CC Croft Manor Ltd

Croft Manor Residential Home

Inspection report

28 Osborn Road
Fareham
Hampshire
PO16 7DS

Tel: 01329233593
Website: www.nursinghomefareham.co.uk

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Croft Manor Residential Home is a care home. People in care homes receive accommodation and nursing or 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. Croft Manor is registered to provide accommodation and personal care for up to 28. At the time of the inspection there were 20 people living at the service, most of whom were living with dementia.

What life is like for people using this service:
We identified significant concerns with infection control procedures in the laundry; these posed risks to people and staff.

People's medicines were generally managed safely; however, the arrangements for managing boxed medicines were not robust.

The quality assurance processes were not robust. They had not identified and addressed the concerns we found during the inspection. Please see the 'action we have told the provider to take' section at the end of the report.

Overall, people were happy living at Croft Manor. They told us their needs were met in a personalised way by staff who were competent, kind and caring.

People's rights and freedoms were upheld. People were empowered to make all their own choices and decisions. They were involved in the development of their personalised care plans that were reviewed regularly.

People felt listened to and knew how to raise concerns. They, and healthcare professionals told us they would recommend the home to others.

The service met the characteristics of Good in three areas and Requires improvement in two areas. For more details, please see the full report which is on the CQC website at: www.cqc.org.uk

Rating at last inspection:
This was the first inspection of the service since it registered with CQC in January 2018. We had not previously rated the service.

Why we inspected:
This was a planned inspection based on our methodology for inspecting newly registered services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was effective.	**Good**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was responsive.	**Good**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Croft Manor Residential 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 as part of our regulatory functions. This inspection checked 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.

Inspection team:
The inspection was conducted by an inspector, an assistant inspector and an expert by experience. 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 Manor Residential Home is a care home registered to accommodate up to 28 people who need support with personal care. 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:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered 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.

During the inspection, we gathered information from:

- Five people who used the service
- Three relatives of people who used the service
- Three healthcare professionals who had regular contact with the service
- Eight people's care records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- A director of the provider's company
- The registered manager
- The deputy manager
- Seven members of care staff
- Two housekeepers and a chef
- The provider's operations manager
- An external activities provider

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection:
• We identified significant concerns with the cleanliness, maintenance and operation of the laundry. The laundry room was in the basement of the home. The walls behind the washing machines were covered in heavy black mould, which was also spreading up the side of adjacent cabinets. As the room was below ground level, a large tank was used to store water discharged from the washing machines before being pumped up into the main drains. The lid of the tank was broken, dirty and covered in mould. The room was heavily cluttered with old cushions and equipment, all of which was covered in dirt and dust. People's clothing was hung adjacent to this clutter and directly above an open waste bin containing used aprons and gloves. There was no system in place to prevent freshly washed clothes and linen from becoming contaminated by dirty clothes entering the laundry or by the dirt and mould present throughout the laundry.
• The only sink in the room was very dirty and heavily covered in limescale; it was also inaccessible due to equipment being stored in front of and in it. Staff told us they washed their hands after handling soiled linen in a ground floor bathroom or in a sink in part of the kitchen. This posed a risk of cross infection if they touched surfaces, such as door handles en-route.
• There were no arrangements in place to clean the laundry room on a regular basis and staff could not tell us when it had last been cleaned. Plaster was coming off the walls in several areas, meaning the surfaces were unhygienic and could not be cleaned.
• Staff told us they "hated" working in the laundry as it was so unhygienic and they felt their health was at risk from mould spores. The registered manager acknowledged that the laundry room had been neglected as there were plans to re-locate it. However, a director of the provider's company was unable to confirm when this would be done and in the meantime, it posed a risk to staff working there and to people whose clothes were washed there.
• Some other areas of the home were not clean. The main bathroom used by people throughout the day was dirty and dusty, including behind the bath where we found spare urine bottles and old socks. In another bathroom, we found a dirty, heavily stained jug that staff said was used to rinse people's hair. The waste bin in the bathroom was not pedal operated, meaning staff had to touch the lid to open it. This posed a risk of cross infection and was contrary to best practice guidance. By the end of the inspection, the first bathroom had been cleaned, the jug had been removed from the second bathroom and the registered manager had ordered new pedal operated bins for the bathrooms and the laundry room.
• A wheelchair being used on the first day of the inspection was not hygienic. The protective covering on one of the arms was perished and the inner foam was coming out. This meant it could not be cleaned effectively.
• Although staff had been trained in infection control techniques, yearly refresher training for three staff members, as required by the provider's policy, was overdue by between one and four years. Therefore, we could not be assured that their knowledge of best practice guidance was up to date.

