Norens Limited

Homecrest Care Centre

Inspection report

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26 October 2021
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03 November 2021
05 November 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Homecrest Care Centre provides accommodation for up to 29 people who need help with personal care. At the time of the inspection 24 people lived in the home. Most of the people living in the home lived with dementia.

People's experience of using this service
At this inspection, we identified serious concerns with the management of risk, care planning and delivery, the management of medicines, staff recruitment, staffing levels and service management.

People's needs and risks were not always properly assessed or managed. Guidance on the support people needed to keep them safe and well was not always in place for staff to follow. This placed people at risk of inappropriate or unsafe care. People's health needs and checks had not always been followed up with other health and social care professionals to ensure their health remained stable.

People were not always protected from the risk of abuse. Some people had experienced unexplained bruising that had not been investigated and reported appropriately to protect them from harm.

Medication management was not always stored or managed safely. Staff lacked sufficient guidance on how to administer as and when required medicines; diabetes management and medication allergies. It was difficult to tell if some medicines were administered in accordance with the manufacturer's instructions. The competency of some staff to administer medicines had not been assessed to ensure sure they were safe to administer medicines.

There were not enough staff on duty to meet people's needs at all times. Staff and the people we spoke with confirmed this. Staff were kind and caring but were task orientated. People told us staff did their best but there wasn't enough of them.

Fire safety arrangements were not adequate; staffing levels at night were a serious concern as they were not sufficient to ensure all people could be evacuated in the event of a fire. The fire evacuation procedure was unclear and there was not enough evacuation equipment in place to help people evacuate.

There was not enough domestic cover to ensure the home was thoroughly clean to good infection control standards. The arrangements in place to mitigate the risk of COVID-19 were also not robust.

Staff recruitment was not safe. The necessary checks on staff suitability had not always been checked fully prior to appointment to ensure they were safe to work with vulnerable people.

The management and leadership of the service was poor. Neither the manager or, the provider had identified the issues we found at the inspection. This was despite a range of audit systems being in place to

monitor the quality and safety of the service.

The manager did not demonstrate they understood the service, people's care needs or their regulatory responsibilities.

Rating at last inspection
The last rating for this service was requires improvement (published 08 February 2020).

You can read the report from our last inspection, by selecting the 'all reports' link for 'Homecrest Care Centre' on our website at www.cqc.org.uk.

At this inspection, we found that the quality and safety of the service had significantly declined. Multiple breaches of the regulations were found, resulting in a rating of inadequate.

At this inspection, breaches of regulations 12 (safe care and treatment); 13 (Safeguarding people from the risk of abuse); 17 (Good governance); 18 (Staffing) and regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, were found.

Why we inspected
We conducted a focused inspection in response to information of concern shared with us by the Local Authority and the general public about the service. As a result, we undertook a focused inspection to review the key questions of safe, and well-led only.

We reviewed the information we held about the service. No areas of concern were identified within the other domains of 'effective', 'responsive' and 'caring'. We therefore did not inspect these domains. Ratings from previous comprehensive inspections for these key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

Special Measures
The overall rating for this service is 'Inadequate' and the service had been placed 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.

Homecrest Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide 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
This inspection was undertaken by two inspectors 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 service.

Service and service type
Homecrest Care Centre is a care home. People in care homes receive accommodation and personal care. 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
We announced this inspection from the car park on the day of the inspection. The inspection took place over four days. The first day was spent on site.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider completed an annual provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, the regional manager, the deputy manager, two care staff and a domestic member of staff. We also contacted the provider and area manager to obtain information about the service. We reviewed a range of records. This included five people's care records, a sample of medication records, three permanent staff files; information pertaining to the use of agency staff and records relating to the management of the service.

We contacted people using the service and their relatives by telephone to seek feedback about their experiences of the care provided.

After the inspection visit
We continued to seek clarification from the manager and provider to validate evidence. We continued to review evidence in relation to people's care, health and safety, maintenance records and the management of the service.

We liaised with the Local Authority to share information about the service and our inspection. We made safeguarding referrals for four people living in the home as we had specific concerns about their care, health and wellbeing.

