Young at Heart Care Homes Ltd

# Little Croft Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Little Croft Care Home provides personal and nursing care for up to 41 people. At the time of the inspection, 35 people were living at the home.

People's experience of using this service and what we found

We identified through our inspection that the home did not have safe staffing levels during the night. The registered manager told us a minimum of three staff were required each night. We identified on a number of occasions that staffing levels fell short to two staff. Some people required two staff to safely support them. This meant some people had to wait to receive care and experienced delays.

We found shortfalls in relation to the management of people's medicines. Medicines trolleys were left locked but unattended in the dining room. Medicines administration records were not up to date and accurate. They were not double signed by two members of staff when medicines records were handwritten and checked into the home.

The providers systems used to monitor and audit the home were not effective and had not identified the improvements that were required. The provider visited the home, but no formal audits were completed which would have helped to identify any shortfalls. The Quality assurance systems the provider had in place were not robust. Action had not always been taken when staff had raised issues and made suggestions about the running of the home, during staff meetings and when they completed staff surveys.

Staff were employed following a safe recruitment process. Staff had received training to keep people safe and knew what action to take in response to any allegations of abuse. The home was clean and tidy throughout. The premises was safe, with regular health and safety and maintenance checks carried out.

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

Rating at last inspection
The last rating for this service was good (published 10 June 2022). At this inspection, the rating had changed to requires improvement.

Why we inspected

We carried out a focused inspection of the home, due to concerns that had been shared with us. We had written to the registered manager and provider to seek assurances. We used this information to help us plan this inspection. We have found evidence that the provider needs to make improvements. . We have

identified some shortfalls relating to managing people's medicines, staffing levels at night and around good governance. Please see the safe and well-led sections of this report.

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-led findings below.

# Little Croft Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This 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 conducted by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Little 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 home 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We liaised with the local authority safeguarding team.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 9 people who lived at the home and 1 relative who was visiting. We spoke with 8 staff members, the registered manager and care manager. We looked at the care records of 4 people and multiple medicines records. We looked at the recruitment records of 4 staff and a variety of records relating to the management of the home, which included audits.

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.

Staffing and recruitment

- We could not be satisfied the systems in place ensured safe levels of staffing during the night. We were told staffing levels were based on the dependency of people that lived at the home, with a minimum of three staff on duty at night.
- There were potential risks to people and staff because of staffing levels during the night. For example, between the 13 March 2023 and 10 April 2023, we found there were 11 nights when only two carers were on duty. We also found further occasions in May 2023 where only two staff were on duty at night.

- Each person had a personal emergency evacuation plan in place, which were reviewed regularly. 11 people were deemed high needs and requiring two staff with moving and handling. This put people at risk when only two staff were on duty. Staffing levels during the night had not taken into account emergencies and the number of staff on duty to respond in these situations were not safe.
- We spoke with people about staffing levels in the home. The overall feedback was that staffing levels during the day were satisfactory. People reported delays in receiving care during the night time. One person told us, "It feels longer in the middle of the night, you get a bit desperate". Another person told us, "You can be a bit drained in the nights, you can be calling and yelling for quite some time."

People were not always protected from risk because the provider failed to deploy enough suitably qualified, competent and experienced staff. This was a breach of regulation 18 (Staffing) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke to the registered manager and shared our concerns about staffing at night. They told us they were recruiting further night staff. Shortages had been caused due to sickness and staff leaving. During feedback, the provider told us staffing levels at night had been increased to four staff.
- Recruitment procedures were in place and ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Using medicines safely

- We observed during the inspection, that 2 medicines trolleys had been left in the dining room. The trolleys were locked but were not chained to the wall or double locked. We were told by the registered manager, the senior carer should have put them back into the storage area where they were double locked. This therefore did not support the safe storage of people's medicines.

● We found medicines administration records were not up to date and accurate. One example included, one person had refused their medicines on 15 and 16 May 2023. We checked the previous months record for the same person. They had not received the medicines with crossings out throughout their medicines record. The entries to the previous and current record did not match.
● People's prescribed medicines were not being signed into the home correctly by staff. This included keeping a tally of the overall stock and balance. They were also not double signed when medicines records were handwritten.

This meant people we could not be sure the provider had safe systems in place for the management of medicines. This was 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 in administration of medicines, and they had their competency assessed.

● Medicines were stored in line with manufacturer's guidelines. Daily checks were carried out to ensure the medicines fridge and room temperatures were within safe limits.

Assessing risk, safety monitoring and management
● People's mobility needs had been fully assessed and where identified equipment was in place to mitigate the risk of falling. Staff had received moving and handling training.

