Heritage Care Limited

The Croft

Inspection report

The Penningtons
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Croft is a residential home situated in Amersham, Buckinghamshire. The home provides accommodation and personal care for up to 60 people. This service does not provide nursing care. At the time of our inspection there were 51 people who used the service. The home is divided into four units, each with their own lounge and dining area.

At the time of our inspection there was no registered manager in post. 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.

The home was overseen by the service's regional manager, who visited the service four days every week. There were also two deputy managers who supported the regional manager. The provider was actively recruiting for a registered manager to run the home.
Our previous inspection carried out in December 2015 found several breaches of the Health and Social Care Act 2008 and associated regulations. We asked the provider to take action to make improvements to the management of medicines, meeting people's social needs, investigating when people were found to have unexplained bruising and ensuring systems were in place to control and prevent infection. We carried out this inspection to see if the provider had made improvements and was meeting the current Regulations. We consider the provider had made significant improvements in previously breached Regulations. However, there were continued ineffective systems for the management of medicines. We have made a recommendation of the implementation of robust auditing to identify shortfalls.

People's feedback about the home was mainly positive. One person told us, "Staff are kind especially [staff name]. The food's not bad. We have exercises and all sorts of things." A visiting professional told us, "The staff here are kind and considerate".

People were safeguarded from abuse and neglect as staff demonstrated good knowledge of what to do if they suspected someone had been inappropriately treated. The provider reported instances where this had occurred to the local authority.

Staff had received training in safe handling of medicines and were competency-assessed to support them in the role. However, medicines were not always managed effectively. Staff had received training in areas such as mental capacity, infection control, moving and handling and safeguarding.
Regular supervisions did not always take place. However the regional manager was in the process of putting in place more robust procedures to ensure staff had supervisions on a regular basis.

People's privacy was maintained and they were treated with respect by staff who knew the people they supported well. Staff appeared kind and considerate with people they supported. We saw several acts of kindness during our visit. For example, one person decided they did not want to sit in the dining room eating

their lunch. Staff ensured the person was safely escorted back to their room at their own pace. The home had several agency staff at the time of our inspection. However, the agency staff had worked at the home for a continuous period of time and demonstrated they knew people well. One relative told us, "I don't know the difference between agency staff and permanent staff; they are all good".

Care plans and risk assessments did not always reflect current needs and in some cases instructions had not always been followed. For example, instructions from the district nurse were not always followed. We found one person did not have a risk assessment for self-administration of their medication. Involvement with people in terms of care plan reviews could not be identified. One person told us they had never seen their care plan.

Activities were planned and people were encouraged to participate. However, some people told us the activities were not to their liking, and at times boring. However, we were aware the home was encouraging members of staff to take part in conducting activities for people. One member of staff we spoke with had recently been appointed to do this. They were enthusiastic and motivated to carry out this role.

The atmosphere in all the units we visited was warm and welcoming and people were happy and content. Staff did not rush people, people were able to sit chatting with each other following lunch or sit quietly in the lounge reading or watching the television.

There were systems in place for monitoring and auditing to enable improvements in the quality of care. However medicines audits had not identified stock control. We noted several items of medicines were out of stock.

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.

Risks were not always appropriately assessed. Guidance for staff to manage risks was not always provided.

Medicines were not always managed effectively.

Staff did not always follow correct procedures for the administration of people's medicines.

Is the service effective?

Good

The service was effective.

Induction procedures were robust and appropriate for new members of staff.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and people's choices were respected.

Supervisions did take place, but these were not always on a regular basis.
However, this was being addressed and systems were being put in place to ensure continuity.

Is the service caring?

Good

The service was caring.

People's views were sought through regular meetings.

Staff knew people well and provided support with kindness and compassion.

Relatives were encouraged to visit on a regular basis.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always follow instructions from professionals. Care plans were not always reviewed with people and their families.

Activities were provided for people who lived in the home.

People's views were sought through regular meetings and surveys

Staff knew people's abilities and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager.

Audits did not highlight where improvements could be made and were not always carried out on a regular basis.

The Croft

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 28 and 31 October 2016 and was unannounced.

The inspection team comprised of one adult social care inspector and a specialist advisor. A specialist advisor has experience in a specific area of care. The specialist advisor was a registered nurse specialising in older people's mental health.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. We reviewed the Provider Information Return (PIR). A PIR 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.

In order to gain further information about the service we spoke with four people who used the service, a visiting healthcare professional, eight members of staff, the deputy managers, the regional manager, and the activity coordinator. We contacted four relatives following our visit.