We concluded the inspection on 05 November 2021.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- New admissions to the service were not fully assessed prior to admission. This meant the manager could not be confident the service was able to meet their needs before they arrived at the home. This placed people at risk of avoidable harm.
- Staff did not have enough information on people's needs, risks or care, in order to care for them safely. This placed them at significant risk of inappropriate and unsafe care.
- Important information about people's diabetes for example their normal blood sugar range and the checks staff needed to undertake were not always identified or carried out to ensure people's diabetes was stable.
- Some people had medical conditions that required clinical monitoring by other health and social care professionals. Records showed the manager had not always ensured these checks were undertaken.
- Some people lived with mental health issues which meant they sometimes became distressed and agitated. Despite this, staff had little guidance on how to support people appropriately in a way that helped minimise their distress and keep them safe.
- Fire safety arrangements were not adequate. A proper fire evacuation drill had not been practiced for some time; the fire evacuation procedure was unclear; there were not enough evacuation aids to help people evacuate and not enough staff at all times to assist people to evacuate to a place of safety.

The provider had not ensured risks to people's health, safety and welfare were adequately assessed and mitigated to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most of the legal health and safety checks on the building and its equipment had been completed. A gas safety check was overdue due to the provider being in the process of installing new boilers.

Using medicines safely

- Medicines were not always stored safely and at times were accessible to people living in the home.
- Some people did not have medication profiles in place to help staff identify them for the purposes of medication administration. This increased the risk of medication errors being made.
- Guidance for staff to follow when administering 'when required' medicines such as painkillers, creams or anxiety medication were not sufficiently detailed to advise staff when, how and where to administer these medicines. Records showed these medicines were administered inconsistently or not at all. It was clear they were not used in a way to maximise people's relief.

● The times medicines were administered were not always recorded so it was impossible to tell if some medicines were given safely.
● Some medicines needed to be given with, before or after food yet these medicines were signed as being given at mealtimes.
● Medication allergies were not always accurately recorded. This placed people at risk of being given a medication they were allergic to.
● The competency of staff to administer medicines safely had not always been assessed to ensure they were competent to do so.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Records in relation to staff testing, including agency staff had not been properly maintained.
● The risks associated with COVID19 were not properly assessed to identify people or staff working in the home who may be at higher risk of contracting the virus than others.
● Records relating to the cleaning of the home and the equipment in use showed significant gaps. There was no evidence of regular cleaning of frequency touched points such as door handles, light switches to mitigate the risk of the spread of infection.

Infection control did not fully adhere to government guidelines to protect people from the risk of, or, spread of infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and people living in the home were involved in the COVID-19 vaccination programme.
● Personal Protective Equipment (PPE) was in use and worn appropriately by staff.

Staffing and recruitment
● Staffing levels were not safe. The manager told us that four staff should be on duty 8am to 8pm each day. Staff rotas showed that on some days there were only three and sometimes only two care staff on duty for parts of the day.
● At the time of the inspection, the ability of staff to meet people's needs was further hindered by care staff having to cover laundry tasks due to a lack of laundry staff.
● Staff told us that there were not enough staff. Their comments included, "If, three care staff on (plus a Senior Carer), there is enough staff on, but at least 2 to 3 days per week, there are not these levels of staff"; "There are times were then are only two carers and a senior and that is hard going, this usually happens two to three days a week" and "I don't feel we are well enough equipped to do everything properly".
● Staff were kind and caring but mostly task orientated. People told us,"The staff are under pressure, there are not enough of them, but they do their best" and "The staff are fine and patient there are just not enough of them about".
● There were only two staff members on duty at night to support 24 people with varying needs to evacuate in an emergency. There was a risk that people would not be safe.
● Domestic staff struggled to maintain standards of cleanliness across the home in the time allocated. A domestic member of staff told us, "I can't clean whole home, I just do what I can".
● The manager said they had reported staffing concerns to the provider on several occasions but a timely response to organising agency cover was not always received. This led to the manager having to cover various shifts in addition to their day job
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There were not enough staff on duty at all times to meet people's needs and keep them safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff were not always recruited safely. Appropriate pre-employment checks had not always been carried out to ensure staff employed were safe to work with vulnerable people.
● The manager had not always ensured staff references were followed up where there were concerns about the staff member's conduct in previous roles in the care sector.
● There was little evidence that gaps in employment were investigated and the personal identity of some staff members had not always been confirmed with photo identification such as a passport or driving licence.