The failure to operate effective systems to prevent and control the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the second day of the inspection, the damaged wheelchair was taken out of service and a system introduced to check wheelchairs regularly. Housekeeping staff had started to clean the laundry room and had cleared the sink to make it accessible. A cleaning schedule was also put in place for the laundry room.

Using medicines safely:
• Arrangements were in place for obtaining, storing, administering and disposing of medicines in accordance with best practice guidance. However, the arrangements for recording and monitoring the use of boxed medicines was not robust. Staff did not always record the number of tablets in stock and carry this forward from month to month. This meant they were unable to account for the number of boxed medicines in stock at any one time, so would not know whether any had gone missing. We raised this with the registered manager who undertook to implement a more robust system immediately after the inspection.
• Staff had been trained to administer medicines and had been assessed as competent to do so safely.
• Medicines administration records confirmed that people had received their medicines as prescribed. The timing of one person's medicines was critical to their well-being and special arrangements had been put in place to ensure they received these consistently. The timing of another person's medicine had been changed, in consultation with the prescribing GP, to enable them to take it at a time more suitable to their routine; this demonstrated a person-centred approach to medicines administration.

Staffing levels:
• People told us there were enough staff to support them and to meet their needs in a timely way. One person told us staff attended "usually quickly", when they pressed their call bell. When asked if they thought there were enough staff, a family member said, "I think there are."
• Staffing levels were calculated according to people's needs, using a recognised tool. The registered manager told us recruiting sufficient staff was a constant challenge and they had had to reorganise the staffing arrangements recently to ensure enough staff were deployed at all times throughout the day.
• Some staff felt this had caused them to become over-stretched. They said this had not affected the people they supported, but had affected their own well-being. Comments from staff included: "We go home exhausted and with a headache as there's no time to drink. Some days we don't even go to the toilet", "[Since the staffing changes], there's been an impact on staff morale. We are all quite low now, not as happy as we were" and "We don't have time to have a drink or go to the bathroom as it's so full on".
• The registered manager told us they kept staffing levels under constant review and assured us they would be increased if people's needs increased.
• The provider had clear recruitment procedures in place. Records confirmed these were followed and had helped ensure that only suitable staff were employed.

Assessing risk, safety monitoring and management:
• With the exception of risk assessments for people using blood thinning medicines, people's care plans contained detailed risk assessments for all identified risks. These explained the actions staff should take to promote people's safety and ensure their needs were met. For example, some people were at risk of pressure injuries and had been given pressure-relieving cushions and mattresses; other people used devices to monitor their safety. A family member told us, "I've had no worries [about my relative]. He has an alarm on his chair and his bed and [as a consequence] has not had any falls."
• Environmental risks, including fire safety risks, were assessed, monitored and reviewed regularly. Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire.
• Lifting equipment was checked and maintained according to a strict schedule. In addition, gas and

electrical appliances were checked and serviced regularly.

Systems and processes to protect people from the risk of abuse:
• People said they felt safe at the home. One person told us they felt secure because "there are people around all the time".
• Appropriate systems were in place to protect people from the risk of abuse.
• Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse.

• Safeguarding incidents had been reported and investigated thoroughly, in liaison with the local safeguarding team.

Learning lessons when things go wrong:
• Incidents and accidents were monitored closely and reviewed to identify any learning which may help prevent a reoccurrence. For example, following a fall, one person had been invited to transfer to a ground floor room to enable staff to provide more support and reduce the risk of further falls.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments of people's needs were completed before people moved to the home. These clearly identified people's needs and the choices they had made about the care and support they received.
• Staff followed best practice guidance. For example, they used nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition. They then took action to achieve positive outcomes for people identified as at high risk.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed; pressure-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions.

Staff skills, knowledge and experience:
• People were supported by staff who had completed a range of training to meet their needs. Most training was refreshed and updated regularly, apart from infection control training, some of which was overdue. You can find more information about this in the Safe section of this report.
• People and family members told us staff were competent. For example, one family member said, "Staff understand the needs of [my relative] and the importance of taking his medicines on time." A healthcare professional told us, "I would put my mum in here. People get good care. Staff are spot-on, even the juniors."
• Staff told us they felt supported in their roles by managers.
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. In addition, staff received an annual appraisal to assess their performance.

