Partnerships in Care Limited

The Croft

Inspection report

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Date of inspection visit:
08 December 2022
13 December 2022

Date of publication:
16 February 2023

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 Croft is a residential care home providing personal care and support and is registered to support up to 8 people. The service provides support to people with a learning disability, autistic people, as well as support for people's mental and, or physical healthcare needs. At the time of our inspection there were 7 people living at the service.

People's experience of using this service and what we found:
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it. We were not confident people had received a well-planned, safe service over the last twelve months.

Right support: Incidents had occurred over a period of time which had not upheld people's rights, safety and dignity. Safeguarding procedures had not been stringently followed in a timely way to ensure people were properly protected. The governance systems in place were ineffective in identifying and improving the service in a timely way to ensure people always received good outcomes of care.

Systems were now in place to ensure any allegation was effectively dealt with and staff responsible held to account. A newly created management team was now in place and care outcomes for people were improving with a greater accountability and improvements in people's care.

Improvements in staff recruitment meant the reliance on agency staff was reducing and shortfalls in training were being addressed. We found however recent concerns had highlighted staff working in an unsupported way without the necessary skills and training to meet people's needs safely.

Staff recruitment was ongoing and staff induction and training was being revisited to ensure all staff had the necessary competencies and attributes to meet people's needs.

Recent care reviews had helped to identify gaps in service provision. Additional hours had been agreed for one person and were being sought for another to enhance their experiences, safety and opportunity.

Right care: Improvements were still necessary to enhance the quality of people's lives and ensure that progress towards goals and outcomes were effectively measured to show how people's wider social, cultural and physical needs were being met.

People have lived together for a long time and as their needs had changed reviews have been held to consider the continued suitability of the service. We discussed this with the manager in relation to the

environment and the need for people to have sufficient space and a low sensory environment which was not always achieved.

A recent reduction of incidents between people could be attributed to more regular staffing and staff having a better understanding of people's needs and creating a more predicable environment for people. However further thought should be given to people's sensory and communication needs and how staff could offer meaningful choices and reduce people's anxiety through greater continuity of care.

Right culture: People were not fully supported to have maximum choice and control of their lives. Staffing levels were in line with people's needs and there was a staff member employed specifically to coordinate and plan activities. People's records inspected showed some activities taking place and the scope of activities was improving since the lifting of COVID 19 restrictions and an improving staffing situation.

The overall governance and oversight of this service had been weak and a number of recent changes in management had affected the growth and stability of the service and resulted in poor outcomes for people living here. An experienced manager had come into post since May 2022 and was making significant improvement.

The current management team were helping to shape a more positive culture. Some of the changes were still being embedded. Better communication, support, training and organisation of shift patterns had given staff more coping strategies and reduction of their stress levels. This was resulting in improved care outcomes for people using the service.

The manager had built confidence within their teams and were open and visible. This helped ensure that past poor practice could be quickly identified and stamped out.

Audits helped to determine shortfalls within the service and the provider was listening and seeking formal feedback from relatives and staff. A visiting professional form had been developed but was not being effectively utilised to source feedback. The provider told us they encouraged and sought feedback from professionals.

Experiences of people needed to be captured in more detail and records needed to show how people were being supported in line with their assessed needs.

Overall improvements were still necessary, and we identified a breach of regulation 12 Safe care and treatment and regulation 17 Good governance.

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 good and the report published (21 August 2018.)

Why we inspected
This inspection was carried out to follow up on concerns raised by the local authority as part of their ongoing monitoring of the service. Action plans had been received from the provider and CQC had sought assurances from the local authority and provider prior to inspecting.

This was a focused inspection that considered safe and well led, we found both key questions required improvement. The overall rating for the service has changed from good to requires improvement with

breaches of the regulations, 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.

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

Follow up
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 Croft

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 two inspectors, one was a medicines inspector.

