Bluecroft Estates Limited

Homefield House

Inspection report

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Date of inspection visit:
29 April 2022
04 May 2022

Date of publication:
27 July 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Homefield House is a residential care home providing personal care for to up to 24 people in one adapted building over two floors. The service provides support to older people and people living with dementia. At the time of our inspection there were 21 people using the service.

People's experience of using this service and what we found
The provider and registered manager did not have effective oversight of the safety and quality of the service.

People were not protected from the risk of avoidable harm and abuse. Staff did not administer medicines safely and staff training was out of date. The provider had not deployed enough staff to meet people's needs and people were at risk from the spread of infection.

Not all staff had received an induction before starting work at the service and they did not always have the information they needed to care for people effectively. People did not always receive timely support at mealtimes and areas of the premises was not decorated to accommodate people living with dementia.

People's care plans were not person-centred and there were limited opportunities for people to participate in meaningful activities.

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 Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about infection control, staffing levels and leadership and management. A decision was made for us to inspect and examine those risks.

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.

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 safeguarding, staffing levels, staff training and the overall management of the service 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Homefield House

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 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
The inspection was carried out by one inspector.

Service and service type
Homefield House 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. Homefield House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager, two senior carers, one care assistant and one domestic staff member. We reviewed six people's care records including their medicines records. We reviewed three staff records in relation to their recruitment, training and supervision. We reviewed a range of documents in relation to the quality and safety of the service.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- The provider did not have robust systems and processes in place to safeguard people from abuse. Not all staff had received safeguarding training and did not know how to record and report safeguarding concerns. One member of staff told us, "We don't have anything to do with reporting safeguarding."
- The registered manager did not keep a record of safeguarding concerns and did not follow local safeguarding procedures to report concerns to the local authority safeguarding team.

Robust systems and processes were not in place to safeguard people from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- People were not protected from the risk of avoidable harm.
- Staff did not have the information they needed to safely manage risks to people. Risk assessments and care plans did not contain enough information for staff to manage people's specific health conditions.
- Accidents and incidents were not investigated to prevent them from happening again. Staff recorded limited information and records were not reviewed by the registered manager. There had been a delay in seeking medical attention for one person who had sustained an injury from falling.
- The provider and registered manager did not routinely monitor or analyse accidents and incidents to learn from these and improve safety.
- Staff involved in accidents and incidents did not have the opportunity to reflect on or improve their practice.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Medicines were not managed safely.
- People did not always receive their prescribed medicines, including eye drops and inhalers.
- Staff had continued to administer one person's prescribed medicine for a further two weeks after the prescriber had instructed staff to stop administering this medicine.
- Staff training was significantly out of date and some staff had not received medicines training at all from the provider. Not all staff had their competency assessed to administer medicines safely.

There had been a failure to ensure the safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was not enough staff to safely meet people's care and support needs. Staffing levels were not reviewed regularly in line with people's changing care and support needs. The tool used to do this demonstrated a shortage of staffing hours.

● Staff had raised concerns in staff meetings about staffing levels but there was limited action taken to ensure that adequate staffing levels were maintained. People had to wait for support to eat and drink and we heard people calling out from their rooms for staff.

The provider had failed to deploy sufficient staff to meet the needs of the people using the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager carried out pre-employment checks to ensure they were recruiting suitable staff.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were not assured that the provider was using PPE effectively and safely.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 accessing testing for people using the service and staff.

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

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

We recommend the provider seeks support from the Local Authority and Infection Control teams around PPE training for staff and to include equipment on the cleaning schedules.

Visiting in care homes

● The provider was following current guidance for visiting at the time of the inspection.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people did not receive effective care, treatment and support.

Staff support: induction, training, skills and experience
- Staff did not have up to date training, skills and knowledge to meet people's needs. Some staff had not received refresher training in diabetes and dementia in the last five years, despite some people using the service having diabetes and living with dementia.
- Not all staff had received a complete induction before working in the service. Some staff had been working at the service for several months and had not completed mandatory training.
- Staff did not receive regular or effective supervision. Supervision records did not consider staff performance or training needs and opportunities for development.

