Croft Carehomes Limited

Croftland Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Croftland Care Home took place on 23 and 30 May 2017. We previously inspected the service in July 2015; we rated the service Requires Improvement. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Croftland Care Home is a nursing home currently providing care for up to a maximum of 55 older people. The home has four distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 42 people were being supported in three of the four units within the home.

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

People told us they felt safe but we found some aspects of the service were not always safe. We observed some staff using unsafe moving and handling practices to transfer people and we also saw staff use wheelchairs which did not have footplates attached. We were not able to evidence that all the slings in use at the home were compliant with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

There were systems in place to ensure staff were recruited safely and people did not raise any concerns there were not enough staff to meet their needs. People and relatives felt staff had the skills needed to meet their needs. New staff were provided with an induction and there was a programme in place to ensure staff received regular training and management supervision.

Medicines were not always stored safely to prevent unauthorised access. We observed safe storage and administration of medicines on two of the units but we raised concerns about some of our observations on the third unit. We checked the stocks of people's medicines and found they tallied with the written records of administration. Staff completed training in medicines administration and had an assessment of their competency to administer medicines.

Peoples care plans contained an assessment of their mental capacity but the assessment was not always decision specific and there was a lack of evidence to support the best interest's decision making process. We have made a recommendation about meeting the requirements of the Mental Capacity Act 2005.

People received support to access external healthcare professionals appropriately.

People spoke positively about the food. Meals looked well-presented and people were offered a verbal choice. On Redwood unit, not everyone was offered a drink at lunchtime and some people had their meal

served to them prior to staff being available to support them to eat.

People were supported by staff who were caring and knew them well. Staff mainly worked on the same unit which enabled them to get to know people's likes and preferences. Staffs' interactions with people were appropriate and staff acknowledged people as they entered communal areas. People told us they were able to choose when they got up and went to bed. People's privacy and dignity was generally respected although we observed two incidents on the first day of our inspection where people's dignity was not maintained.

People told us there was a range of activities provided for them including trips out within the local area.

Peoples care plans were person centred and recorded details about their likes, dislikes and preferences. Care plans were reviewed and updated at regular intervals. Staff recorded the daily care and support people received including safety checks and personal care.

The registered manager recorded information regarding any concerns or complaints, including the action taken to address issues raised.

People spoke positively about the management of the home. Meetings were held regularly with staff and people who lived at the home, to gain their views and share information.

There was a system of governance in place and this was undergoing further development. Regular audits were completed both internally and by external organisations. Where concerns were identified, these were recorded and action plans implemented, however, the required actions were not always addressed in a timely manner.

The registered manager submitted statutory notifications in line with their regulatory duties and we saw the previous CQC inspection report and rating was on display at the home.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all aspects of medicines management was safe.

We observed two incidents of inappropriate moving and handling and we saw staff transferring people in wheelchairs without footplates.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received on-going training and management supervision.

Mental capacity care plans and capacity assessments were in place but they were not decision specific and there was a lack of evidence regarding best interest's decision making.

People spoke positively about the meals provided at the home.

People had access to external health care when required.

Is the service caring?

Good

The service was caring.

We observed kind and caring interactions between staff and people who lived at Croftlands.

People were cared for by staff who knew them well.

People were supported to make choices about their daily lives.

Is the service responsive?

Good

The service was not always responsive.

People were provided with a range of activities to participate in.

Care plans were person centred and provided adequate detail to enable staff to provide peoples care and support.

People's concerns and complaints were recorded and acted upon.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

There were systems of governance in place but identified shortfalls were not always addressed in a timely manner.

There was a registered manager in post.

Regular meetings were held with staff and people who lived at the home.

