Croft Carehomes Limited

The Croft Care Home

Inspection report

17 Snydale Road
Normanton
West Yorkshire
WF6 1NT

Tel: 01924223453
Website: www.croftcaregroup.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

The inspection of the Croft Care Home took place on 16 and 24 January 2018 and was unannounced on the first day. The home had previously been inspected in October 2016 and was rated as requires improvement. There was a breach of Regulation 12 as people's care and treatment was not always provided in a safe way. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key question, safe, to at least good.

The Croft Care Home is a 'care home' for up to 29 people. On the day of the inspection there were 22 people in the home. People in care homes receive accommodation and nursing or personal care as a single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they felt safe and we found accidents and safeguarding concerns were well managed. Risk management had also improved with person-centred risk reduction measures in place.

Staffing levels were mostly acceptable although we observed there were times of the day where extra staff would benefit the people living in the home.

Medication was administered safely, but there was an issue with stock control which was immediately investigated. The registered manager took prompt action to address this with the staff and implement more robust procedures for auditing medication. We recommended the provider reviews the medication audits weekly until they are satisfied the practice is consistent.

We had concerns about infection control practice in the home as certain areas were unclean and this had not been identified in recent audits.

Staff had received regular supervision and training.

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

People had appropriate support with their nutritional and hydration needs, and were supported to access other external health and social care services as needed.

Staff displayed compassion and kindness, and were empathetic if people became anxious or distressed.

They respected people's privacy and promoted their dignity.

Care plans were person-centred and identified people's abilities and preferences. We saw these were met on a number of occasions during the inspection visit.

Complaints were managed with apologies if necessary, and remedial action. We checked the outcome of one and saw the improvements had been sustained.

There was a pleasant atmosphere in the home and people spoke positively of the recent changes. The registered manager had a clear vision for the home and this was reflected in staff and resident meetings. However, the quality assurance processes were not sufficiently robust to identify the areas of concern noted above.

We found a breach of regulation in relation to premises and equipment and have made a recommendation in relation to governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

Areas of the home were unclean and the auditing processes were insufficient to remedy this.

Although there were conflicting views about staffing levels we saw no significant impact on people, and a medication concern was dealt with promptly.

People told us they felt safe and appropriate action was taken if there were incidents, and risks were well managed.

Is the service effective?

Good

The service was effective.

People were supported well with their nutritional and hydration needs and the registered manager was acting in accordance with the requirements of the MCA and DoLS.

Staff had received appropriate training and received regular support from the registered manager.

People had access to other services as required and the premises had suitable signage to aid orientation.

Is the service caring?

Good

The service was caring.

Staff showed kindness and compassion, and were respectful of people's dignity.

People had been involved in their care plans where they had the capacity to agree and we saw their privacy was guarded.

Is the service responsive?

Good

The service was responsive.

People's care records reflected their individual needs and we

observed these were met as far as possible.

Complaints were managed and responded to well.

Is the service well-led?

Requires Improvement

The service was not always well led.

People and staff spoke highly of the improvements to the home, especially in regards to person-centred care which was an ongoing cultural shift.

Although there was a comprehensive auditing programme in place, not all audits were effective in identifying areas of concern.

The registered manager displayed a commitment to ensuring high quality care and was keen to continue developing the home and its care delivery.

The Croft Care Home

Detailed findings

Background to this 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 was planned to check 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.

This inspection took place on 16 and 24 January 2018 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors and an expert by experience on the first day, and one adult social care inspector on the second. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we requested a Provider Information Return (PIR) which was returned to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with 10 people using the service and two of their relatives. In addition, we spoke with 10 staff including one care worker, three senior care workers, the activity co-ordinator, two members of the domestic and laundry team, the cook, the care co-ordinator and the registered manager.

We looked at three care records including risk assessments, three staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in October 2016 the provider had been in breach of Regulation 12 as care was not always delivered in a safe way. During this inspection we found improvements had been made in relation to risk management in regards to people's individual needs. However, on this inspection we had concerns with parts of the environment and infection control practices.

We observed an unguarded portable heater in the main lounge on the second day of the inspection which was promptly removed and we found some radiators were hot to touch. We spoke with the registered manager about these concerns and they spoke with the provider about checking the radiators. This had been resolved on the second day of the inspection.

