Warmest Welcome 2 Limited

The Crest Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Crest care home provides personal care and nursing care for up to 31 older people living with dementia. At the time of the inspection 26 people were living at the service. The service is an adapted building, split over two floors and is serviced by a lift.

People's experience of using this service and what we found
The systems for recording, managing and general oversight of accidents, incidents and safeguarding concerns was not effective. Whilst no one was hurt as a result, these shortfalls increased potential risk of harm.

We found gaps and inconsistencies in care plan records and other documentation such as monitoring forms and cleaning records. Where actions had been identified these had not always been completed in a timely manner.

Medicines were stored, administered and disposed of safely, however we have made recommendations around 'as and when required' medicines.

Staff were recruited safely, and this was on-going. The service was using agency staff which families and staff felt at times affected the quality of the service provided. The registered managed tried to ensure regular agency staff to minimise the impact.

Audits and governance processes were in place. However, these weren't always effective in identifying issues found as part of this inspection. The Care Quality Commission (CQC) had not been made aware of notifiable incidents as required. However other relevant agencies had been made aware and families were informed and regularly updated.
During a COVID-19 outbreak, restrictions to all visitors into the home was not in line with government guidance or the providers own policy. The approach taken was not person-centred and did not seek alternative options to minimise impact on people.

Staff and their families felt the registered manager had made improvements since starting in their role and felt they were approachable and open to feedback. People appeared happy and comfortable at the service. One family member told us, "Shortly after my family member went in the home there was a real transformation in them. I can see they are healthy, and they appear happy."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Rating at last inspection

The last rating for this service was good (published 11 March 2020)

Why we inspected
We received concerns in relation to staffing and how the provider managed safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

The Provider has taken some action to address findings from the inspection and mitigate risk. However, the provider needs to make further 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.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, person-centred care and good governance at this inspection.

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

Since the last inspection we recognised that the provider had failed to notify CQC of incidents where required to do so. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Crest 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 carried out by two inspectors.

Service and service type
The Crest is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Crest is a care home without nursing 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
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, Healthwatch and other professionals who work with the service.

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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with and received feedback from six members of staff including the registered manager, deputy manager, operations manager, senior care assistant and care workers.

We reviewed a range of records. This included five 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 continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant 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.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- People were at increased risk, because there was not a robust system in place to record and monitor accidents, incidents or safeguarding concerns. As a result, it was not always clear what action had been taken.
- Where risks had been identified and documented, action was not always taken in a timely manner. For example, a fire risk assessment completed in September 2021 identified areas of risk around fire doors, action had not been in a timely manner. This had put people at risk of harm.
- Where people had lost weight and were identified as high risk, action had not been taken or documented around how the provider would mitigate this risk. There was no evidence that this had impacted people.
- Guidance for staff on how to manage risk wasn't always consistent. For example, when people were on increased observations this wasn't always clear. This led to observations not always being carried out as expected. We found no evidence that people had been harmed as a result of this.

The provider failed to do all that is reasonably practicable to mitigate risk. This was breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider has completed actions highlighted in the fire risk assessment.

Preventing and controlling infection

- We were assured that the provider was meeting shielding and social distancing rules.

- We were assured that the provider was admitting people safely to the service.

- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured that the provider was accessing testing for people using the service and staff.

- We were assured that the provider's infection prevention and control policy was up to date.

- We were somewhat assured that the provider was preventing visitors from catching and spreading

infections.

● We were somewhat assured that the provider was using PPE effectively and safely.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

Inspectors were not asked to evidence their COVID-19 vaccination status when we visited the home. This had also been highlighted on an internal audit of the service. Staff did request evidence of a COVID-19 test and the sign-in form asked for confirmation of vaccination status.

We observed breaches of PPE during the visit, for example, staff having their masks under their chin.
The environment could be better layout to further promote safety and hygiene, such as location of bins, PPE and staff facilities.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● The homes visiting policy was aligned with current government guidance. However, not enough had been done to communicate the visiting options available to people and their families. People had not had the option to receive essential care giver visits during the outbreak. The provider had removed the visiting pod in July 2021. As a result, options for safe visiting were limited to window and garden visits.
● This resulted in blanket restrictions to visiting during an outbreak that lasted four weeks. Risk assessments and care plans did not reflect the impact this had on people using the service and how this could be mitigated.
The provider failed to support and enable the relevant people to make or participate in making decisions about the person's care and treatment. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider discussed this with families after the inspection and the home re-opened shortly after the inspection, allowing visitors as per the government guidance.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Using medicines safely; Learning lessons when things go wrong
● Staff were not familiar with how to access person-centred protocols for people who were receiving 'as and when required' medicines. Staff were not recording effectiveness of these medicines, which is needed for appropriate review of their use.

We recommend the provider considers current guidance on 'as and when required medicines' taking action

to ensure they update their practice accordingly.

● Medicines were safely received, administered and returned to the pharmacy when they were no longer required.
● The provider was investing in a new electronic medicines management system to help overcome some of the shortfalls with their current systems.
● Where issues had been identified on audits, effective action had been taken to develop new ways of working to prevent reoccurrence.

Staffing and recruitment
● The service used agency staff to cover staffing shortages. Staff told us the quality of care wasn't as good compared to when contract staff worked. The registered manager was working to recruit more contract staff and regular agency was used to try and provide consistency of care.
● Recruitment checks were in place to ensure new staff were safe to work with vulnerable people.

Requires Improvement

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were not always well managed. There was a lack of checks in place to identify the issues we found on inspection. For example, the recording and reporting of incidents in the service was inconsistent and only when the information was requested by CQC were the shortfalls identified.
- The registered manager was aware of issues with recording and documentation. However, action had not been taken to reduce this. For example, there were multiple gaps in the cleaning records and no weekly or monthly checks had been completed as per the provider's procedure. This was an area of concern due to the on-going COVID-19 pandemic.
- The registered manager was aware of their legal requirement to notify CQC about certain events however had failed to submit notifications as required. This is being looked at outside of this inspection.

We found no evidence that people had been harmed however, systems were not in place to demonstrate a strong governance oversight of care being provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act (Regulations) Regulated Activities 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

- The registered manager had displayed an open approach and listened when things went wrong to staff, people and their relatives. They had been honest and worked in partnership to make improvements. Staff, people and their relatives were happy with this approach and told us the registered manager was approachable.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff told us they felt supported by the registered manager and they felt comfortable raising concerns or areas for improvement.
- The registered manager had a plan in place to reintroduce champion roles within the service and had increased the frequency of individual supervisions to improve communication with staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Satisfaction surveys were sent out via email to people's relatives however the response rate was low. Online relatives' meetings had been carried out during the COVID-19 pandemic when face to face meetings

weren't an option.

● People and their families were involved in the day to day care they received. Families told is they were updated regularly by the registered manager over the phone and found the service to be responsive to their requests.

● The service had good working relationships with other professionals and key agencies such as district nurses and the community mental health team. This helped ensure people got the support they needed from the relevant professionals.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to support and enable the relevant people to make or participate in making decisions about the person's care and treatment. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that is reasonably practicable to mitigate risk. This was breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to demonstrate a strong governance oversight of care being provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act (Regulations) Regulated Activities 2014. Regulation 17(1)(2)(c)