Croftland Care Home with Nursing

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 May 2017 which was unannounced. An unannounced inspection is where we visit the service without telling anyone. The inspection team consisted of three adult social care 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. The expert by experience on this occasion had experience of working in health and social care. One inspector also visited the home again on 30 May 2017. This visit was announced and was to ensure the registered manager would be available to meet with us.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the communal areas observing the care and support people received. We spoke with eight people who were living in the home and six visiting relatives. We also spoke with the registered manager, deputy manager, two nurse, a senior carer and three care assistants, an activity organiser, a cook,

the administrator and two visiting healthcare professionals. We reviewed four staff recruitment files, eleven people's care records and a variety of documents which related to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Croftlands. Comments included, "I feel very safe", "Yes, I have no complaints about safety" and "Oh yes I am safe here." A relative told us "This is why I placed my relative here, as I feel [person] is very safe here."

We observed medicine rounds on each unit. We saw one nurse administered the medicines in a safe way, checking the medicine administration records (MAR's) prior to dispensing the medicines and signed the MAR following administration. We also observed a senior carer administers people's medicines. They asked people if they wanted their medicines and where a person declined, this decision was respected.

On two of the units the medicines were stored safely. The room and the medicines trolley were kept locked and a check was maintained on the temperature of the room to ensure the temperature did not affect the efficiency of the medicines. On another unit the medicines room was not locked when the nurse left the room to administer people's medicines. We raised this with the nurse and they informed us they always closed the medicines trolley and locked it, however, we saw fortified drinks and thickening agents were on the shelves which could be accessed by anyone who entered the room.

However, on another unit we found that not all aspects of medicines management were safe. One person's medicines were administered covertly; this is where the medication is administered in a disguised form. We saw the person was given a cup of tea which contained their medicines while they were sat in a communal area. We asked the nurse how they knew the person had taken all their medicines, they replied, "If the teas' gone I know [person] has had it. If it hasn't I know [person] hasn't had it." After we spoke to the nurse they asked a member of staff to observe the person to ensure they had taken all their medicine. We raised concerns regarding this approach because in January 2017 the registered manager had notified us of an incident at the home where it had been unclear if another person had drunk another person's drink in which staff had placed their covert medicines. We informed the registered manager of this at the time of the inspection.

We also noted one person was prescribed a pain relieving medicine to be administered as a regular dose but staff were administering the medicine on an 'as and when required basis'. When we brought this to the attention of the nurse, they said they would speak with the persons GP regarding changing the administration instructions. Information regarding one person's bedroom number had not been updated and was incorrect, which could result in their medicines being administered to the wrong person.

These examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed controlled drugs, these are specific medicines which are classified under the Misuse of Drugs Act 1971 and there are regulations regarding their management and administration. We saw they were stored and administered in a safe way. Where people were prescribed medicines which were to be taken 'as needed' (PRN) and we saw there was a protocol in place. Having a protocol in place provides

guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We completed a random stock check of three people's medicines and found the stock tallied with the number of recorded administrations. Where medicines were administered from the original box, supplied by the pharmacist, staff recorded the administration on a stock balance sheet as well as the medicine administration records (MAR's). A senior staff member said this helped to reduce the risk of making mistakes with medicines.

A senior carer told us they had completed medicines training and an assessment of their competency had been completed but they were unsure if competency assessments were completed regularly. From our discussion with them and our observation of their practice we did not have any concerns regarding their skills. When we checked their personnel file we found the most recent medicines competency assessment was dated August 2014. We raised this with the clinical lead and they completed an assessment of the senior carer on the day of the inspection. We also checked the personnel file for one of the nurses who was on duty on the day of the inspection and saw their induction paperwork included a section to confirm they were competent to administer people's medicines. Having well trained staff reduces the risk of making mistakes with medicines.

The clinical lead completed a monthly audit which included general safety, administration and stock control. We also saw an audit had also been completed by an external consultant and the action taken by staff to address points raised in the audit. Audits provide an opportunity to identify any shortcomings or areas for improvement to enable them to continuously improve the services they provide.

Each of the care plans we reviewed contained a variety of risk assessments, including falls, bedrails, skin integrity and malnutrition. We saw these were reviewed and updated at regular intervals and recorded the level of risk for each individual. Nurses and senior care staff we spoke with were able to tell us about actions they would take where people were identified as being at high risk. For example, one of the nurses we spoke with told us a person had been having frequent falls and a referral had been made to the falls team. A senior staff member talked to us about another person who was at high risk of falls and had also lost weight. They told us changes had been made to the person's diet and they were in the process of making a referral to the falls team and the dietician. Assessing risks helps to identify where staff may need to take additional actions to reduce the risk of harm to a person.