Supporting people to eat and drink enough with choice in a balanced diet:
• People's dietary needs were assessed and met consistently, although the way in which meals were offered was not supportive of people living with dementia. People were asked to choose their meals in advance, but most people could not remember what they had ordered and some could not make an informed choice due to cognitive impairment. The registered manager told us they were planning to update photographs of meals and said they would also explore other ways to offer choice in a more supportive way for people.
• People were offered regular meals, including regular snacks such as biscuits and fresh fruit. One person described the food as "excellent" and others described it as "good" or "very good".
• Staff monitored the amount people ate and took action if people started to lose weight. For example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• A choice of drinks was available and accessible to people throughout the day and we heard staff encouraging people to drink often.

Staff providing consistent, effective, timely care:
• People told us they received all the support they needed at the time they needed it. One person said, "We're really well looked after." A family member told us, "[My relative] is comfortable, warm, and well looked after."
• We observed people being supported in a safe way when staff supported them to transfer between armchairs and wheelchairs.
• People were supported to access healthcare services when needed. Care records confirmed people were regularly seen by doctors, specialist nurses and chiropodists. A community nurse told us, "Staff are quick at ringing to get us to check things."
• When people were admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood.

Adapting service, design, decoration to meet people's needs:
• The home had been adapted to meet the needs of older people with reduced mobility. A passenger lift gave access to the first floor; handrails were available for support where needed and large signs helped people to find the bathrooms.
• People had level access to a garden, including to a raised bed for growing produce.
• Refurbishment of the communal areas of the home was planned for the coming year, together with the creation of a wet room to enable people to shower if they wished.

Ensuring consent to care and treatment in line with law and guidance:
• Staff protected people's human rights by following the Mental Health Act, 2005 (MCA). The 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.
• Where people did not have capacity to make decisions, best interests decisions were made in consultation with family members and other relevant people. We found the views of those consulted were not always recorded to confirm they agreed with the decision made. However, when we discussed this with the registered manager, they undertook to ensure these were recorded consistently in future.
• 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 found that they were. Some DoLS authorisations had been made and others were awaiting assessment by the local authority.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and were involved as partners in their care.

Ensuring people are well treated and supported:
• People told us they liked living at Croft Manor and were treated with consideration. One person said, "They [staff] treat me well here, consistently." Another person said of the staff, "They're all very nice."
• Family members praised the friendliness of staff. Their comments included: "They [staff] are lovely here, very welcoming" and "There's a family atmosphere. You're welcomed as soon as you get here and are offered drinks."
• We observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. During the drinks round, a staff member asked a person, "Would you like two biscuits, one in each hand? That's what I call a balanced diet." This caused the person to laugh with the staff member.
• Staff showed a good awareness of people's individual needs, preferences and interests. This was confirmed by healthcare professionals, comments from whom included: "Staff are very friendly and really know their patients" and "They [staff] know their patients and are always very thoughtful".

Supporting people to express their views and be involved in making decisions about their care:
• People's protected characteristics under the Equalities Act 2010 were usually identified as part of their needs assessments before they moved to the home.
• People's other diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Some staff had received equality and diversity training and further training was planned for the coming year.
• Records confirmed that people were involved in meetings to discuss their views and make decisions about the care provided. This included their choice of activities, food and how they wished to be supported.
• Family members were kept up to date with any changes to their relative's health needs. When asked about this, one family member told us, "Staff are approachable and we are always kept informed, for example if they've had to have the doctor in."

Respecting and promoting people's privacy, dignity and independence:
• People were encouraged to do as much as they could for themselves. For example, staff described how some people could brush their own teeth if the toothbrush was prepared for them and they were given time.
• Staff described how they supported people's privacy and dignity. This included giving people private time, listening to people, respecting their choices and closing doors and curtains when providing personal care.
• Some rooms were double rooms but were being used for single occupancy to give people the maximum level of privacy.

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

People's needs were met through good organisation and delivery.