One care worker told us they were "always short" of basic things including laundry items like sheets. In one of the bedrooms we saw the mattress protector was ripped and needed replacing. We asked the registered manager about the checking of mattresses and pillows and they advised us mattresses were checked monthly but pillows were not. Some pillows had protective covers and others did not. There was no specific laundering system in place to ensure all got washed at regular intervals. There was evidence that the emergency lighting was checked weekly. However we noticed there were light bulbs missing in parts of the home which posed a risk to people who lived there. The provider assured us after the inspection new lighting units were on order as these had failed. We were advised this work had been done by the end of February 2018.

We found areas of concern in regards to infection control. The home had last been inspected by the local authority Infection Control team in November 2017 and there were a number of areas still outstanding from the action plan. A further visit was scheduled for March 2018. The registered manager explained a programme of refurbishment was in progress. This included the treatment room where medication was stored which was in urgent need of a deep clean. We found pockets of uncleanliness in the kitchen although all cooking equipment was clean. We found jars and cold meat opened in the fridge in the kitchen but no dates recorded as to when they had been opened which posed a potential risk to people. We noted a deep clean of this area had been scheduled for 26 January 2018. Staff had an understanding of the principles of infection control measures and had access to personal protective equipment in each bedroom, toilet and bathroom.

Cleaning schedules were ad hoc as not all rooms had them. We found some areas of the home needed further cleaning, and a light pull in the ground floor shower room needed replacing. Although the registered manager advised the ground floor sluice room was no longer used as harmful chemicals had been removed, it was unlocked and posed a potential hazard for people if they wandered into it. These areas of concern demonstrate a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the premises were not clean in all areas and systems for ensuring this were not robust.

Every person we spoke with told us they felt safe. One person told us, "Nobody can come in that door and staff look after you."

We spoke with one care worker who told us they had received training in relation to safeguarding and told us they were confident in how to report any such concerns. If they witnessed poor practice, they would not hesitate to report them and one care worker added "Oh every time, I would blow the whistle".

The registered manager had a sound understanding of safeguarding and explained how people's mental capacity would determine the level of action taken. We looked at safeguarding records and found details were logged and appropriate action was taken in each instance, including full investigations. Referrals to the local authority and notifications to the Care Quality Commission were made as necessary.

We had conflicting feedback from people about whether they had the choice when to get up. Some people told us, "Staff don't make you get up" and another said, "They don't make you go to bed." We looked in people's daily notes and saw people were up at various times of the day, reflective of their preferences. However, others told us, "They seem to get us up early" and another said, "They like us in bed before the night staff come on, some get up at 5.30am. They like us up before the day staff come on." One care worker also stated, "Although the manager has told us people should be left to wake in their own time, the practice of getting people up early was 'custom and practice' as day staff expected it." They explained this was because this alleviated the pressure on the day staff.

There were also differing views on the number of staff available. One person told us, "Staff are sometimes a bit short" and another said, "Staff are busy and short staffed." However, other people told us, "They get extra staff when they are short" and "Staffing is OK." We looked at the staff rotas and spoke with the care co-ordinator. They told us there was always a senior care worker on each shift and we could see evidence of this from the rotas. The care co-ordinator showed us the dependency tool they used to determine if the staffing levels were relevant to people's needs. The registered manager advised the provider had never refused a request for extra staff. Our observations did not indicate people had to wait for long periods for attention but staff were constantly busy, leaving little time for direct interaction with people.

We looked at staff recruitment records and found appropriate checks had taken place. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Where people needed staff support with their mobility this was provided and staff encouraged people to be as independent as possible. We saw all equipment checks had been carried out as required under the Lifting Operations and lifting Equipment Regulations (LOLER) 1998.

Where people had had falls we saw a detailed analysis of what had happened and whether any further preventative measures could be used. The registered manager conducted a monthly overview to ensure all appropriate action had been taken. Where falls had resulted from poor practice, such as the incorrect positioning of equipment, this had been swiftly identified and followed up by the registered manager who spoke with the staff concerned. Falls risk assessments were in place to support staff to manage people safely which included prevention strategies.

The registered manager ensured there were weekly fire checks and had staged two mock evacuations, the last one being in November 2017. The home had also had an external fire risk audit in October 2017. Each person who lived at the home had a Personal Emergency Evacuation Plan (PEEP). One care worker told us they felt confident of what action to take if there was an emergency situation and outlined the processes in place.