The provider had failed to ensure staff had received suitable training to meet the needs of the people they care for and support. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the registered manager reviewed their processes for delivering and recording staff supervision.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Staff were not always guided to support people in line with best practice. People's care plans did not always include information about their specific health conditions, including Parkinson's Disease, Dementia and Diabetes.
- Information from health and social care professionals was not always included in care plans to ensure staff had up to date, accurate information.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- People did not always receive consistent, effective or timely care.
- One person was discharged from the Speech and Language Therapist department as staff stated this was not required, despite a deterioration in the individuals health.
- We found one person had recently been reviewed by a physiotherapist and staff were instructed to support with exercises as part of their recovery following surgery. There was no information recorded to evidence that staff followed this instruction.
- People were not always supported to receive timely access to healthcare services. This included emergency care where people had falls and showed signs of injury.

Adapting service, design, decoration to meet people's needs

● The service was not decorated to meet the needs of people living with dementia. The lounge was painted in light colours rather than contrasting colours, as per best practice.

● Poor quality flooring had recently been installed in some bedrooms and in some rooms the flooring was heavily damaged. The registered manager confirmed that the provider would be taking action to replace the flooring.

● The provider had recently installed a wet room to the first floor to make the bathroom more accessible for people. A second wet room was in progress to the ground floor at the time of the inspection.

Supporting people to eat and drink enough to maintain a balanced diet

● People did not receive timely support to eat and drink. Care plans and risk assessments did not contain enough information for staff about people's specific dietary needs.

● People with diabetes did not always have access to an appropriate diet. Options were limited to diabetic ice cream which was served most days.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had sought consent from people for their care and treatment. Where people were deprived of their liberty the appropriate applications and authorisations were in place.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans did not always reflect people's current care and support needs.
- People were not consulted about the type of activities provided to ensure these were meaningful and supported people's individual needs and interests. The provider employed an activities coordinator. However, only a limited number of people used the lounge where activities took place. One person told us, "I have never seen staff take people out into the gardens for a bit of fresh air."

Improving care quality in response to complaints or concerns

- The provider had policies and a system in place to respond to complaints, however, we found these were not always handled sensitively.
- There was no analysis of complaints and concerns or evidence of changes to practice to improve the quality of care people received following concerns and complaints.

We recommend the provider reviews their current systems and processes for responding to and learning from complaints and updates their practices accordingly.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care plans did not contain any information to demonstrate how the provider was meeting AIS or evidence any consideration about people's communication needs.

We recommend the provider reviews current guidance about AIS and updates their practices accordingly.

End of life care and support

- Care plans contained very little information about people's wishes nearing the end of their lives.
- There was no one receiving end of life care at the time of the inspection.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There were widespread and significant shortfalls in the overall management of the service leading to multiple breaches of regulations. This had impacted on the care and support people received.
- Governance systems were not robust. Audits were ineffective and did not identify or prompt action to address the concerns we found in the safety and quality of the service. The provider and registered manager did not routinely audit medicines to ensure they were safely administered. We found some audits contained conflicting information.
- The quality assurance arrangements in place did not evidence learning outcomes to improve the service and the registered manager did not carry out thorough investigations following accidents and incidents including safeguarding concerns and there was limited evidence of learning from incidents.
- Complete and contemporaneous records were not always kept and staff did not always have the information they needed to care for people.
- People did not receive high quality, person-centred care. There was a clear lack of effective oversight from the provider which impacted on the outcomes for people. The provider and registered manager had not completed thorough checks on people's care and the quality of their daily experiences to satisfy themselves the service was good.
- The management arrangements within the service were ineffective and contributed to the shortfalls identified during this inspection. The registered manager is responsible for one other location and shares their time between both locations.

The provider failed to operate a robust governance system. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider and registered manager had not submitted required notifications to CQC, including abuse and allegations of abuse. This will be considered outside of the inspection process.

The failure to submit statutory notifications to CQC was a breach of Regulation 18: Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009: Regulation 18

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

● People and staff had complained about the quality and effectiveness of the care, including staffing levels. The registered manager had not acted on this feedback to drive improvements.
● The registered manager was unable to provide any evidence of feedback from people who use the service, staff or their relatives. Questionnaires had been placed in the entrance during the inspection to gather people's views on 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 registered manager understood their responsibilities and the requirement to be open and transparent.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to ensure the safe management of medicines and protect people from the risk of harm. This is a breach of Regulation 12 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There had been a failure to ensure the safe management of accident and incidents and protect people from the risk of harm. This was breach of Regulation 12 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 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust governance system. This was a breach of regulation 17 (Good governance) 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 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient

numbers of trained staff to meet the needs of the people using the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.