Care plans contained moving and handling risk assessments and care plans, but we noted the care plan for one person did not record which hoist or sling staff were to use. In another care plan we found all their care plans had not been updated to reflect the changes to their mobility. For example, their communication care plan recorded they liked to mobilise around the unit but their moving and handling records referred to their need for a hoist. Ensuring this information is detailed and accurate reduces the risk of people receiving unsafe or inappropriate care. We brought these matters to the attention of the registered manager and amendments were made to the relevant care records.

During our inspection we observed poor moving and handling techniques from two staff on one of the units. On the first day of our visit we observed two incidents where staff placed their arms under the person's armpit to assist with the transfer. Using this method is no longer considered good practice and can cause serious harm to the person and staff. When we reviewed the care plan for one of the people we saw staff had made an entry which referred to the person having bruising on their arms and legs. We informed the registered manager about this and when we returned on 30 May 2017 we saw evidence of the action the registered manager had taken to address this, including a referral to the local authority safeguarding team and a supervision meeting with the relevant staff. During the inspection we also saw examples of staff using

safe moving and handling techniques and where people wished to mobilise independently we saw they were able to do so.

On the first day of our inspection we saw staff transfer people on three separate occasions in wheelchairs without footplates. It is essential that wheelchairs are used with footplates to prevent harm to people who are using them for transport. We saw a person sat in the dining room in a wheelchair which did not have any footplates, we asked a care worker about this and they told us they were aware the wheelchair should have footplates but they said they had been unable to locate them that morning. We brought this is to the attention of the registered manager and on the second day of our inspection we did not see any wheelchairs being used which did not have footplates attached.

On the first day of the inspection we noted one person was sat in a wheelchair that did not have footplates and the brakes had not been applied. We saw the person attempt to stand, although staff responded promptly. We asked two members of staff about this person and they told us the person frequently removed the brakes themselves, they also told us the person lacked capacity to assess the risk of harm to themselves. But when we reviewed their care plan we saw their risk assessment made no reference to this aspect of their care. We brought this to the attention of the registered manager.

We saw evidence external contractors were used to service and maintain equipment, for example the gas appliances and the fire detection system. We also saw evidence that moving and handling equipment had been serviced line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). However, we saw a sling draped over a hoist and two slings in people's bedrooms where the serial numbers were unreadable. When we reviewed the LOLER records for the home, dated October 2016 it listed 25 slings that were 'not located' and therefore had not been tested. This included the sling which was identified to be used for a person whose care records we had reviewed. We brought this to the attention of the registered manager at the end of the first day of the inspection. When we returned for the second day of the inspection the registered manager showed us an audit which had been completed of all the slings in the home. They told us all slings where the serial number could not be read had been removed from service. This showed the registered manager had responded promptly to reduce the risk of harm to people. Following the inspection we spoke with the registered manager and they confirmed the service contractor had since returned to the home and all the slings in use were compliant with the LOLER regulations.

These examples further demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded and the registered manager showed us how they logged and analysed them. This enabled the registered manager to identify possible trends and provide an opportunity to implement changes and learning.

There were systems in place to reduce the risk of fire. We saw evidence external contractors serviced the fire alarm and relevant fire equipment. There were also a number of weekly checks completed by a member of staff to ensure on-going monitoring of the fire detection and evacuation systems. In the fire file there was a Personal Emergency Evacuation Plan (PEEP) summary sheet for each unit. A PEEP is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. We saw fire drills were held on a regular basis, we asked the registered manager if they had a system in place to enable them to easily identify staff who had not attended a recent drill. They told us they did not but they assured us they would implement one following the inspection. Participating in regular fire drills helps to ensure staff are confident in their role in the event the fire alarm is activated.

