Countrywide Care Homes Limited

Croft House Care Home

Inspection report

High Street
Gawthorpe
Ossett
WF5 9RL

Tel: 01924273372

Date of inspection visit:
18 December 2020

Date of publication:
23 February 2021

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 provides nursing and residential care for up to 68 people. There are three separate units within the home providing residential, nursing and dementia care. All bedrooms are single occupancy with en-suite facilities. The home is situated in its own grounds with car parking facilities in the village of Gawthorpe. At the time of our inspection there were 60 people using the service.

People's experience of using this service and what we found
Infection prevention and control (IPC) practices were unsafe because staff were not using personal protective equipment (PPE) correctly which increased the risk of infection transmission. Part of the home was awaiting redecoration, but it had already had wall paper and paint work removed. This meant the walls could not be sanitised to manage the risk of infection transmission.
The safe administration of medication was not consistent in the service. There was a heightened risk of medication errors due to the systems in place. A lack of oversight meant audits weren't effective and correct medication practices weren't followed.
People were not always treated with dignity and respect. The support some people received in regard to their nutrition and hydration did not promote their dignity or treat the person with respect.
People felt safe living in the service. People appeared to be relaxed and comfortable in the service and people had a good rapport with staff. Staff knew people's preferences and staff had good interactions with the people using the service. People and their relatives spoke positively about the staff, service and the care people received.

Audits were not robust and did not identify issues affecting the safety of comfort of people who used the service. Where issues had been identified, these were not consistently acted upon.
Staff did not receive manager supervision in line with the provider's policy.
Staff had been recruited safely and all training was up to date. Staff knew what to do to raise concerns and there were regular staff meetings where updates were provided and any issues of concern could be discussed.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service were in place but the service did not follow this practice.

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

Rating at last inspection
The last rating for this service was good (published 30 October 2017).

Why we inspected
The inspection was prompted in part due to concerns received about a COVID-19 outbreak at the service. Furthermore, there had recently been a specific incident where someone had died at the service. This

incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

Following the inspection, the provider had taken timely action to provide additional support at the service to ensure the safety and wellbeing of the people using the service. This has mitigated some of the risk identified at the inspection.

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 regulation 10 (dignity and respect), regulation 12 (safe care and treatment), regulation 17 (good governance), regulation 18 (staffing) and registration regulation 18 (notification of other incidents) at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore 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 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
One inspector and a specialist advisor who had expertise in Infection Prevention and Control practices conducted the inspection.

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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service plus seven members of staff including the registered manager, the deputy manager, the quality assurance manager, care practitioner, two care assistants and a domestic member of staff.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with five members of staff and four relatives. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
• The service was not safely preventing and controlling the spread of infection.
• People were not consistently screened for COVID-19 on arrival to the service and "track and trace" information was not obtained.
• People were at risk of infection transmission through the medication round. For example, a medication trolley was not cleaned before administering medication, the dispensing member of staff did not change their PPE or sanitise their hands for the duration of administering medication. Hand sanitiser was unavailable on the trolley. The two medication rooms were had debris on the side and staff were unable to wash their hands due to items being stored in the sink.
• Staff could not safely put on and take off PPE as this was stored in people's rooms. Staff needed to cross the room to collect the PPE. This exposed people to risk of infection transmission. There was also no hand sanitiser along the corridors of the service or bins for staff to dispose of PPE.
• There was structural damage on the first floor where the service is awaiting a refurbishment which has been delayed. The first floor had exposed plasterwork and removed wall paper. These surfaces could not be effectively cleaned and decontaminated.
• Staff, including senior members of staff, were not effectively wearing PPE. Staff did not sanitise their hands effectively, change their mask or change aprons in line with guidance.
• The concerns were shared with the provider who took immediate action to ensure the safety of the people living at the service.

This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Using medicines safely
• Medicines were not stored or dispensed safely.
• People were at risk of missing medication or being given incorrect medication due to the systems and lack of oversight of the medicines procedure. When we inspected, one person's medication could not be found by the dispensing member of staff. It was ultimately found by the registered manager after this being raised by the inspection team.
• There were gaps in staff knowledge in relation to using the electronic medication system. This resulted in unsafe practices such as one person's medication had run out of date in their "dossett box", there was a hand-written note to remove the out of date medication. This was not recorded on the persons electronic medication record. This increased the risk of medication errors.
• Handovers were not robust where important information was not handed over regarding those people who required medication "as required". This placed people at risk of not being given the correct medication.

This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Systems and processes to safeguard people from the risk of abuse
• The service had some systems and processes to protect people from the risk of abuse but these were not always effective.
• Spot checks and quality audits were not completed to monitor the care people received. People were not consistently treated with dignity and respect and the service did not have systems in place to recognise this. Some people were not supported at meal times to eat safely and with dignity and respect.

This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

• Air mattress for people were not reliably set to the correct setting. Staff were unaware of the correct setting and there was no handover or audit to check this. To work correctly air mattresses need to be set taking into account the person's weight and skin integrity.
• Staff were up to date with their safeguarding training and staff recognised the signs of abuse, neglect. Staff were confident in how to raise a concern. One staff member said "I would go to the manager to report this. [The deputy manager] is very good."
• The service held regular staff meetings where updates would be shared, any issues of concern could be discussed and notes from this meeting with shared amongst staff who were unable to attend. The provider shared updates on a weekly basis regarding any changes in policy or information which affected the service. This was sent directly to staff through an internal email system.