We looked throughout the home and observed care practices and people's interactions with staff during the inspection. We reviewed eight people's care files and the care they received. We observed the administration of medicines on three of the units and looked at the medication administration records on each of the units. We checked some stock of medicines including controlled medicines. Some prescription medicines are controlled under the Misuse of Drugs legislation1971. These medicines are called controlled medicines or controlled drugs. In addition, we reviewed records relating to the running of the service such as audits, training records, staff personnel files, complaints and compliments and minutes of meetings.

Observations where they took place were from general observations.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection the provider was not meeting regulations by undertaking investigations when unexplained bruises were found on people's bodies. Having ineffective deployment of staff. Insufficient systems for preventing and detecting the spread of infection and not managing medicines safely. We found the provider now had a robust investigation procedure in relation to unexplained bruising where it occurred. Staffing arrangements were now managed safely, senior members of staff offered additional assistance during busy periods. The provider had a robust cleaning schedule in place to monitor the cleanliness of the home. However, medicines were not always being managed safely.

People said they felt safe living at the home. One person told us, "The staff here are very caring I have only one concern. They do not have the time to stay with me until I finish my medicine". Another person told us, "I am supposed to have my tablet before food, but they give it to me with food, so I have to wait until I have digested my food to take it. I have tried explaining this to them and the doctor says that I am not allowed to take it with food." Following the inspection we were informed by the provider that this issue had been raised with the GP. The medicine was now being given before food.

We observed the administration of medicines during our inspection. The correct procedure for safe administration of medicines was not always followed. For example, we found a member of staff signed the medicine chart before they observed the person take the medicine. This put the person at risk if they refused to take the medicine. Other members of staff may have mistakenly believed the medicine was given when in fact it had been refused. We spoke to the member of staff about this and they told us they knew this was not safe practice. They continued the rest of the medicine round following the correct procedure and only signed the medicine administration record (MAR) when people had taken them. We were also aware another member of staff left a tablet in a person's room on their table without it being in a medicines container. This put the person at risk of not taking the tablet and also a poor infection control practice.

During our inspection we found one person self-administering their medicine without a risk assessment in place. We checked the person's medicine and found it to have expired some time ago. We spoke to staff and the regional manager about this and they told us they would ensure the risk assessment for the medicine was put in place and order a new supply of medicine for the person. We noted the medicine to be spray which was used for chest pain. However, there was no evidence in the person's care plan that they person suffered with chest pain. We spoke with the person about their medicine and they told us they use the spray when they need it. When we spoke with staff about the person's spray for their chest pain they were not able to confirm if the person suffered with chest pain or if they used the spray. We spoke with the regional manager about this and they assured us this will be looked into with immediate effect.

We also were aware of several items of medicines out of stock. These were mainly creams for fragile skin conditions and analgesia. This put people at risk of not receiving adequate pain relief or having their skin condition deteriorate by not having their prescribed creams.

This is a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

We found most risk assessments were in place to ensure people's safety. However, from some identified risks we could not always see clear guidance for staff to follow in the care plans. For example, one person had a behavioural care plan in place. The risk assessment and care plan did not identify potential triggers or guide staff how to manage challenging behaviour appropriately. One entry stated the person was 'rude' however, there was no information why the person became rude or what staff should do when this happened. However, when we spoke to staff they could clearly give examples of positive de-escalation techniques used to support the person. This demonstrated that staff knew people they were supporting well, but the care plans and identified risks did not always confirm this.

The provider followed robust recruitment procedures. Interview records demonstrated prospective staff members' employment histories were reviewed as part of the recruitment process. Disclosure and Barring Service (DBS) checks were completed before staff were appointed to positions within the home. We could see evidence of agency staff training details and induction procedures when they first worked at the service. Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character.

The service ensured there were sufficient numbers of suitable staff to keep people safe and meet their needs. During busy periods senior staff offered additional assistance as required.

Policies and procedures about the safeguarding of adults accurately reflected local procedures and included relevant contact information. Safeguarding information was displayed in the home to ensure people, relatives and visitors could raise issues outside the service if they wished. Staff we spoke with all said they would not hesitate to report any concerns to the appropriate person.

Good

Is the service effective?

Our findings

During our previous inspection the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). People had restrictions placed on them without evidence that the MCA had been followed in accordance with regulations. We found the provider was now meeting this regulation. We saw evidence that mental capacity assessments had been carried out to determine people's capacity. Any restrictions placed on people were in their best interest. We saw decisions had been made in the person's best interest with the relevant professionals involved.

We found during our last inspection supervisions with staff was not being carried out on a regular basis. During this inspection we found supervisions continued to be irregular. However, we were aware the provider was in the process of putting systems in place to ensure all staff had regular supervisions.

People told us staff had the skills needed to meet their needs. One person told us, "They seem to know what they are doing". Relatives we spoke with told us, "Staff were competent and know what is what. They will always contact us if anything changes."

