Inspection Report on

Croes Atti

CROES ATTI RESIDENTIAL HOME
PRINCE OF WALES AVENUE
FLINT
CH6 5JU

Mae’r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

06/02/2020

Description of the service

Personal care for 31 adults is provided at Croes Atti which is located in Flint. The service also has a dedicated unit, Oak View which supports people living with dementia. There were 30 people resident on the day of the inspection.

Flintshire County Council is the registered provider and Mr Mark Holt is the responsible individual (RI).

The manager is registered with Social Care Wales (SCW).

Summary of our findings

1. Overall assessment

People are treated in a caring manner, with dignity and respect and have positive relationships with staff. People living in the service, their relatives and visiting health professionals spoke positively about staff and their caring and understanding approach, were happy with the care and support provided and told us staff communicate changes in health quickly and discuss ways in which support can be changed to support individuals further. However, the written record requires improvement to fully evidence this approach. Improvements are also needed in relation to other records within the service. The training programme, in its current form is unclear and details documented relate to core training and not training that may support specific areas of practice, staff files require auditing to ensure they contain all required information and records to evidence environmental and equipment checks should be readily available. The areas for improvement have been discussed with the RI who has provided details of the actions taken and those proposed.

2. Improvements

The home was recently re-registered under the Regulation and Inspection of Social Care Wales Act 2016 (RISCA) and this was their first inspection under the new legislation. Any improvements will be considered as part of the next inspection.

3. Requirements and recommendations

Section 5.2 of this report sets out the areas where the service can be improved and areas where the provider is not meeting legal requirements. These include:

Staff training
The management of records

- Personal care records and supporting charts should be fully completed to reflect the care and support people have received.
- Assessment records and personal plans should include signed consent.

- Six monthly reviews of medication should be requested.
- The front door should be secure and safe from unauthorised access.
- Evidence of service checks and equipment should be available.
- The statement of purpose should be kept under review to show the providers position in relation to the Welsh Active Offer.
- Policies and procedures should be readily available for staff to access easily.
- The training programme should be clear and evidence the training received by staff.
- Training specific to need should be available for all staff.
- An audit of staff files should be completed.

An up to date progress report of actions taken should be forwarded to CIW to provide details of the improvements being made.

1. Well-being

Our findings

People living in the service are offered warmth, encouragement and emotional support in their day-to-day care. Observation of staff practice demonstrated they understood each person and the support provided was personalised. Positive interaction was evident between staff and people living in the service and we saw staff spending time with people following completion of personal care tasks, this was welcomed by each individual. Their manner was different with each person demonstrating staff recognised their individuality. Residents and relatives were positive about the care and support provided by staff and felt it was in line with their wishes. One relative commented '*staff support my relative and their independence to the best of their abilities, they don't de-skill them so they won't lose their abilities'*. Individual's emotional needs, especially when they were distressed, were responded to positively and difficult situations were managed with compassion and respect. One relative told us staff had taken time to understand their relative and were now clear of what triggers may change their behaviour and acted quickly to reduce the person's distress, '*they understand her ways'* this was supported by another relative who described how staff reduced their relatives anxiety which calmed the individual and reassured the relative they were being well looked after. People are treated with dignity, respect and the care and support is individualised.

People living in the service feel safe but improvements are needed in the management of records to demonstrate people are fully protected from abuse and neglect. Residents and relatives were satisfied with the care and support provided and felt reassured by the care provision. Staff were able to explain why changes to support had been required and direct us to additional records which would support their comments but, all personal plans did not fully reflect the support required or the rationale for the changes in support. Staff received mandatory training but the records did not fully evidence any training specific to the range of needs supported, staff files lacked required information and service records were not located on site. Staff training and recruitment records must be reviewed to evidence staff fitness. The management of records does not fully evidence that processes are in place to ensure people are protected from harm and neglect

The service incorporates features which support people living with dementia. The home was spacious and enabled people freedom of movement between communal areas, bedrooms were personalised but, further attention was needed to areas to support people living with dementia to maintain and promote orientation.

