Akari Care Limited

Crofton Court

Inspection report

Edward Street
Blyth
Northumberland
NE24 1DW

Tel: 01670354573

Date of inspection visit:
16 December 2020
17 December 2020

Date of publication:
05 February 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Crofton Court is a residential care home providing accommodation and personal care to up to 50 older people some of whom are living with a dementia related condition. At the time of our inspection 39 people were living at the home. Accommodation is available across two floors.

People's experience of using this service and what we found
The service was not always well led. There had been numerous changes within the management structure at the home which had impacted upon the quality of the service. Effective systems were not in place to monitor quality and audits had not always been completed regularly.

People were not always protected from the risk of harm. Staff did not always follow government guidance in relation to safe infection prevention and control procedures. People did not always receive their medicine as prescribed and a high number of medicine errors had been reported. There were not always enough staff deployed to meet people's needs and there was a dependency on the use of agency staff within the home. During the inspection the provider authorised the use of additional agency staff to support the home until more staff could be recruited. Systems were in place to safeguard people from the risk of abuse. Staff spoken with understood their responsibilities in how to protect people.

Risk assessments did not always contain enough information to guide staff in how to provide support and had not always been reviewed at the frequency identified by the provider. Systems were not in place to monitor people who were assessed as being at risk of dehydration. A member of the management team had started to review accidents and incidents to share any lessons learnt with the whole staff team.

An effective system to ensure staff were supported and appropriately trained was not in place. There were gaps in the training deemed as mandatory by the provider. Feedback from staff detailed they did not always feel supported or valued by the provider, which impacted upon the morale of the home.

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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 March 2020) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We undertook this focused inspection to follow up on specific concerns we had received about the service. The inspection was prompted, in part, due to concerns received about medicine errors, management of the home, staffing, a lack of activities for people and the infection prevention and control practices of staff. A decision was made for us to inspect and examine those risks.

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 three breaches in relation to safe care and treatment, staffing and good governance at this inspection.

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 request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Crofton Court

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.

Inspection team
The inspection was conducted by one inspector.

Service and service type
Crofton Court 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 did not have a manager registered with the Care Quality Commission. This means the provider is 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 held about the service, including the statutory notifications we had received from the provider. Statutory notifications are changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams and Healthwatch to request feedback. 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 of this information to plan our inspection.

The provider was not asked to complete a 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.

During the inspection
We spoke with two people who used the service and three relatives about their experience of the care provided and observed staff interactions with people. We spoke with eight members of staff including the home manager and regional support manager.

We reviewed a range of records. This included care records for four people and multiple medicines records. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with a health professional and the local authority to share details of our inspection observations. We contacted a further four staff by email to request their feedback and received one reply.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely
At our last inspection medicines were not always managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

• Medicines were not always managed safely; 27 medication errors had been identified during the months of November and December 2020. One health and social care professional told us, "The amount of medication errors reported is very concerning."
• Treatment rooms were not clean or well maintained. The cleaning of the home's treatment rooms was not included in the cleaning schedule tasks.
• Medicines which were waiting to be returned to the pharmacy were not stored securely within treatment rooms.
• Records were available to show staff were monitoring the temperature of the medicines fridge. However, there was no evidence available to demonstrate the action taken by staff when the temperature had exceeded the maximum normal range.
• In line with the provider's policy, signage was not displayed on the treatment room door to indicate the storage of oxygen. In addition, records were not available to demonstrate the cleaning of oxygen cylinder valves.

The provider's failure to ensure proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Staff did not follow government guidance for wearing and removing Personal Protective Equipment (PPE). For example, staff were observed wearing face masks under their nose or moved face masks from their face to take drinks. Staff failed to follow the correct procedures and replace facemasks after each incident where they had been touched.
• Government guidance in relation to infection control procedures was not followed. Some staff were observed to touch people when providing support without wearing gloves and aprons. Also, staff did not support people to following social distancing guidance.
• Cleaning was not always taking place in line with the requirements identified by the provider. There was no system in place for the cleaning of communal resources used by people.

• PPE was not stored appropriately in bathrooms. This meant PPE was at risk of contamination.

The provider's failure to ensure infection control policies and procedures were followed by staff was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we recommended the provider kept staffing and recruitment under review to ensure the use of agency staff was minimised. The provider had not made improvements.

• The provider used a dependency tool to assess the staffing requirements for the home. However, there were not always enough staff deployed to meet the needs of people and there continued to be a reliance on the use of agency staff.
• Some tasks were not completed due to staffing shortages. For example, medicines which needed to be returned to the pharmacy had not been processed. We were told this would normally be completed by the senior carer working on night shift and as agency staff were covering these shifts this task had not been done.

The provider's failure to ensure enough staff were available to meet people's needs contributed to a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection the newly recruited home manager said they did not feel staffing levels were safe. The provider responded to this feedback and authorised additional use of agency staff to increase staff numbers until permanent staff could be recruited.
• Relatives gave positive feedback about staff. One relative told us, "I can have a laugh and joke with the staff. It's great because you feel like you part of the family."
• Procedures were in place to ensure staff were recruited safely.

Assessing risk, safety monitoring and management
• Risk assessments did not always provide detailed information to guide staff when supporting people with specific health conditions. For example, a care plan for one person with epilepsy did not provide information of how long staff should wait before calling 999 if the person did not recover from a seizure.
• Risk assessments had not always been reviewed at the frequency identified by the provider.