● Risks in relation to people receiving care and support had been assessed. There were appropriate risk assessments and management plans in place. The provider used an electronic recording system, which identified risks to people.
● The environment was safe. Regular checks had been carried out, which included, but were not limited to, electric, gas safety checks and moving and handling equipment.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living in the home and with the care provided by the staff. Comments included, "I feel safe. No problems here" and "Oh yes.  I would not be here otherwise."

● We found safeguarding incidents were reported, recorded, and investigated. Safeguarding referrals had been made to the local authority. There had been occasions when the local authority felt they had prompted the home to raise safeguarding concerns. We spoke to the registered manager about this and discussed the referrals they had made.
● The staff were knowledgeable in relation to safeguarding people from abuse. One staff member told us, "I think people receive good care. If I had any concerns people were being abused, I would report this."

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 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 home was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. 8 people that lived at the home had an authorised DoLS in place.

Preventing and controlling infection
● We were 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 promoting safety through the layout and hygiene practices of the premises.

● 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 supported to receive visits from friends and family in line with current government guidance. There were no restrictions on visitors to the home.

Learning lessons when things go wrong
● Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Accidents and incidents were monitored by the management team.

● Accident forms were completed electronically by staff. They were checked by the management team and signed off. The registered manager monitored trends in people falling.

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 for this key question 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

● We were not satisfied with the quality assurance monitoring systems in place. Improvements were required to some audits to ensure they were more robust and effective. An example were the monthly audits of the medicines systems were carried out by the care manager. This recorded if tasks were met or not met. The audit did not pick up on shortfalls that we found with any action taken.

● The provider carried out regular visits to the home and supported through daily calls with the management team. No formal audits of the home were taking place by the provider, to evidence how they were monitoring the home and the management team.

● The provider had carried out a staff survey in March 2023. The overall results from the staff survey had not been analysed, shared with staff and an action plan put into place.

● Improvements were needed to the recording of some care documentation. One example included a staff member had written in a person's daily notes on 8 May 2023 at 12.44 hrs, that a person had been checked all night and was settled. This was before all night checks had been completed that night. We did find no evidence of harm as other records demonstrated night checks had been carried out.

The providers systems in place for monitoring the quality of the service were not always robust. They had not identified obvious short falls in practice. This was a breach of regulation 17 (Good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

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

● The staff described a positive culture within the home. Comments from staff included, "I feel we have a really nice staff team. We all care for each other and want the best for the residents". Another staff member told us, "We want to provide a good standard of care to people. I think we really do try hard. The staff are hard working."

● People's care was planned with them, and their preferences were known by the staff. People's records demonstrated a person-centred approach by the staff. The staff knew each person's individual choice about how they liked to spend their day.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The staff told us they received regular supervision with the management team and felt supported within their role. There comments included, "Yes, I have supervision and attend team meetings and handovers" and "I have had regular supervision. I do feel supported".

● Staff meetings were held with the staff team. We looked at the staff meeting minutes held in April 2023. We found the registered manager had not responded when the staff had raised concerns, about other staff practice, the treatment of people and staff competence. When we asked the registered manager what had been done, they were unaware of the comments. They could not show us any evidence of the actions they had taken, but advised they would investigate .

● Handover meetings took place at the start of every shift. Updates on important information and regarding people's wellbeing were shared with the staff.

● People were able to give feedback regarding the care they received from the staff and were able to make suggestions. Resident meetings were held and provided an opportunity for people to share their views on the home.

Continuous learning and improving care; Working in partnership with others; 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 and registered manager understood their responsibilities under duty of candour. The Duty of Candour is to be open and honest when untoward events occurred.

● The registered manager was knowledgeable about their responsibilities and of the types of significant events which they were required to notify CQC about. Records showed the home had submitted notifications to CQC where needed.

● The registered manager told us they used accidents, incidents, complaints and safeguarding as learning tools to improve the home. The lessons learnt were used to enhance staff knowledge and to improve on the service delivery.

● The home worked well and effectively with health and social care professionals to ensure people received good care. This included for example, GP's, district nurses, tissue viability nurses, occupational therapist, physiotherapist, commissioners, and the dementia wellbeing team.

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<br><br>The provider did not ensure that had safe systems in place to manage the administration of medicines safely. Medicines were not stored safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems for monitoring the quality of the service and ensuring people and staff were kept safe were not always robust. They had not identified short falls in practice. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People were not always protected from risk because the provider failed to deploy enough suitably qualified, competent, and experienced staff. |