2. Care and Support

Our findings

Care and support is delivered in a dignified and respectful manner but, personal care records require further development to ensure there is clear evidence of the care and support provided. Pre admission assessments were completed and this was confirmed in conversation with a resident and two relatives who told us they had visited and had been told '*everything*' about the service. We viewed a selection of personal plans, those for permanent residents included one page profiles, provided details of all aspects of the care and support needed to assist the person and of reviews carried out. A resident and the relatives spoken with confirmed they had been involved in the process but when viewing a sample of assessments and plans we noted not all evidenced individuals signed agreement. Care must be taken to evidence people's involvement. We did note, on the file of a person who had been receiving short term care since October 2019, there was no plan available. We were told a bedroom support plan was developed which included an overview of the support required until the full plan was produced, but the actual plan was not in place. A full plan should be available within seven days of admission. Medication was managed effectively and a support plan, to assist the person, was included on files, there was evidence of reviews being completed but not at formal intervals. Two relatives told us how staff had discussed their relatives medication with them, explained why changes were needed and of the outcome of the review. We viewed a sample of support charts. The detail of one re positioning chart was confusing, the dates were not always included and there was no specific frequency to the times of repositioning and charts to document when creams had been used or oral health care monitored, were not fully completed. Personal plans must include sufficient detail to inform and enable staff to meet the individuals care and support needs, without this information staff cannot be responsive or pro active in identifying and mitigating risks.

We viewed records which demonstrated the involvement of GP's, district nurses and community psychiatric nurses and the personal plans showed when changes had been made to the delivery of support but we did not always find a separate record detailing the specific actions or actions or guidance prescribed. When reading one plan staff had recorded they had noticed a 'bruise', there was evidence staff were monitoring the area and the deputy explained the GP had visited and the cause was due to medication resulting in its review but there was no record of the discussion with the GP. One visiting health professional told us '*staff are wonderful with patients. Always communicate with us any concerns and will ask for advice. Care is provided to an excellent standard from start to the patient's end of life*'. Improvements to the records are required to evidence people receive the right care at the right time.

People feel safe and reassured but the systems to evidence how people are protected require development. One Deprivation of Liberty Safeguard (DoLS) was fully completed and authorised, others completed had been applied for but not yet authorised and many required renewal. The manager had contacted the local authority for updates regarding progress but this was not formalised. The applications should be reviewed to ensure they remain current and applications reapplied for where necessary. People are enabled to make choices and decisions in their daily life, where mental health limits this decision making, verbal cues were observed and when greater decisions were needed health professionals and relatives were consulted to discuss ways in which the best interests of the person were considered. The provider's quality review process engaged with people in various ways to gather their views regarding the operation of the service. Residents have families or friends who speak on their behalf and people told us they felt able to raise concerns and confident they would be addressed. Reviews with health professionals provided people with further opportunities to raise any concerns they may have. Overall there are systems in place to keep people safe and enable them to express views.

People's individuality is respected by staff and support is provided with dignity. The Provider had achieved the bronze standard and was working towards completion of the silver level of the 'Progress for Providers'. This is an award developed by the local authority which recognises the importance of providing person centred care, enabling people to receive care and support in the way they want and to find ways of improving upon areas that are not effective. Staff were able to describe the support individuals required and how it was provided. We observed a number of occasions where staff positively interacted with people living in the home. We saw staff taking time to assist with medication and noted staff eating their own meals with residents which enabled them to observe, assist and encourage people in an unobtrusive manner. One relative said staff were '*excellent*' and another said they were '*brilliant*'. People have positive relationships with staff who take time to listen and understand their individual needs and preferences.

Overall, staff have an understanding of the identified needs of people living in the service and information is shared verbally but written records do not always evidence this understanding. Verbal information can be misinterpreted, comprehensive written records should be maintained to provide clear direction for staff when providing care and support

3. Environment

Our findings

The environment is comfortable and well maintained. When we arrived the front door to the service was unlocked and we could enter easily which increases the risk of unauthorised entry. We recommend the security of the entrance be reviewed. Accommodation was offered on one floor, one side of the building supported people who required assistance with personal care the other supported people living with dementia both areas were noted to be clean. However, we were told there was no specific cleaning schedule in place. One room was a designated smoking room and although there was an extractor fan in place, this was not eliminating the smell effectively. This should be attended to. The systems in place to monitor domestic standards could be further strengthened to ensure peoples safety and comfort.