Safe recruitment practices were in place. We asked one member of staff about the recruitment procedure. They told us they had attended the home for an interview and they had then had to wait for references and Disclosure and Barring Service (DBS) check to be returned prior to them commencing work at the home. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable groups. We looked at four staff recruitment files and saw application forms had been completed; references and DBS checks had been obtained. We also saw a regular check was completed on the professional qualifications of nursing staff employed at Croftlands. This showed the registered manager had ensured staff members were continuing to meet the professional standards that are a condition of their ability to practice.

When we asked people if there were enough staff on duty to meet their needs, one person said, "There is enough staff – they are good", a second person said, "There is not enough staff, they come when they can." Staff told us they were busy but did not express concerns regarding the staffing numbers at the home. The registered manager told us they planned the rota to try to ensure there was either a nurse or a senior carer on each floor as well as care staff. There was also a 'floater' on duty each day who worked between the units throughout the day. One of the staff we spoke with told us the 'floater' came on their unit at noon, "If we are busy, they stay and that is good, they help with lunch and then I can do the medicines." In the two days we spent at the home, we observed staff to be consistently busy although staff did not appear anxious or worried about their workload.

All the staff we spoke with told us they had competed training in safeguarding and staff were clear about what to do if they were concerned people were at risk of harm or abuse. A staff member said, "It depends on the severity, but we would report on an accident or incident form, fill in a body map. We tell safeguarding. We can also escalate to CQC if we need to." Another staff member said, "If a service user hit another service user, I'd inform the manager, I have rung safeguarding myself. Last week a service user hit another, we did half hourly observations for a couple of days." The manager told us they actively encouraged staff to report incidents, they told us all incidents were logged and reviewed by themselves so they could check for themes or trends which may need addressing. This showed there were systems in place to protect people from the risk of harm or abuse.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke with told us they thought the majority of staff were trained to be able to meet their needs or their family's needs. Comments included; "The staff are brilliant, they also call the doctor if I need them" and "The staff do know what they are doing."

We spoke with one staff member who said they had completed a period of induction which included the completion of training and shadowing another experienced colleague when they commenced employment. We checked the personnel file for this member of staff and two others who had been employed for less than a year and saw evidence of their induction. This covered a range of topics including their role, duty rotas and policies. This showed new staff were supported in their role.

Staff told us they completed training in a variety of subjects. The training was predominantly e-learning but staff also told us they completed a practical element to their moving and handling training. A senior staff member said they were qualified to train other staff in moving and handling techniques; and the registered manager notified them when staff were due to have this aspect of their training refreshed, allowing them time to set aside for this to be done. Two of the staff said they had very recently attended face to face training in how to support people with behaviour which challenged others. The registered manager told us they had received positive feedback from staff regarding this training and they planned to enable more staff to be able to attend in the future.

The administrator provided us with a training summary report. This recorded there were 61 staff employed at the home, of which, 75% had 90%or above compliance with training requirements. The administrator told us the system they currently used flagged up staff in amber when training was due to be refreshed, they said the colour changed to red if staff had not refreshed the training within the set timescale. They explained this enabled them to monitor staff compliance and take action where needed with non-compliant staff. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

We checked to ensure staff received regular supervision of their performance and development needs. All the staff we spoke with said they received regular supervision from a more senior colleague. When we checked four staff personnel files we saw evidence of regular management supervision. Two of the nurses we spoke with also told us they regularly supported staff when they were providing personal care for people. They said this enabled them to observe staff practice; this helps to ensure staff have the skills and competencies to meet people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us fourteen people who lived at the home were subject to a DoLS authorisation.

On one of the units we saw one person who was visibly upset and constantly asking for money. We asked a member of staff if the person could be given a small amount of money, they responded, "They will then ask for the bus stop it isn't just about money it is about wanting to go home." We noted the person had been living at the home for less than two months and we saw they were highlighted on the registered manager's information sheet that this person required a DoLS application to be submitted. Following the inspection we spoke with the clinical lead and asked them to ensure their application had been prioritised, we also discussed methods being employed by staff to reduce the person's anxiety.

