork-mashable food and they had introduced options such as hot diabetic puddings and cakes for people to enjoy. They told us, "I try to make things as tasty as possible within the nutritional guidelines." They showed us a list they had of people who required a specific diet, such as diabetic or soft diets. Most food we saw cooked on the day of our inspection was freshly prepared on the premises, including cakes. Foods were supplemented with fresh cream, full fat milk and butter where required. There was a four-weekly rotating seasonal menu which had just been introduced.

We observed the mealtime experience and found it a relaxed and unhurried experience, with people and staff chatting together. People told us they had enjoyed the food on offer. Comments included, "We get some good meals. Very tasty. I have lots that are my favourites", "I don't think you'd get a better meal than that. Beautiful", "It's always warm when we get it" and "We get plenty of food. It's good." Food looked nicely presented and nutritious. We tasted a sample of the food and found it to be very tasty. We identified some areas for improvement when observing mealtimes. A staff member approached someone who was at risk of poor nutrition and having their food input monitored and removed their half-eaten plate of food at lunchtime without attempting to encourage them to eat more, saying, "You've done quite well." Staff later explained that the person had 'good days' and 'bad days' with their food consumption. However, they agreed a more consistent approach needed to be taken. We also found one person was not offered a drink until after they had eaten their breakfast whilst sitting in the lounge in the morning.

People assessed 'at risk' nutritionally were referred to the GP or dietician and supplements were prescribed where required. Some people were having their fluid intake monitored. However, these were not reviewed to flag up where people had not received enough to drink. For example, on the day before the inspection, staff had only recorded giving one person 490ml. This had not been reviewed or investigated.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

Two people had DoLS in place with no conditions and others were waiting assessment from the local authority. Staff had received training in MCA/DoLS and staff we spoke with understood what this meant. The manager understood their responsibilities under the Act and was aware of the need to assess each person's capacity individually to ensure referrals were made appropriately.

Care records showed most people had capacity assessments in place demonstrating care decisions were made in people's best interests. For example one person was receiving medicines crushed up in their food. We saw clear best interests processes in place to support this which included evidence of discussions held with the GP, nurse, relative and pharmacist. However, we identified one person had bed rails in place and another person had a sensor mat in place, these had not been subject to best interest decisions, showing an inconsistent application.

Care records contained information about people's LPAs (Lasting Power of Attorney). An LPA is a legal document that allows the nominated person to make decisions for you, or act on your behalf, if you're no longer able to, or if you no longer want to make your own decisions.

We saw staff sought people's consent before providing care and support. For example, the staff member administering medicines on the day of our inspection asked people if it was okay for them to do this.

People's health care needs were supported. Care records evidenced people had access to a range of health care professionals including GPs, dentists, podiatrists, district nurses and chiropodists. The service worked with health care professionals to ensure appropriate plans of care were in place in relation to people's health and welfare. We did find one person who had behaviours that challenge should have been offered a mental health assessment, this was actioned by the manger during the inspection.

Work was being undertaken to improve the environment. For example, on the day of the inspection flooring was being replaced in the toilet areas with other work due over the coming weeks. Most areas were very pleasant for example bedrooms were highly personalised and nicely presented and the dining room had been tastefully decorated. Plans were in place to make the garden area more secure to maximise people's ability to enjoy it.

Is the service caring?

Our findings

People and relatives praised staff and said they were kind, caring and treated them well. One person said "Staff are nice, food is nice, they are all lovely." Another person said "What lovely staff." A relative said "Marvellous, no fault in the home at all. They even look after me. All good staff." A health care professional told us, "Staff are lovely. They seem to care about the patients. People are generally well looked after and well dressed."

We observed care and support and saw people were consistently treated in a positive way by staff. We heard one person telling staff, "You are lovely." A staff member replied, "That's very kind. You are too." Staff complemented people on their appearance and patiently supported people when mobilising, taking care not to rush them. Staff engaged in conversation with people whilst helping with care tasks, making for a friendly and kind atmosphere. We saw a staff member having a chat with people about the films they could watch, explaining each of them in a clear and thoughtful way. They had arranged for one person to have a local paper from the town they were from, showing a person-centred approach. People looked well cared for, relaxed and comfortable in the presence of staff.

The new manager clearly cared about improving the experiences of people in the home. They had worked hard in the limited time they had been in post to make people's lives better. This included taking action to get areas of the building redecorated and ensuring people had new duvets and mattress protectors to make their rooms more pleasant.

Staff we spoke with knew people they supported well and were able to give examples of how they provided care and support to each person. We saw them talking to people about topics that were important to people. People had information recorded about their lives and history in their care files to help staff better understand them.

People said staff treated them well and respected them. We saw staff knocked on people's doors before entering and asked people's consent before assisting them. Staff adjusted people's clothing to maintain their dignity and talked clearly and respectfully to them.

People said there were no restrictions on visitors and people could visit whenever they liked. People's were listened to. For example, they were given choices as to what to drink and eat and whether they wanted to join in in the activities. However, care records needed to better evidence people's involvement in the creation and review of their care and support plans.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the manager, staff, people and relatives showed us discrimination was not a feature of the service. For example, different diets were provided to cater for diabetics and vegetarians and people were supported to maintain their faiths.

Is the service responsive?

Our findings

People and relatives praised the care people received, they said it was appropriate and met individual needs. We saw liaison took place with professionals to ensure the right care. For example, in sourcing equipment to reduce the risk of pressure sores, although, at the time of inspection there were no pressure sores in the home. One person had been admitted to the home with one that had healed following the provision of appropriate care.