Corridors are spacious and bright enabling people to move around freely the additional inclusion of visual clues such as colour schemes or signage would assist with orientation. There were a number of communal areas which provided people with opportunities to find a quiet space or socialise. There were different types of seating offering choice and comfort to suit different abilities. Bedrooms were personalised to varying degrees and were based on people's individual preferences and people had been encouraged to bring personal belongings and pieces of furniture to personalise their room however we noted there was little to distinguish one bedroom door from another. We saw people using all communal areas of the home and the layout promoted independence, meaning people were able to find their way around independently however, bathrooms and toilets were not clearly identified which was not helpful in aiding people with orientation. The home was decorated to a good standard but further attention should be given to the use of visual clues and signs to assist individuals in orientation.

The provider has systems in place to service equipment and monitor the environment, records to evidence the safety of equipment and of specific checks completed should be available on site. The records viewed showed the service of equipment such as hoists were not current and the fire risk assessment available to view was not in date. We discussed this with the manager and RI who explained the local authority maintenance department complete checks and the information was retained at head office. Records should also be available on site to evidence the checks and their frequency. We did view fire records which confirmed the annual service was completed in June 2019 and weekly checks of the fire alarms were carried out with a record maintained. Personal Emergency Evacuation Plans (PEEP) for people living in the service were completed to ensure staff awareness of each individual's abilities to leave the home if needed in an emergency. Equipment to reduce risks to the safety of individuals were used. The district nurses complete assessments to determine if bed rails were required and was visiting on the day to carry out an assessment for one person. Sensors were in place in some rooms which alerted staff to the movement of people at risk of falling. The safety, condition and use of the grounds were considered as

part of the maintenance programme. There was a secure patio area which included raised beds and a covered, seating area for people to sit and enjoy the gardens. People live in accomodation which supports their well-being however, the environment could be improved further to maximise independence and demonstrate unnecessary risks are identified and addressed.

4. Leadership and Management

Our findings

The statement of purpose provides information about the service and facilities available. In reference to the 'active offer' of the Welsh language it stated '*Croes Atti is working towards the Active Offer. There are currently a number of care assistants who are fluent in Welsh*' documentation could be translated into Welsh and Welsh language courses were available through the providers training programme; we looked at staff training records but Welsh language training was not reflected. At the time of inspection, English was the main language spoken in the care home (none of the resident group spoke Welsh and only one staff member was Welsh speaking). The lack of an 'active offer' does not have any negative impact on the current resident group, however, the statement of purpose should be reviewed to enable prospective people to make informed decisions around the services ability to adequately meet their individual language need.

The provider should ensure that all staff receive training appropriate to the work they are to perform. The training programme was unclear and was difficult to follow without assistance. The deputy explained the list was of training completed in the current year, and the dates documented showed refreshers completed or the date the training was valid until. It is recommended that the method of recording training be reviewed to ensure clarity and to evidence the training staff have received. We noted the training listed was mandatory such as manual handling and first aid but training to manage the variety and range of needs such as tissue viability, early onset dementia and epilepsy were not included. It is important that all staff have an understanding and awareness of the health needs they are required to support. The staff files viewed showed some courses had been accessed but subjects on each file varied. This was discussed with the regional manager on the day, who provided us with evidence of additional training courses available. We also discussed this with the Responsible Individual (RI) who confirmed if required courses were not available these would be accessed externally and advised this would be addressed. The lack of training to support all assessed needs is a breach of the regulations. As actions are being taken to address the shortfall a non compliance notice has not been issued but the situation will be reviewed at the next inspection.

Records relating to people living in the service, staff and the environment must be up to date, available and in good order. We found areas of practice which could be improved. Staff files varied in content with each of those viewed lacking a piece of required information. Service records were not available on site, the file of policies and procedures had not been reviewed for some time, charts were incomplete and personal plans required additional information to ensure they fully reflected the care and support provision. This is a breach of the regulations as records must be available on site to evidence the effective operation of the service. A non-compliance notice has not been issued on this occasion as the provider is taking action to rectify the situation.