Staff recruitment practices were not managed safely. This was a breach of Regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from the risk of abuse.
● Some people had unexplained bruises that had not been investigated or reported to the local authority safeguarding team or CQC as potential incidence of abuse.

The arrangements in place to identify and respond to possible incidences of abuse were not robust or always followed to protect people from harm. This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with said they felt safe in the home. Their relatives felt the same.

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 requires improvement. At this inspection, this key question has 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

- At this inspection, serious concerns with the management of the service and the delivery of care were found. As a result, the service failed to meet its regulatory requirements and failed to ensure risks to people's health, safety and welfare were mitigated.
- We discussed the concerns found in relation to risk management, service delivery, medicines, staffing, staff recruitment, infection control and safeguarding with the manager and regional manager. They were not able to explain why these failings had occurred, and why they had not been picked up and addressed in the day to day management of the service or by the audits (governance systems) in place to monitor quality and safety.
- The manager, at this inspection, did not appear to have a clear understanding of the service and their regulatory requirements. They did not have sufficient oversight of the management tasks they had delegated to other senior staff.

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

- The service failed to promote good outcomes for people as people's needs and risks were not always adequately assessed or care planned.
- It was difficult to tell if people received the support they needed as care plans were limited and did not cover all of their needs and risks.
- Some people's daily records did not show they always received sufficient hydration and nutrition to promote good dietary and health outcomes. One person told us, "Meals are ok, but I sometimes feel I am not nourished enough, we don't get enough greens or salads" and "Meals are terrible, you get no choice, they do give me a butty if I won't eat the meal".
- The manager had not always ensured that people's health conditions were subject to regular review and support from other health and social care professionals such as the diabetic nurse or the chiropodist, as required. One person said, "I need my toenails doing, I keep waiting for them to be done." A relative told us, "His fingernails are long and need cutting and his toenails need cutting".

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; Continuous learning and improving care

- The manager had not always reported notifiable incidents to CQC as required. For example, safeguarding events such as unexplained bruising.

● Access to information about the service was difficult to obtain. The manager went on annual leave after the first day of inspection and senior managers including the provider did not have access to some of the manager's files. This was not good practice and did not show that senior managers and the provider had full oversight of the service at all times.

The governance arrangements in place were not robust. The management and leadership of the service was poor. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were accident and incident audits in place that showed what action had been taken after an accident or incident occurred to prevent it happening again.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us that staff engaged with them well and kept them informed of their loved one's progress.

● People we spoke with said the manager was approachable and pleasant. Relatives confirmed this. One person said, "I speak with [Name of manager] she passes, and I feel I could speak with her if I needed to, she is very pleasant. I think things could be improved by more staff".

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 had not ensured risks to people's health, safety and welfare were adequately assessed and mitigated to prevent avoidable harm. The management of medication was unsafe. Infection control did not fully adhere to government guidelines to protect people from the risk of, or, spread of infection.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel the registration of this location with CQC.

We issued the manager with a Notice of Proposal to cancel their registered manager status.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The arrangements in place to identify and respond to possible incidences of abuse were not robust or always followed to protect people from harm.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel the registration of this location with CQC.

We issued the manager with a Notice of Proposal to cancel their registered manager status.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements in place were not robust. The management and leadership of the service was poor.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel the registration of this location with CQC.

We issued the manager with a Notice of Proposal to cancel their registered manager status.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment practices were not managed safely.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel the registration of this location with CQC.

We issued the manager with a Notice of Proposal to cancel their registered manager status.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff on duty at all times to meet people's needs and keep them safe.

The enforcement action we took:

We issued the provider with a Notice of Proposal to cancel the registration of this location with CQC.

We issued the manager with a Notice of Proposal to cancel their registered manager status.