The MCA also provides the legal framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves. Where a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney.

In order to support people living with dementia to make decisions, staff need to establish whether the person has capacity to make decisions and identify when decisions need to be made on behalf of the person and in their best interests. Each of the care plans we reviewed contained a mental capacity care plan which recorded, for example, if people could retain information or make decisions about their daily lives. One of the care plans recorded staff were to act in the persons' best interests when supporting them with their personal care as they were unable to make decisions regarding this aspect of their care, but there was no evidence of the best interest's decision making process regarding this aspect of their care.

We reviewed the care plan for a person who had their medicines administered covertly. We found there was a record of the best interest decision, which included the input of their GP and an independent mental capacity assessor (IMCA). There was also a letter of authority from their GP to administer their medicines covertly. However, we could not locate the mental capacity assessment although the best interests recorded that an assessment of the person's capacity had been completed. We brought this to the attention of the registered manager and they provided a copy of the assessment following the inspection.

The care plan for another person had a mental capacity assessment in place but the assessment was not decision specific. For example, their mental capacity care plan recorded had 'no concept of personal safety', this statement was also recorded on their mental capacity assessment but there was no record of the best interest's decision making process for any aspect of their care. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

We recommend the registered manager seek advice and guidance from a reputable source, regarding MCA assessments.

Staff told us they had completed e-learning in MCA and DoLS. Their responses to our questions and our observations of their actions demonstrated they understood how they were to apply the principles of the MCA in their role. We heard staff offering people choices, for example, what they wanted to eat or drink, if

they needed assistance. We also heard staff respect people's wishes when a choice had been made.

The majority of the people we spoke with told us they were happy with their meals. Peoples comments included; "The food is brilliant", "I have a full English breakfast and cornflakes, the food is marvellous", "The food is very good, if I do not like it, they will give me something else" and "I am a fussy eater, the staff know and I get what I like. I do enjoy the food." A relative commented, "My relative loves the food; they have actually put on weight."

On Cedar unit staff told us people were prompted to sit at the dining table to eat their lunch but they were free to eat where they chose, however, we noted the dining tables could only seat six people yet the unit could accommodate a maximum of 10 people. At lunchtime a member of the catering team came to the unit to serve lunch. They offered a verbal choice to people, although where people did not indicate which meal they wanted the staff member made a choice on their behalf. We asked them about this and although we were satisfied they were trying to ensure they made a choice the individual would prefer there were no alternative methods of offering a choice to people, for example, visual choice of two plated meals or picture cards.

On Ash unit we saw the menu was written on a whiteboard for people to see, tables were set with appropriate cutlery and at lunchtime three staff were present. Some people ate at the dining tables and we saw four trays were served to people in their rooms. Staff offered drinks and we noted one person had a glass of wine with their lunch. People looked as though they enjoyed their meal and they were able to eat without being rushed. Where people needed support to eat we noted this was provided.

On Redwood the cook brought the lunchtime meal onto the unit at 12.45; they asked people what they wanted to eat and began to serve meals to people and staff provided cutlery and napkins to people as they received their meal. We heard the cook ask one person what they wanted to eat and then ask a member of staff if they were going to support the person to eat. At 1pm we noted their meal was still in front of them but no member of staff had supported them to eat, although when a member of staff went to assist them they supported them in a nice manner, prompting them to eat a little bit more. One person said they wanted a sandwich as an alternative to the meal, this was provided for them by the cook. But we also noted one person still had their lunch in front of them at 3.15pm which was presented to them at 1.00pm.

We saw a member of staff move a person's recliner chair into a seated position before they supported them to eat; this helped to reduce the risk of the person choking on their food. However, the staff member placed the person back into a reclined position and walked away when they had finished their meal without offering or providing the person with a drink. We noted other people in the dining room were not all offered or provided with a drink.