One person told us, "They keep up with our tablets and make sure we take our tablets." We heard one

person complain of a headache but they were not due for painkillers until lunchtime which we saw were duly given.

We observed medication being administered. People were given time to take their medication and advised what it was for. Staff had undertaken their medication training within the past year and all had received thorough competency checks through three separate observations and a written test.

We checked the stock of controlled drugs and found stock levels did not match the records because one drug did not need to be in the controlled drug cabinet as it was not a legislative requirement to be in there. It was agreed by the staff member and registered manager one tablet was missing. An immediate investigation was conducted which identified poor stock control measures were in place and staff involved were spoken with, with appropriate warnings issued. The audits had failed to identify issues with the stock controls but staff had been given clear guidance and reminded of key principles by the second day of the inspection. The registered manager had also implemented an improved medication audit process to reduce the likelihood of further incidents. We recommend the registered manager reviews this on a weekly basis until they are satisfied the improved practice is embedded.

The fridge for storing medication was locked and temperatures were recorded. Appropriate written guidance was in place for the use of thickening agent, antibiotics and 'as required' medication. Bottles of liquid medication had opening dates written on them and topical medication was also recorded on the medication administration record.

Good

Is the service effective?

Our findings

People spoke positively of the food. One person said, "Some lovely meals, I like fish" and another told us, "Food is great, brilliant, you can pick what you want." We observed people were offered a choice of tea or coffee and biscuits during their mid-morning break. One relative we spoke with was complimentary as to how the home had encouraged their relative with their nutritional intake, and told us they had put weight on.

We saw people deemed at nutritional had risk appropriate care plans and assessments were in place. Food and fluid charts were completed which provided a basic overview of what people had eaten and drunk. The registered manager analysed people's weights on a weekly, if necessary, and monthly basis so any concerns could be quickly addressed and appropriate external support sought if needed.

We observed most people were assisted to the dining room to eat their meals, with the choice of where they would like to sit. Two people chose to remain in the lounge and ate their meals in there. Tables were set with cloths, condiments, mats and cutlery. We observed food was hot and flavoursome, and people were offered second helpings. A selection of cold drinks were offered with the meal and tea was offered during the pudding. People had been asked their choice of meal earlier that morning and their meals were duly prepared. However, we did not hear these choices were checked at the point the meal was plated which would have ensured people were still happy with their choice. We saw people had access to assistance if needed such as plate guards and coloured crockery.

We found some staff's induction was brief but when we asked the registered manager about this they explained these staff had previous experience of care delivery so this had been sufficient. Where staff needed further support this was offered and provided. We found staff received regular supervision and where practice fell short, this was discussed with the staff member and then reviewed to see if improvements had occurred.

We saw staff had access to a range of training including food hygiene, infection control, mental capacity and equality and diversity. The training matrix showed staff had covered most topics as the provider had a three yearly renewal programme.

The home had been redecorated in most of the communal areas but we found due to the presence of the smoking room there was a stale smell at certain times. We spoke with the registered manager who was fully aware of this but explained they found the smoking room was an asset to the home as people could still smoke inside and it was part of the person-centred care offered. The registered manager explained this was part of their compliance with the aims of the Equality Act 2010. The décor inside had been chosen by the people who used it and they appeared happy and settled in there.

People had different coloured doors and there were pictorial signs to promote navigation around the home. Rooms were personalised and we saw people's wishes to have their rooms how they chose were respected, with appropriate risk and care assessments in place to manage this if necessary. The dining room had been

completely redecorated to improve lighting and accessibility, including the replacement of all the dining room furniture. Some rooms were in need of further redecoration and replacement of the carpets due to malodour but the registered manager assured us this was part of the ongoing refurbishment plan.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. We found people had the appropriate authorisations in place and none had any conditions attached.

Staff's knowledge and understanding of the MCA and DoLS was vague but we saw they offered people choice and gained consent before providing assistance. The registered manager had a good grasp of the DoLS requirements including discussing whether a person lacked capacity due to their communication difficulties which had involved further discussion with the supervisory body in one instance.

We saw evidence people had access to health and social care services. People were seen by district nurses, GPs, chiropodists and other professionals as necessary.