Staff we spoke with told us the training was good and they had the skills that enabled them to meet people's needs effectively. Staff had attended training in relation to safeguarding of adults, manual handling, and infection control and had opportunities to attend additional training, such as end of life training and blood sugar monitoring.

One newer member of staff told us that their induction was detailed and informative. Another member of staff told us they had recently attended training in blood sugar monitoring. They said the results of blood sugars they measured were given to the community nurse when they visited people in the home to monitor their diabetes. This demonstrated working effectively with professionals involved in the care and support of people in the home.

Some staff told us they felt supported in their role and had regular supervisions. Others said they did not feel supported. Staff comments included, "It's been hard here; I can't remember when my last supervision was. We do not really have a manager now, but it does not matter, the support is the same. It's so busy. We just know our job and just get on with it". We were aware the regional manager was in the process of ensuring a robust method of monitoring staff supervisions was put in place to ensure the continuity of supervisions for all staff.

We observed staff assisting with care duties during the medicine round. This is the key activity in the medicine use process and it is the point at which there are many opportunities for error.

We recommend staff administering medicines are not disturbed and focus on the administration of medicines before assisting with daily care tasks.

The MCA provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Act requires 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 interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People's consent to care and treatment was sought in line with legislation. The members of staff we spoke with demonstrated a good understanding of the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

People were supported during meal times. We saw staff assisted people who required support to eat and drink in a sensitive and dignified way. People were offered a choice of meals and any dietary requirements were catered for. Mealtimes were relaxed and people were able to remain at the dining table as long as they wanted. Relatives were able to join their family member for a meal at their request. We saw relatives included in the lunch time meal during our inspection.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required.

Good

Is the service caring?

Our findings

People provided mainly positive feedback regarding the caring nature of staff. One person told us, "I like it really. Staff are kind, especially [name of staff]. Everybody is kind." One family member told us. "I can't fault it at all. I do not know the difference between agency staff and the regular staff. They are all good".

We observed staff communicated with people in a warm, friendly manner. They showed caring attitudes whether conversations were outwardly meaningful or not. We observed relationships between staff members to be courteous, professional and friendly. All staff we saw enjoyed their work, including the domestic member of staff who was cheerful and busy. One member of staff told us, "We are a very good team; I will always speak positively about the home". We spoke with another member of staff who had worked at the home for many years. They told us, "I love it. I am coming back tonight to do a night shift."

People told us their privacy and dignity was respected. We observed staff knocked on people's doors and waited to be invited in. Throughout the inspection it was noted that staff were not rushed in their interactions with people. We saw staff chatted to people and supported them to engage in activities.

Although staff were busy, we observed staff to be compassionate and caring. One person commented, "You can see they are busy. They never have time to stop for a chat. I sometimes feel lonely, but I know they care". One member of staff commented, "We know that people are vulnerable, and we take great time to minimize this".

People in the home looked smartly-dressed and well cared for. Staff knew people well and were able to explain people's individual likes and preferences in the way they were supported. The home used agency staff due to difficulty in recruiting permanent staff. However the provider tried to ensure the same agency staff are used to ensure continuity of care.

People were able to personalise their rooms with photographs and ornaments they brought in from their own home. One person enjoyed art work and had various paintings they had painted displayed in their room. Memory boxes were outside people's rooms with various items of their past to remind them of things that were important to them. The service supported people to exercise choice, independence and control, wherever possible. One member of staff told us, "We try and encourage them to do as much as they can."

People had care plans in place for end of life preferences that enabled them to be actively involved in making decisions about their care, treatment and support. We saw people had discussions around their end of life wishes. In addition do not attempt resuscitation (DNAR) orders were in place in people's files, after this was discussed with the GP and families.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection the provider had not ensured there were activities available to meet people's social and emotional needs. The provider now had an activity programme in place with a full time activity coordinator and additional assistance from a member of the care team. In addition assistance from college students was in place to offer support with activities and to accompany people during visits to places outside of the home.

We had conflicting information about people and their relatives' involvement in their care reviews. One person told us, they had never seen their care plan. Relatives we spoke with were not sure if they had been involved in a review of their family member's care plan. Whilst a member of staff told us they had regular reviews with families. We asked one relative if they had been involved in their family members care plan reviews and they told us, "Not that I know of". We could not see evidence of reviews in the care plans we looked at. However, we could see that staff had regularly updated care plans or when people's needs changed. We spoke with the deputy manager about care plan reviews and they said it is sometimes difficult to get families to come in and discuss their relative's care plan.