Service and service type
The Croft 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 Croft 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

The manager for this location, has been in post since May 2022, and had been registered since September 2022, but this registration was cancelled in error in December 2022 whilst cancelling a registration for a separate location. The manager of the service is currently in the process of resubmitting their application to the CQC for registration.

Notice of inspection
This inspection was unannounced on the first day and announced to the manager for day 2. Inspection activity started on 08 December 2022 and ended on 16 December 2022.

What we did before the inspection
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 reviewed all the information received about the service including notifications and feedback from the local authority and safeguarding team. We used all this information to plan our inspection.

During the inspection
On the first day of our inspection we carried out observations of care as most people could not tell us about their lived experiences. We did however speak to people over lunch. We reviewed the environment and reviewed 2 care records. We reviewed medicine administration and associated records for 7 people and spoke with 3 members of staff about medicines and the quality assurance officer who was present on the first day. On the second day of our inspection we carried out further observations, spoke to 3 care staff, an activities staff member, and a relative. On both days of inspection, we spoke with the manager, operational manager and. Following the inspection, we spoke with a further relative by telephone.

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

●A refurbishment programme was underway, but we found some areas of the home did not adequately meet people's assessed needs or uphold their dignity. For example, both toilets smelt strongly of urine despite evidence that they had been regularly cleaned. The manager confirmed the flooring needed replacing. The bathroom was functional but did not create a relaxing, sensory space.

●Internal space was compromised and did not fully meet people's needs, safety or promote their independence. For example, the laundry room was very small and communal areas such as lounges were found to be noisy which did not uphold people's sensory preferences for low stimulating, quiet environments, as detailed in their care plans.

●The shared hallways were narrow, and incidents had occurred between people using the service due to a lack of personal space and one person going into other people's rooms.

●One person was living with dementia and another person's risk assessment stated they could eat non-food items. One-bathroom cabinet was unlocked and contained razors and paint which if digested could cause serious harm. Toiletries were also left out making them accessible and placing people at risk of harm.

●The fridge contained cooked, unlabelled and uncovered foods. This increased the risks of staff serving out of date food.

●Individual risk assessments were not always followed by staff. For example, we observed a person eating unsupervised and food was not prepared in line with their plan of care which could increase their risk of choking. Guidance around using a vagal nerve stimulator did not explore any associated health risks or provide guidance to staff about how to check if the device was working effectively.

●People could experience distress behaviours and had positive behavioural support plans in place, but we saw limited evidence that these were drawn up in consultation with other professionals and in line with recognised best practice. They were not cross referenced with other key documents or reviewed regularly after incidents. We saw the word, 'challenging behaviour' used which did not demonstrate a sufficiently person-centred approach.

Using medicines safely

●We noted that some people's topical medicines such as creams and emollients were not being safely stored, placing people at risk of accidental harm. We also found that the application of topical creams was not being recorded and containers were not being handled in a way that identified their shelf-life and how long they had been in use.

●There was written guidance available to help staff give people their medicines prescribed on a when required basis (PRN). Pain assessment tools were in place but did not accurately explore all the ways people might express pain particularly where unable to verbalise this to staff.

● The service was initially unable to provide evidence that all people living at the service received regular reviews of their medicines in line with nationally recognised guidance. The information has subsequently been provided by the GP and shared with us.
●We identified fire safety risks around the use of paraffin-based topical medicines, so we asked the service to put in place appropriate risk assessments to protect people from potential harm.
●Senior staff carried out frequent checks of medicines, however, medicine errors that staff had identified were not being logged and handled in a way that would have led to further learning and improvements.

Risks associated with people's medicine, their physical care and support were not effectively controlled and people lived in an environment which had not been adequately maintained. The above evidence supports a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had received training on medicine management and been assessed as competent to give people their medicines but we have identified a number of concerns about medicine practices so recommend staff competencies be revisited.
●Records showed that people received their oral medicines as prescribed and these were being stored securely and at appropriate temperatures.
●Information about how people preferred to have their medicines given to them and information about people's known medicine sensitivities and allergies was available for staff to refer to. Body maps were available where people had topical medicines applied.