Personalised care:
• People told us their needs were met in a personalised way and this was confirmed by family members. One family member said of the staff, "They are always willing to listen. If I say, 'This is how [my relative] likes something doing', then that's how they do it."
• Care plans had been developed for each person. Most aspects of the care plans provided sufficient detail to enable staff to provide support in a personalised way. However, they lacked detail about how people wished to be supported with personal care. For example, some people's care plans simply said, "Two carers to assist with all personal care" without specifying what that meant. We raised this with the registered manager who assured us they would add more information to this part of people's care plans to help ensure consistency of care delivery.
• The lack of information in people's care plans was mitigated by the fact that staff understood people's needs and knew how to support them according to their individual wishes and preferences.
• Staff used hand-held devices to record the care and support they had given. However, we found the information recorded was not always accurate. For example, staff had ticked a box to show that a person's skin was alternately "intact" and "not intact" during consecutive checks over a period of days. They had also ticked a box on several occasions to show that bed rails had been put in place when the person did not have any bedrails. The registered manager felt this was due to misunderstandings by staff and undertook to provide more guidance to staff about the inputting of information.
• Staff responded promptly to changes in people's needs. A family member told us their relative's mobility varied from day to day and said staff supported them in an appropriate and flexible way, for example, by helping them to bed early if they became tired. A healthcare professional told us staff were able to identify when "someone was not their normal self" and would always seek advice.
• People were empowered to make their own decisions and choices. For example, we heard staff asking people, "Would you like a tea or coffee?" If the person declined, they said, "Let me know if you change your mind." People could choose when they got up and went to bed, where they took their meals and how they spent their day.
• People's communication needs were met. For example, staff successfully used a whiteboard to communicate with a person with impaired hearing; some information was available in accessible, picture based formats, including the provider's complaints procedure and CQC information about 'What you can expect from a care home'.
• People had access to a range of activities, including from external activity providers. One of the activity providers told us, "It's lovely, I get to know people and what they like. For example, we have one lady who likes to dance and another who like Irish jig music. I bring my saxophone sometimes and play to them." Other activities included one-to-one conversations with people, hand massage, quizzes and crafts. A family member told us, "[My relative] joins in the floristry, craft and singing."

Improving care quality in response to complaints or concerns:
• There was an accessible complaints procedure in place and people told us they felt able to raise concerns.
• The complaints policy was advertised on the home's notice board and was available in a large-print format if needed.
• No complaints had been recorded since the provider had registered with CQC. However, the registered manager described how they would use learning from any complaints to help drive improvement within the service.

End of life care and support:
• Staff were not supporting anyone with end of life care at the time of the inspection. However, people's end of life wishes were recorded to help ensure they would be met.
• Most staff had experience of delivering end of life care. Some had received relevant training and further training was planned for the coming year. Staff expressed a commitment to supporting people to have a comfortable, dignified and pain-free death.
• Letters from the families of people who had recently died at the home commended staff for the compassion and care they had shown.

Requires Improvement

Is the service well-led?

Our findings

Our findings
Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was quality assurance process in place, consisting of a range of regular audits by managers. Whilst these had brought about some improvement, the systems were not fully effective. For example, the infection control audits had not picked up the cleanliness and maintenance issues in the laundry or the lack of pedal operated bins in some areas. This had led to a breach of regulation. The medicines audits had not identified the anomalies we found with the quantity of boxed medicines in stock; although the audit forms included a section for checking these, we saw it had rarely been completed.
• We raised these issues with the registered manager, who acknowledged this was an area for improvement.
• There was a clear management structure in place, consisting of the provider's operations manager, the registered manager and the deputy manager. Staff understood their roles and communicated well between themselves to help ensure people's needs were met. One staff member said, "We get a handover [meeting] at the start of the shift and work as a team."

Promoting person-centred care and support and a positive culture that is open, inclusive and empowering, which achieves good outcomes for people:
• People told us the service was run well and they would recommend it to others. One person said, "It's lovely here, you won't do better." A family member told us, "The home seems well run. I wouldn't want [my relative] to go anywhere else." A healthcare professional said they recommended the home to their patients and felt the registered manager "wants what's best for people".
• The registered manager demonstrated an open and transparent approach to their role. Where people had come to harm, relevant people were informed, in line with the duty of candour requirements.
• Friends and family members could visit at any time. They were made to feel welcome and were offered meals and drinks.

Engaging and involving people who use the service and staff:
• The provider consulted people in a range of ways. These included quality assurance surveys, residents' meetings and one-to-one discussions. The registered manager had acted on people's comments; for example, people had asked for a singer to visit more often and this had been arranged.
• Staff spoke positively about the registered manager, describing them as "approachable" and "supportive". Comments from staff included: "[The registered manager] is very good. You can speak to him about anything" and "Staff are listened to. [The registered manager] is very approachable and understanding".

Continuous learning and improvement:
• The registered manager analysed feedback from people, staff and audits. They used the findings to drive improvement. For example, a review by an external consultant identified that duty of candour procedures not being followed consistently and we saw this had been addressed.
• The provider had a rolling plan to refurbish the home, including the lounges, the kitchen and the laundry within the coming year.

Working in partnership with others:
• Staff had links to other resources in the community to support people's needs and preferences. This included links with local church communities and with a school whose children were invited to visit the home and send cards to people at Christmas.
• The providers and the registered manager had worked with social care professionals and the local authority to develop and improve the service.

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 The provider had failed to operate effective systems to prevent and control the spread of infection. Regulation 12(1) & 12(2)(h).