When necessary health and social care professionals were involved in people's care and support needs. We saw a visiting district nurse attended to a person's clinical needs during our visit. The nurse told us staff 'do their best' but do not always follow instructions. For example, one person had swelling in their legs following a fall. The nurse had given staff instructions to ensure the person had their legs elevated to reduce swelling. We saw that the person did not have their legs elevated during our visit. We spoke with a member of staff working on the unit and they told us the person refuses to have their legs elevated. However, there was no documentation in the person's care plan or daily notes to reflect this.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the service. People's views were sought through meetings and surveys. People told us there were regular meetings and they were encouraged to discuss any aspect of the home. Comments from one person were, "We have meetings every three months, where I can discuss anything". There was an annual survey for people and families to comment how they felt about the service. In addition, a relative's forum was available for families to contribute and have their say on how the home was run. A comments box was displayed at the front of the home for people and staff to share their thoughts and suggestions. None of the people we spoke with had any complaints about the service. People told us they would first raise concerns with staff. We were not aware of any complaints about the service.

People were supported to take part in activities. The home employed two activity coordinator's. We saw a weekly timetable of activities was available. People we spoke with had mixed views about what was offered to them in terms of the activities. One person told us, "We have activities and all sorts of things going on". Whilst another person said, "I find them patronising for grown people. They need to talk to me and see what I like. They also do not have enough staff to do this, and the staff look bored, but want me to be interested". We observed an activity on the second day of our inspection. We saw people disengaged with the activity

coordinator and most of the time the activity coordinator talked with a member of staff. We spoke with the regional manager about this and they noted our comments and told us they were 'working on it'.

The home recently welcomed and facilitated students in the process of completing their social care courses. The students offered additional assistance with activities and trips out. All of the students had Disclosure and Barring Service (DBS) checks and were closely monitored by the student's college placement officer. The students would offer quality time with people in a relaxed manner as the students were not responsible for other tasks and daily duties.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection we found audits were not effective in monitoring the quality of care. Where shortfalls were identified there were limited examples of action plans to ensure improvements were made. The provider had made some improvements in this area, however, care plan audits had not identified that some risk assessments were not in place. Medicine audits had not identified stock control. We were aware the provider was in the process of making improvements to ensure a more robust auditing procedure was in place.

The service did not comply with their conditions of CQC registration. The previous home manager left their post in August 2016. They did not become the registered manager.

The service's regional manager was overseeing the home since the previous home manager left, and visited the home four days each week. The regional manager had support from a deputy manager who had worked at the service for several years and a relatively 'new' deputy manager, who was appointed in July 2016. The management team worked cohesively to ensure the smooth running of the service and to ensure the period of uncertainty for people and their families was reduced. The service was keen to appoint a new registered manager as soon as possible. During the inspection, two applicants were interviewed at the service in an attempt to fill the vacant manager position.

People told us, "I don't know who the manager is". Relatives said "It's all very confusing we are never sure who is in charge". One member of staff told us although they don't have a registered manager they know what to do and feel they are supported. However, another member of staff said. "There is no support and not enough communication". We spoke with the regional manager and the deputy managers during feedback about the management structure. They told us the exit of the person who they had hoped would become the registered manager had caused uncertainty and they were aware work still needed to be done. However, with the appointment of the new deputy they felt this was a time of positive change to drive improvements and put new systems in place to ensure better quality of care.

We were aware of improvements that were already made to the service since our previous inspection. One relative told us, "They have bucked their ideas up. They are going in the right direction. The new deputy manager comes round to see everyone on the unit every day which is really good."

The service was open and transparent and had a well-developed understanding of equality, diversity and human rights. The regional manager had notified CQC about significant events, as required by the Regulations. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

We saw staff appeared settled and worked together as a team. The atmosphere in the home had improved significantly since our last inspection. The appointment of new senior staff with vision and motivation had commenced improvement of a positive workplace culture. The new deputy manager told us, "I know where we want to be". They told us they were enthusiastic about the new challenges their role presented. We were

aware they had already put improvements in place with a relatives' forum and a newsletter to keep people informed of events at the home. One family member told us, "The monthly magazines are good; You can catch up on what's going on."

We reviewed the home's audits. These included care plan audits and medicines audits. Although audits were carried out, they did not always identify shortfalls. For example, the last medicines audit was carried out in June 2016 and did not identify insufficient stock of medicines. The care plan audits did not highlight that some risk assessments were not in place and that some people's end of life wishes were not documented. We spoke with the regional manager about the completion of audits and they told us they were aware the medicines audit was not carried out for several months. However, they stated the service was putting systems in place to address this. The newly appointed deputy manager had extensive previous experience in this area and we were aware plans were in place for them to undertake the completion of robust auditing to ensure any shortfalls were highlighted.

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 12 HSCA RA Regulations 2014 Safe care and treatment There were insufficient quantities of medicines to ensure the safety of service users and to meet their needs. Staff did not administer medicines appropriately to make sure people were safe.