Systems and processes to safeguard people from the risk of abuse
● The risks associated with poor culture had been mitigated as far as reasonably possible following a number of concerns last year. We found however staff were not fully listened to at the time and were working in difficult circumstances with insufficient support from management.
●Adequate oversight would have ensured risks associated with poor care could have been identified sooner. For example, by ensuring adequate numbers of sufficiently trained staff at all times to meet the bespoke needs of people using the service.
●At least one staff member's disciplinary proceedings concluded the staff member had not been adequately supported or trained and had been put in a difficult situation working long hours with insufficient numbers of staff.
● Incidents between people using the service had also occurred which meant people did not always feel safe. The provider has notified CQC of these incidents.
●The new manager was sufficiently challenging and supportive of their staff to ensure going forward, staff were delivering high standards of care and supporting people in line with their individual preferences. All the staff we spoke with were confident that actions would be taken if they raised concerns and they knew what constituted a safeguarding concern and how to escalate it.

Lessons learnt
● Safety debriefs were held with staff, which provided an opportunity to review an incident and agree actions to avoid or further reduce the likelihood of reoccurrence.
●We saw evidence of changes made in response to the outcomes of debrief meetings, for example, shift patterns had been reviewed to help ensure staff were not working for long periods of time with the same person as it was recognised it could be stressful to do so. However, we did not see how changes in staffing was appropriately communicated to people to minimise the impact of change on their wellbeing.
●The provider had addressed concerns about underperforming managers and senior managers and had strengthened its governance processes through meetings to review incidents and learn and share lessons

across the organisation. There was an overview and analysis of incidents to help identify route cause analysis.

Staffing and recruitment

● Staffing had stabilised in recent months with staff being recruited to replace and compliment the use of agency and bank staff. Some staff were new to their role so were still within their probationary period and getting to know people they supported better.

●The manager confirmed that a recent audit on staff files had highlighted gaps in staff records and not all staff had a recorded induction on file. Recent disciplinary action against a member of staff could not be taken forward as there was limited evidence that the staff member had been adequately supported in their role or that there were enough sufficiently trained and competent staff on duty. We reviewed staff recruitment records, and these demonstrated a robust recruitment process.

●People's needs had been reviewed recently by the local authority and additional funding had been agreed for one person in line with their changing needs. Staff had requested some individual hours for another person to support their needs more appropriately. This might be difficult given the large number of vacancies the home was carrying.

Preventing and controlling infection

●We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the home had ran out of paper hand towels, this was being addressed by the manager. There were strong odours in the toilets and the manager confirmed the flooring needed replacing. Some areas of the home had scuffed walls and there was some damage to the ceiling of a person's room from a leaking roof.

● We were assured that the provider was preventing visitors from catching and spreading infections. Risk assessments were in place which included steps taken to ensure the safety of people using the service and their visitors. Staff and a visitor were observed wearing masks and there was plentiful PPE around the service.

●Staff received infection control training to help ensure they understood how to reduce the risk of infection and cross contamination and how and when to use PPE.

●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.

Visiting in care homes

People were safely supported to receive visitors. Inspectors were asked to complete a disclaimer stating they were not exhibiting any symptoms which could be related to COVID- 19 or other infections prior to entering the service. All staff and visitors observed good infection control practices but a lack of hand drying paper towels made it difficult for staff and visitors to follow relevant guidance. .

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

●We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. Documentation described how consent was sought and how decisions were made in the person's best interest as necessary.