The care plans we reviewed contained an eating and drinking care plan. One of the care plans recorded the person required a pureed diet but normal fluids, and we saw they received this at lunchtime. Another care plan noted 'prefers meals to be hot or [person] will push it away and refuse to eat it'. We reviewed the food diaries for two people; on one of the records we saw staff recorded what the person had been given and what they had eaten. Staff also recorded where the person had refused their meal and the food they had been offered by the night staff. On the second persons' records we saw staff had recorded a similar level of detail including where they had been provided with mid-morning snacks. We noted they had been prescribed a nutritional supplement a few days prior to the inspection and although this was not recorded on their charts as having been provided, it had been signed as administered on their MAR and the stock balance indicated staff had provided the supplement to them. This level of detail is important to ensure an accurate record of people's dietary intake is retained.

The nutritional information in the care plan for one person, noted they required a soft diet, although this appeared to be due to them not having any teeth and pouching their food rather than due to a problem with their ability to swallow. On another document, a nutritional screening tool, 'normal diet' was highlighted. When we looked at a random sample of food diaries we saw staff had recorded the person had eaten chips on 22 May 2017. We brought this is to the attention of the registered manager to enable them to ensure the person's care records were an accurate reflection of their needs and staff understood what foods the person could eat safely. On the second day of the inspection the registered manager told us the persons care records had been reviewed and a referral to the speech and language (SALT) had been made.

We noted that people were weighed at regular intervals. We saw the care plan for one person recorded they were to be weighed weekly due to recent weight loss, when we reviewed their weight records we saw this had been completed. Although the section to record their body mass index and MUST score were not always fully completed, the clinical lead showed us a monthly weight audit, which recorded people's monthly weights, MUST score and the action taken to address any issues identified. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. This shows there was a system in place to monitor people's weight and nutritional risk.

We saw evidence in each of the care plans we reviewed that people received the input of external healthcare professionals, for example, GP's, district nurses and dieticians. One of the nurses told us about a recent referral they had made to the dietician and the rationale behind that decision; however, they had failed to record this action in the person's notes. When we spoke with a visiting healthcare professional, they told us they had no concerns regarding the home, the staff were knowledgeable and followed there instructions appropriately.

The home was split into 4 distinct units. Only three of which were in operation during the time of our inspection. There was directional signage on Ash and Redwood units including pictorial signage on the doors of toilets and bathrooms; this can help people who may have a cognitive impairment find their way around their home. There was no directional signage on Cedar, after the inspection the registered provider told us this had been removed due to causing some distress to people who lived on this unit.

Redwood unit was dedicated to supporting people who were living with dementia. Bedroom doors were painted in various colours, toilet doors were painted yellow while doors which were not accessible to people who lived on Redwood unit were painted to blend in with the wall colour. The handrails on the corridors were also painted in a contrasting colour to the walls. This enabled people to see them more clearly. However, Cedar unit which also supported a number of people who were living with dementia, was decorated in neutral colours. Using colour and appropriate signage can help people retain a level of independence and help orientate them to their surroundings.

Ash and Redwood units had a separate lounge and dining room, while Cedar unit had a lounge and a combined lounge/dining room. Redwood unit also had a reminiscence lounge which contained a sofa, chairs and activity items. All the lounge and dining rooms were open allowing freedom of movement for people who lived at the home. None of the units which were being used had direct access to outside.

Good

Is the service caring?

Our findings

People we spoke with told us they felt well cared for. One person said, "They are always here for me." Another person said, "They are not in my face, they give me my space" and a third person told us, "They are very good to me, they are my friends." Two of the relatives we spoke with said,
"My relative is very happy here, the staff are really caring" and "We have not been here long, but the staff seem to be really nice." Another relative commented, "They are good to my relative, they have gone worse now. [Person] is in a wheel chair most of the time but the staff do try and talk to [person] and engage [person]." A visiting health care professional told us people who lived at the home always looked well cared for and staff seemed 'nice and caring'.

Staff told us they worked predominantly on one unit. One of the staff said, "I work on this unit all the time, although if I pick up shifts I work on other units. I think that is better, we get to know people really well. Although staff do move, we do have continuity." Another staff member said, "I mainly work on Redwood unit; you get to know the people really well, what their characters are." A nurse said, "I work on this unit nearly all the time." Having continuity of staff helps to ensure people are cared for by staff who know them well.