The registered manager was able to explain how they followed relevant guidance around best practice including medication, personalisation and health and safety. They advised us, "I have focused strongly on improving people's experience of care so their dignity and wishes are respected. I am keen for people to be as independent as possible."

Good

Is the service caring?

Our findings

One person told us, "Staff are good to you and help me" and another said, "Staff are kind in general." A further person was keen to share, "We have a bit of fun with them." Another person told us how they liked to look smart, "I like my hair doing. They come every week."

We observed staff showed appropriate care intervention skills such as bending down to talk to someone and speaking respectfully with people at all times. Each person was acknowledged by their name and staff clearly knew people well.

We saw one person was increasingly agitated as the morning went on but each care worker took their time with the person, to sit and hold their hand and speak with them in a calm reassuring manner. At no point did staff given any indication how busy they were but were patient and compassionate in their approach. One care worker gently stroked the person's forearm to provide comfort and was very discreet in their discussion. The person visibly relaxed and became more settled during the conversation.

People had been involved in the creation and review of their care plans which was demonstrated by their written consent where they were able to give this.

People's dignity was respected by care staff offering people the chance to freshen up after meals. We observed one person spoken with very discreetly, asking if they were happy to change their jumper as it was stained. The care worker sought the person's consent by saying, "I know you like to be tidy." The person happily obliged.

We observed staff knock before entering people's rooms, ensuring people's privacy was respected.

People received visits from the local church who conducted services on a regular basis for those who wished to attend.

Good

Is the service responsive?

Our findings

One person told us, "We watch TV and listen to the radio, do exercises every month and activities when the person is here." One relative we spoke with told us, "They say I can visit when I want but want us to avoid mealtimes."

On the first day we observed people were encouraged to join in a game of skittles during the morning, and in the afternoon, dominoes was played by some people. A game of catch also took place which included nine people. On the second day there were more structured craft activities as the activity co-ordinator was present. The activities co-ordinator told us about plans for outings and parties. They explained their ideas of wanting to engage with the local community more but were unable to do so until a second person was appointed as there was no staff capacity currently to manage this. The registered manager advised us the additional worker was due to start in March.

Care records were person-centred and contained all aspects of a person's needs such as their communication ability, personal care support needs, nutrition, mobility and medication needs. Where people had specific needs there were additional care plans in place to aid staff in supporting people safely and in line with their preferences as far as possible. Records contained current photographs of people and contained the person's consent to being shared with relevant parties.

People's records had detailed life histories which helped staff form and develop relationships with people living in the home. These included reference to people's families and friends, interests and previous employment. They helped staff understand people's routines and preferences which we observed being met for people during our time in the home. We saw evidence care plans were reviewed at a minimum of three months, more if people's needs changed and any changes were incorporated into a revised care plan. Daily records reflected accurately what support a person had been offered and if there were any concerns. Although most were task-based, entries did indicate where people had made their own choices and had their preferences met.

One person said, "I would complain to the manager or the deputy, no need to complain. The owner comes round, there is nowt to complain about." Another person told us, "If I had a complaint I would complain to the nurses." We looked in the complaints file and saw there had been three during 2017. Each of these had been acknowledged and addressed in full, with successful outcomes in each case. We saw the provider and registered manager had arranged a meeting in one instance where the concerns were discussed openly and resolved. We also saw where improving care records had been an outcome, these were being completed. This showed the complaints had been taken seriously and measures taken to address the issues were monitored.

The provider had also received seven written compliments ranging from praise for the food, to thanks for the general care offered to people. We saw these had been shared with staff to ensure due recognition was given.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post.

The provider had an audit programme which included accidents, safeguarding, medication and people's dining experience. The accidents analysis identified all risk reduction measures had been put in place and shown to be successful in all but one situation, although there was evidence of appropriate and timely actions to support the individual with their more complex needs. Whether it was an accident or incident the registered manager had assessed the action taken and reviewed if further learning needed to take place with staff.

The health and safety audit had been completed in October and December 2017 which contained the same outcomes, but had not identified the issues we found. We looked at the cleaning schedules for the kitchen. They were in a file which was old, difficult to navigate with loose sheets of paper and plastic wallets. There was evidence of how frequently kitchen items should be cleaned e.g. floor daily, deep fat fryer periodically but we found blank entries for some days. Although the registered manager audited the cleaning schedules, most areas were ticked as being satisfactory which did not reflect what we found. This meant the audits were not always meaningful and did not identify effectively where there were concerns.