We discussed our findings with the area manager on the day of the visit. We were shown where policies and procedures could be downloaded and these were current and up to date. We recommend all policies and procedures, relevant to practice in the service, be available as a hard copy to ensure staff are able to easily access the information as it is required. We viewed the RI quality of care review for the period April – September 2019 which showed views from people using the service had been gathered. We noted areas we had found required improvement corresponded with areas identified within the report however the areas would not be followed up until the next review which would begin in March. Following the inspection we spoke with the RI who confirmed that the monitoring process had now been reviewed and areas identified as part of their review would be included within an action plan, this would then be monitored at the area manager's monthly visit and would provide direction for the basis of the next quality review. The RI confirmed the provider's head office retains details of service and equipment checks and the full recruitment details of each staff member but confirmed that an audit of staff files would be completed and a system to enable information to be available on site would be considered. This will be followed up at the next inspection to ensure the actions taken evidence the commitment of the provider to quality assurance and constant improvement.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

None

5.2 Recommendations for improvement

We have advised Flintshire County Council that improvements are needed in relation to staff development (Regulation 36.(2) (d)) staff must receive training appropriate to their role. We have not issued a notice of non-compliance on this occasion, as there was no immediate or significant impact at the time of the inspection for people using the service.

We expect the service provider to take action to rectify this and we will follow this up at the next inspection.

We have advised Flintshire County Council that improvements are needed in relation to the management of records (Regulation 59) as records retained on site were not up to date and the full detailed records were retained at the providers head office. We have not issued a notice of non-compliance on this occasion, as there was no immediate or significant impact at the time of the inspection for people using the service.

We expect the service provider to take action to rectify this and we will follow this up at the next inspection.

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- Assessment records and personal plans should include signed consent.
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An up to date progress report of actions taken should be forwarded to CIW to provide details of the improvements being made.

6. How we undertook this inspection

This was the first inspection of the service following re-registration under The Regulation and Inspection of Social Care (Wales) Act (RISCA) 2016. The inspection was completed as part of our inspection programme.

We, Care Inspectorate Wales (CIW) carried out an unannounced inspection on the 15 January 2020 between the hours of 08.45 am and 6.30pm. This was a full, scheduled inspection reviewing all four quality themes. In addition we received concerns which raised issues around the care and support provided these were considered within the inspection process.

We based our findings on:

- Observing staff interaction and engagement with people living in the service. The Short Observational Framework for Inspection (SOFI2) tool was used to formalise observations. With this tool we can record life from the perspective of the person using the service; how they spend their time, activities, interactions with others and the type of support received.
- Conversations with four people living in the service, the domestic worker, administrator, hairdresser, two senior care workers and the deputy.
- A review of information held by CIW about the service including the Statement of Purpose.
- Viewing communal areas and a selection of bedrooms.
- Reading five personal plans.
- Reading three staff files and the staff training programme.
- Reading the Providers Quality of Care Review for April-Sept 2019.

We completed the King's Fund environmental assessment tool with the deputy, this is a nationally recognised tool which was developed to bring together best practice in creating a supportive care environment for people living with dementia.

Questionnaires were completed by three staff and a visiting health professional, we also spoke with four relatives by telephone following the inspection. Comments have been included in the report.

Feedback was given to the deputy and area manager during the inspection and the manager and RI by telephone following the inspection.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Care Home Service**
Service Provider	**Flintshire County Council**
Registered Service	**Croes Atti**
Responsible Individual	**Mark Holt**
Registered maximum number of places	**31**
Date of previous Care Inspectorate Wales inspection	**This was the first inspection since the service attained registration under The Regulation and Inspection of Social Care Act (Wales) 2016.**
Dates of this Inspection visit	**15/01/2020**
Operating Language of the service	**Both**
Does this service provide the Welsh Language active offer?	**No**
Additional Information: **The service is working towards providing an 'Active Offer'**	

Date Published 24/03/2020

No noncompliance records found in Open status.