People's care needs were assessed but the quality and accessibility of care records needed improvement. People's needs were assessed prior to admission to ensure the service could offer the support they needed. Following admission, a range of care and support plans were put in place, these covered areas which including mobility, social activities, medicine management and personal care. Some plans needed more details for example personal care plans needed details of people's bathing and showering arrangements. Care plans were presented in different formats which made it challenging to find information on people's needs. They also lacked accessibility to people who used the service. For example, three people's care records were stored in each lever arch file, meaning each person didn't have an easy to access, confidential care file. It was not possible for people and/or their representatives to quickly view information on their care needs.

Daily records of care and support were kept. However, when we looked at some people's records, there was a lack of evidence they had been offered regular baths and showers. The manager had introduced a new task sheet to ensure these were robustly monitored going forward.

Care plans were evaluated monthly, however evaluations often stated "no changes" rather than evaluating the success of people's care and support arrangements. One person had lost weight however their nutritional care plan had been updated with "no changes" demonstrating the review had not been accurate.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service asked people about their future wishes and produced end of life care plans to help support people at the end of their lives. The quality of these varied. We saw new end of life care documentation was being introduced to rectify this.

We looked at what the service was doing to meet the requirements of the Accessible Information Standard 2016. People's communication needs were assessed during admission and care plans put in place to meet their needs. However, there was no accessible information standard policy in place and staff and management had not received training in the subject. We spoke with the registered manager about the need for this to ensure the service reviewed its performance against this standard. We found some documents such as care plans and the lunchtime menu were not very accessible to people who used the service. At lunchtime we heard one person ask the staff member what the options meant since they did not

understand the food description.

We recommend the service looks at ways to ensure information is presented in an appropriate format for people.

We observed that more interaction and activities were needed with people at times particularly in the mornings. One staff member said "There could be more activities, not been too much going on today." A limited range of activities currently took place, mainly in the later afternoon when the activity co-ordinator was available. This was due to them covering extra shifts as cook due to staff sickness. However, they told us they would be able to spend more time on activities once another staff member returned and they had ideas for future activities such as trips out, bird watching and a book club. Staff ensured a couple of people who enjoyed the open air were supported to go for a walk on a daily basis. Two volunteers were due to start at the service once their DBS checks had been finalised. They had assisted at the manager's previous service with activities such as yoga and flower arranging. We saw during our inspection some people watched old films during the late morning and early afternoon. Later in the afternoon, a number of people enjoyed preparing poppies for Remembrance Day with the activities co-ordinator, listening to wartime poetry and taking part in a quiz.

People said they were happy with the home and found the new management team approachable. We saw there was a willingness from the new manager to address any concerns or issues people had. We found some practices relating to the management of complaints needed improvement. For example, we found evidence not all verbal complaints had been logged appropriately as complaints and therefore it was difficult to see what action had been taken to improve the service. A low number of formal complaints had been received. Whilst people had been responded to, it was not evident whether lessons had always been learnt from these.

Is the service well-led?

Our findings

A registered manager was not in place. The previous registered manager had left in August 2018. A new manager was now in post who told us it was their intention to apply to become the registered manager for the service.

In April 2016, we reported that lack of continuity of management was a long-standing problem, within the service with frequent management changes taking place. This was still a feature of the service, with three managers being in post during the last 12 months. We found that many systems and processes were disjointed, with the quality and format of documentation such as care records varying dependant on when and by whom they were completed. There were a number of areas that needed improving in the service for example medicine management systems, training compliance, communication and care documentation. The service would need to ensure a clear improvement plan was created and implemented by a consistent management team to help achieve a consistently high performing service.

The new manager was supported by a deputy manager. They were open and honest with us about the current quality of the service and the improvements they needed to make. Many of the issues we identified during the inspection had already been identified by the manager. We felt assured that if they remained in post, these improvements would be actioned. Everyone we spoke with praised the management team and said they were approachable and listened to any concerns.

Staff said that morale had improved and they praised the approach of the new management. One staff member said "Things are going really well. [Manager] is making improvements." Another staff member said "Much more organised now." Most staff told us they would recommend the service to people. One staff member said, "In six months time, I think it would be a definite yes."

Policies and procedural documents were in place but were not always kept up-to-date. The registered manager had recognised this and told us they planned to put in place a new system of policies based on up-to-date guidance and best practice. This would help improve working practices in line with the latest guidance.

Audits and checks were undertaken by the service for example of the environment, infection control, medicines management and care plans. The new manager was looking to develop these further. For example, care plan audits did not provide clear evidence that actions had been signed off. The manager told us they were going to reorganise how care plan audits were completed once an electronic care record system had been introduced in the next few months.

Staff and resident meetings were periodically held, although a staff meeting had not been held since 2 August 2018 and a resident meeting since 9 May 2018. The new manager had plans in place to make these meetings more regular. People's and staff views had been obtained through an annual survey and further engagement through these methods were planned. We saw the manager had engaged with people and staff to determine areas that needed improving in the home. For example, in making environmental improvements and replacing bedding and sheets.

The service worked in partnership with other agencies such as district nurses, the local pharmacy and GPs. The manager told us they had fostered good relationships with other agencies, including the local authority, at their previous service and they were looking forward to maintaining and building on these at Homecroft. However, they acknowledged and were aware more work needed to be done to improve communication with the local district nursing team. This was confirmed by a member of the district nursing team we spoke with.

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 (1) (2c) An accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was not always in place.