The provider's failure to assess, monitor and mitigate risks to people contributed to a breach of Regulation 12 (Safe care and treatment,) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Premises checks had been completed to help ensure the safety of the building.
• Emergency plans were in place to ensure people were supported in certain events, such as fire. Records stated how many staff would be required to support each individual.

Systems and processes to safeguard people from the risk of abuse
• Staff understood their role in how to protect people and told us they would be confident to raise any concerns if they suspected any form of abuse.
• Systems were in place to safeguard people from the risk of abuse. A relative told us, "I have no safeguarding concerns. This is the only place I would want [name of relative] to be. She has got all the care she needs and has told me before the staff make her feel special."
• One health and social care professional shared information of a safeguarding nature. We passed this feedback to the local authority safeguarding team. The provider responded to these concerns immediately.

Learning lessons when things go wrong

• The provider's systems for reviewing accidents or incidents were not always followed by staff.

• Staff said they were not encouraged to reflect on their practice to consider alternative ways of working to deliver improvements.

• The deputy manager, who was supporting the home from another of the provider's locations, had started to review accidents and incidents to share any lessons learnt with the staff team to deliver improvements.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection we recommended the provider reviewed best practice in relation to supporting people with nutrition and hydration needs. The provider had not made sufficient improvements.

• People assessed as being at risk of dehydration did not have a target fluid intake recorded in care plans. Therefore, we could not be assured people were receiving enough fluids to keep them hydrated. In addition, records did not evidence what action had been taken by staff if people had not achieved their target fluid intake for the day.

While we found no evidence people had been harmed, the provider's failure to ensure people's hydration needs were adequately risk assessed and monitored contributed towards a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's told us they enjoyed the food and staff worked to make meal times a socially enjoyable experience. One person said, "The chef is great here."
• Some people preferred to eat their meals in their rooms and staff accommodated these requests.

Staff support: induction, training, skills and experience
• Supervision and appraisals had not been provided for staff at the frequency identified by the provider. This was reflected in the feedback we received. One staff member said, "I've only had about two supervisions in the time I have been here. There is no structure in place for supervisions."
• Training the provider deemed mandatory had not always been delivered to staff.

The provider's failure to ensure staff were adequately trained and supported contributed towards a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Newly recruited staff completed an induction programme.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection we recommended the provider reviewed best practice in relation to capacity and consent. The provider had made improvements.

• DoLS applications had been made to the local authority for people who were unable to consent to their care and treatment. However, records to show when applications had been made were not up to date.
• People's ability to consent to their care and treatment had been assessed. Best interest decisions had been undertaken for people who were unable to consent to decisions taken on their behalf.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Pre-admission assessments were completed for people. In light of the Covid-19 pandemic staff had adapted how they assessed people's needs prior to their admission to the home. This included speaking with stakeholders and gathering information remotely.

Adapting service, design, decoration to meet people's needs
• Adaptations had been made within the environment to meet the needs of people. This included changes to support people living with a dementia related condition to help orientate them to their surroundings.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• People were supported to have access to a range of healthcare professionals to ensure they remained healthy. Staff followed any recommendations provided by health care professionals.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• There had been several recent managerial changes within the home. A new home manager had been recruited and had been in post for five days at the time of the inspection. However, they left during the inspection process. The provider arranged for one of their existing experienced regional managers to manage the home until a new home manager could be recruited.

• Robust systems were not in place to monitor quality within the service. For example, a monthly regional manager audit had only been completed twice during 2020.

• A thorough review of medicine management had not taken place to identify the cause of the high volume of errors which were occurring. Following the inspection, the provider told us a systematic review would be undertaken.

The provider's failure to ensure effective quality monitoring systems were in place was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider wrote to us to provide a comprehensive action plan detailing how they planned to address the short falls identified within the service.

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 management team were aware of their regulatory responsibilities. Any statutory notifications the provider was required to submit to CQC had been done in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; continuous learning and improving care; working in partnership with others

• Surveys were used to gather the views of people, staff and relatives. The provider told us questionnaires had been sent to people to find out what was important to them. The provider had responded to feedback they received by implementing an activities schedule for people to provide meaningful activities.

• Visits to the home had been affected as a result of the Covid-19 pandemic. Alternative ways for people to maintain contact with their relatives and friends had been introduced. This included window visits, video

and phone calls. Relatives provided feedback there had been some difficulties with telephones being answered in a timely manner. We shared this feedback with the provider who acted to try and prevent this from happening in the future.
• Relatives provided positive feedback regarding staff and the updates they received. One relative said, "Basically I can't praise the staff enough who are providing the support. All of the staff, care staff, senior staff, domestics. I never leave there sad as I have a good memory, it's just brilliant."
• The home had received infection control support and guidance from external health professionals and further support was planned.
• Some links had been established within the local community. One staff told us, "At the start of the pandemic the public were sending cards and pictures [to the home]."

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure compliance with regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety. Regulation 17 (1)(2)(a)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that enough suitably trained and competent staff were deployed to safely meet people's needs. Staff training was not up to date. Staff had not been routinely supervised or appraised in their roles. Regulation 18 (1)(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 always ensure care and support was provided in a safe way. There was a failure to properly assess, monitor and mitigate risks to the health and safety of people. There was a failure to ensure the proper and safe management of medicines. Infections prevention and control procedures were not robust. Regulation 12 (1)(2)(a)(b)(g)(h)

The enforcement action we took:

We issued a warning notice.