The medication audit reflected the key areas for consideration but needed to be more robust in regards to conducting more thorough stock checks which the registered manager had actioned by the second day of our visit. The dining audit focused on people's experience and we saw if actions were required, they were followed up at the next audit to ensure practice had not slipped. Other audits considered if staff treated people with dignity and respect and whether care files reflected accurately people's needs and had all the necessary information. We recommend the registered manager reviews the audits in place and considers whether they are providing the level of scrutiny required.

One person told us about resident meetings; "We have residents' meetings and discuss together what you eat, I can complain about losing stuff in the wash and staff sort it out". Another person said, "We have occasional resident meetings, but lately they have been noticeable only by their absence." We saw minutes of meetings held in July, October and November 2017 which discussed the role of the keyworker, activities, meals and reflected people's views of these.

There was a summary of findings from the resident and relatives' surveys of 2017 where feedback had been very positive. However, the original documentation was not evident so it was difficult to determine the amount of initial responses. Responses had been analysed and the one area with a low response had been actioned.

Staff meetings were held and any significant issues discussed, including learning from any safeguarding incidents or accidents, good practice in key areas such as medication and infection control and clear direction given to all staff about expectations around care delivery and conduct.

Not everyone we spoke with knew who the registered manager was. However, people did indicate they saw the providers visit and spoke with them. One person told us, "I am asked my opinion by the owner." Staff were complimentary about the registered manager. One care worker told us, "They're too nice to be a manager." All staff we spoke with stated the registered manager was approachable and they felt listened to. They recognised there had been lots of changes since the present manager had been appointed and that "Staff seem a little more settled. There's been a big change in staff." However, staff also acknowledged there was also room for improvement in the commitment of some staff, which we saw had been identified at a recent staff meeting as well.

The registered manager was keen to stress their office door was open for staff and people living in their home to raise any concerns or issues. We observed the registered manager to be open and honest in their discussions with people, and clearly understood how people responded best. They told us they promoted good practice through, "being out there, available and approachable. I'm happy to tell people where improvements are needed and will follow up any concerns I have found." They continued, "I am keen to encourage staff to learn and be better which is why the Vanguard is great. I am also keen to ensure staff contribute to discussions about how problems can be solved as they tend to respond better by walking alongside them rather than imposing ideas."

The registered manager spoke with us about the positive value of being linked to the Wakefield Vanguard project which exists to reduce the number of unnecessary hospital admissions from care homes by promoting better falls prevention and looking at risk reduction measures. The registered manager told us about one person who had initially struggled with their mobility but was now independent with some motivational support from staff. They also told us how they were keen to establish a more pro-active relationship with their local GP surgery to ensure people's health was monitored on a regular basis, rather than just at times of crisis. Local nursing staff had been invited into the home to share Christmas dinner with people.

The registered manager told us about plans to move to electronic care records and medication systems to further minimise the risk of errors. They received support from the provider's registered manager quarterly meetings where managers from all the provider's homes met to discuss key policies and procedures and share learning.

We asked the registered manager what their vison for the home was and they said, "To be as family an environment as far as possible. Where people are treated like they are part of the family and staff all remember it is people's home." They told us they felt supported by the provider and they often visited the home. The care director offered regular supervision and also conducted spot checks. Another director was very pro-active in managing all deliveries to the home, and the owner visited regularly.

We asked the registered manager what they felt may be a risk to the home and they explained it was "To ensure the staff group remain committed. I'm very mindful not to put too much pressure on them and I will cover shifts if needed." We asked them what they felt they had achieved and they explained they felt their biggest achievement was 'a change in culture'. The staff group was 70% new and they had worked alongside all staff, including new ones, to ensure the focus of person-centred care was delivered at all times. The registered manager explained staff would do 'extras' such as ensuring people had everything they needed if family were not involved or if there was a particular thing a person wanted. They told us, "Meeting needs is not caring. Staff need to be caring and this can't be taught. If I find staff have not been caring this will not be tolerated."

The ratings from the previous inspection were displayed in the home and on the provider's website in line

with the legal requirements.

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 15 HSCA RA Regulations 2014 Premises and equipment The premises were not clean in all areas and systems for ensuring this were not robust.