Assessing risk, safety monitoring and management
• The service did not reliably assess risk and monitor people's safety.
• Some people at the service were given a pureed diet. Staff were unclear why these diets were in place and there was no evidence of health professionals recommending a pureed diet. An incorrectly assessed diet can place people at greater risk of harm.
• Some people who required support with their oral care did not have access to tooth paste. There was a lack of knowledge between staff as to how people without teeth needed to be supported with oral care.
• People were not involved in their care planning and people living with dementia were not given choice and control over their care decisions. For people who were assessed as lacking the mental capacity to make a certain decision, the least restrictive option was not always used. For example, we saw people having drinks in a spouted beaker. Staff were unclear why these people needed spouted beakers and there were no risk assessments to detail why people couldn't drink from an open cup.
• Peoples care plans were kept up to date, they were legible and all staff could access and contribute to the care plans. There was no evidence of staff or management questioning the care plans and checking if they were still correct for the person which placed people at risk of harm.

This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staffing and recruitment
• Staff were recruited safely and training was up to date.
• The provider used a dependency tool which tells the service what staff mix is required to safely meet people's care needs.

Learning lessons when things go wrong
• The service did not learn lessons when things went wrong.
• The service had experienced several significant events which would require an internal investigation and consideration of lessons learnt to ensure any mistakes were identified to avoid repeated incidents in the future. There were no lessons learnt of these events and this placed people at a high risk of events repeated in future.

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 good. At this inspection this key question has now deteriorated to inadequate. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Managers were not clear about their roles, and did not understand quality performance, or risk and regulatory requirements.
• The majority of staff had not received a supervision in 12 months which was not in line with the provider's policy. The provider's policy state that four supervisions are needed each year as well as an annual appraisal. These did not take place in 2020.
• Staff had a good understanding of the role and responsibilities with one staff member saying, "I love my job."
• IPC audits had been completed with issues being identified but not consistently acted upon. For example, it had been recognised the risk the pending redecoration of the first floor posed but this was not raised in line with the provider's escalation process.
• There was no documentary evidence of spot checks, quality monitoring and a home walk round overview had been completed prior to the inspection. This meant that the registered manager did not check whether staff were delivering good care or check staff knowledge about how to put on and take off PPE correctly and how to santise their hands. For example, staff were not using PPE correctly and staff were unaware of PPE training they had completed. These issues may have been recognised through routine audits and spot checks. As a result, people were at greater risk of harm due to poor practices not being rectified.
• The concerns were shared with the provider who took immediate action to ensure the safety of the people living at the service.

Continuous learning and improving care
• The service did not promote continuous learning and celebrate success to improve care.
• When things had gone wrong, lessons were not learnt from this and the findings shared with staff to reduce the risk of a similar incident reoccurring. This placed people using the service at increased risk of harm.
• Staff told us the manager was not visible or accepting of new ideas. One staff member said, "[registered manager] wasn't approachable. [Staff] wanted to do different activities with people but [registered manager] wouldn't use the budget to spend on people."
There had been several significant incidents at the service but lessons learnt or practice changes had not been discussed at staff meetings. This meant people's outcomes were not improved

This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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
• Some documentation had been altered to appear that supervisions had taken place in 2020 rather than 2018, when this was not the case.
• The provider did not always act within its legal responsibility to ensure a duty of candour.
• CQC had not been informed of the death of a person using the service.
• The service had informed CQC and the local authority of other incidents.

This was a breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registrations) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The culture was not open or inclusive and did not achieve good outcomes for people.
• There was a lack of oversight and involvement from the registered manager. This meant people's choices and preferences were not considered at a management level. Staff had a good understanding of people's preferences but this was not reflective in the support and response from the registered manager. For example, staff reported a desire to expand the activities or use staff in a different way to benefit the people using the service but this was not acted upon by the registered manager.
• Staff said that the registered manager did not inspire and motivate staff to improve practice and promote person centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager did not engage and involve people using the service and people's characteristics were not considered.
• The manager did not have a visible presence in the service and people using the service were not engaged in the development and improvement of the service. There were no meetings for people using the service to attend, relative meetings or engagement activities such as questionnaires or one to one time to discuss preferences.
• Senior staff attended a weekly meeting to discuss any provider updates and staff meetings took place every two months. Staff found these meetings were productive to receive updates and share ideas, although some staff report these ideas were not acted upon.
• Relatives spoke highly of care staff with whom they had a relationship. One relative said, "[member of staff] is accommodating and helpful. They have time to chat and provide reassurance." Most relatives reported that they had video calls with their relative on a weekly basis however other relatives reported they didn't receive updates from the service if they didn't ring.

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

Working in partnership with others
• The service did not consistently work in partnership with others.
• The service had working relationships with commissioners, the local authority and external healthcare staff. These partnership networks were not always used to ensure the safe care of people using the service. For example, support had not been sought from the Speech and Language Team or Occupational Therapy Team to ensure people had access to the right equipment and dietary plan. As a result, people did not

always receive the right care.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times when they received care. Staff did not always treat people in a caring and compassionate way 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager did not ensure staff had supervision in line with the providers policy to ensure staff competence 18(2)(a).

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure people were protected from the spread of infection through robust control systems 12(2)(h). The registered manager did not ensure people's medication was stored and dispensed safely and in line with it's policy (12(2)(g).

The enforcement action we took:

CQC have issued a warning notice.