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 good. At this inspection the rating has changed to requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to ensure people had received a good, safe service in the last twelve months and had failed to identify through their internal governance systems areas which required improvements. Actions were not taken in a timely way and staff were working under considerable stress. This had resulted in unsafe ways of working.
- The service had previously had a long-standing registered manager and after their departure a number of managers had been recruited but not retained over the last year. This had affected the leadership and stability of the service. Changes in senior management further destabilised this service. Several staff commented on the impact of having different managers in short succession and staff said their initial induction was poor.
- Regular audits were taking place to identify actions to improve the service, despite this we found areas of concern during our inspection which did not assure us of the day to day safety of the service. For example, unsafe products left out.

Weak governance resulted in people not receiving safe care. The above evidence supports a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some of the shortfalls of the service were identified by the local authority when they visited earlier in 2022. The provider assured us they were already aware of these shortfalls and had a plan in place to address the concerns. We saw an extensive action/ improvement plan. Most actions had a compliance date of the end of December 2022.
- We were assured by the actions the provider had already taken which included the recruitment of an experienced manager. Feedback about the manager was positive and staff described them as being supportive and hands on. We found them to be realistic about the 'improvement journey' the service was on.
- A recent change of senior management meant more support for the manager and staff and this was helping to ensure people received good outcomes of care in line with regulation.

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

- Concerns acted on by the provider earlier in 2022 indicated a poor culture of care resulting from

untrained, and unsupported staff. Subsequently staff had received additional training and visible management meant staff felt supported. All staff spoken with felt able to go to the senior management team should they have any concerns about care practices. The manager was observed gently questioning staff practice and setting very high standards.

●The introduction of a deputy manager and senior oversight on shift meant care staff were more supported and seniors took accountability to ensure things were happening as they should. However, at the time of our inspection, the teams were not fully embedded and working effectively as inductions were still in process.

●There was limited evidence of how people were supported in line with their preferences and had opportunities to develop their wider skills and achieve their goals. Daily contemporaneous records were kept by these were limited in detail.

●The provider had a recognised tool which if used correctly measured and recorded progress and change within the service. This had not been fully implemented and meant there was no consistent way of staff recording people's progress and achievements.

●A key worker system, which means a key member of staff for each person to review their needs and spend time on a one to one basis with the person had not yet been established as a lot of staff were new and still building relationships with people. Once a key worker system has been established this would hopefully build in further consistency for people.

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 provider was honest with us about what had gone wrong and how they were addressing the problems within their service and learnt across the organisation.

●Families told us they had lost confidence in the service within the last twelve months and had felt the management was poor. Wider engagement had since taken place with staff's and relatives views taken into consideration as to how to improve the service and meet the needs of people.

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

●Staffing levels were planned in line with people's needs but records did not show how people's wider needs and goals were being met.

●Staff practice did not always promote people's choices and independence. For example, we saw lunch was prepared by staff without consultation or involvement of people using the service. Staff did not fully involve people or promote choices around what people might want to eat by showing different food choices or clearly explaining different options. The manager told us people were involved in food planning and preparation, but this was not what we observed.

● We observed one person's dignity was compromised and felt more consideration should be given to people's sensory and communication needs to ensure people were appropriately supported.

●We found the environment was noisy and not in line with people's needs and more consideration could have been given to peoples need for personal space. Activities were planned with some people going out and some engagement between staff and people using the service was observed

●A family member visiting the service was fully involved and consulted about their family member's care. They were happy with how their relative's needs were being met but this had not always been the case when they described communication in the past as, "Poor". Their relative's needs had changed, and they had felt their needs had been poorly understood but were pleased with the reasonable adjustments that had been made recently.

● Engagement with families had improved and their input valued. People were supported to maintain contact with family and the wider community using public facilities and accessing services appropriate to their needs.

●Improvements were being made in the service. Engagement with other health and social care professionals was improving and the provider was open and transparent about the improvements they still needed to make. Documentation viewed in care plans did not show a collaborative approach to managing risk.

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 Risks associated with people's care, were not fully mitigated placing people at risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Internal governance had not ensured shortfalls in care were identified in a timely way, which resulted in poor outcomes of care for people using the service.