Staff photographs with their name and designation were on display on the entrance to the home. This enables people and visitors to the home to identify staff and their role within the organisation.

We observed care interactions which were kind, patient and sensitive. Where people were unable to verbally respond to staff we often saw their facial expression to show affection or happiness when staff spoke with them. Staff acknowledged people as they entered communal areas and as they passed them in the corridors. We observed a person who was crying and a member of staff came quickly to support them and on the first day of our inspection the news channel on the television was showing some images which may have been upsetting for people. We heard a member of staff say, "If the news is upsetting you, we can switch it off." The person responded saying they wanted to continue to watch the programme. The staff who administered people's medicines were attentive, interacting positively as they supported people to take their medicines and lowering themselves to the level of the person they were talking with.

Staff, including catering staff knew people well. At lunchtime on one of the units a member of staff told us they had not been employed at the home very long and therefore did not know everyone's name. At lunchtime the cook advised them as to peoples preferred method of being served, for example on a plate or a bowl. We spoke with another staff member about the people they supported; they expressed knowledge of people's likes and preferences.

Staff told us people were able to decide when they wanted to get up, go to bed and when they wanted a bath or a shower. This was confirmed when we spoke with people and personal care records also evidenced people had regular baths and showers. Another staff member told us they encouraged people to get out of bed each day but they added "If they decline, we respect that." However, we noticed on Redwood unit a number of people remained in their wheel chairs in the dining room and were not offered the opportunity to

go to their bedroom or to the communal lounge. One relative commented, "When my relative came here they were often moved from the wheel chair into a chair. Now they keep [person] in the wheel chair all day and do not make an effort, maybe they are busy."

Care plans recorded people's preference as to whether they wanted their bedroom door locked when they were not in their room and if they wanted a key to their door. Staff we spoke with understood the importance of maintaining people's privacy and dignity. One member of staff said, "People are in a public place, I ask them if they want to be moved to a private area. I close the door and curtains." We saw one person remove the blanket from their legs which left them exposing their legs; staff responded discreetly and prompted the person to replace the blanket. This showed staff took steps to maintain people's dignity.

Good

Is the service responsive?

Our findings

People and staff told us that Croftlands provided a number of activities within the home and also enabled people to take part in activities outside the home. People told us, "There is always something to do, boat rides, going to see vintage cars, or even just a walk", "There is so much we can do here, I am so happy" and "I used to go out with my son, this stopped; now the staff take me out. I am so happy."

A member of staff said, "We give a lot of support to the service users who come with very complex problems. We go around daily to people and try to find any new activities to add to the list, we involve them all the time." Another staff member commented, "We have activities both in the morning and afternoon which are displayed for the whole week on the notice board, we go for trips and invite relatives to join us." One of the activities co-ordinators told us if people were bedbound or remained in their rooms they set time aside to sit and chat with them, read or do hand massages.

We saw an activity board displayed in the reception area which outlined the events that were scheduled to take place on a daily basis. This included; a boat trip, nail painting, baking and a man bringing owls into the home. There were photographs and information regarding recent activities in the entrance to the home and we saw people making a large collage called 'fairyland'.

On Ash unit we saw people were involved in nail painting, one to one dominos and the use of dolls for people who wished to hold them. On the first day of the inspection on Redwood unit people were sat in the lounge, there was no television or radio on and we did not observe any activities. We saw one person had been sat in their wheelchair all afternoon, when their relative arrived they gave them some magazines which they happily engaged with. On the second day of the inspection the atmosphere on Redwood unit was more positive and homely, some of the staff were singing with people and as they went about their duties and we saw staff playing dominoes with one person.

On Cedar unit we saw there were a couple of large, lightweight books containing pictures. We saw a person sat with one of the books, they kept putting the book down, then picking it up and looking at it again. Later in the day we saw another person picking the book up to look at it. Another person spent time throughout the morning sat at the table with a jigsaw. A senior staff member told us, "If it is quiet I will take them out for a walk, we chat to them and try to spend quality time with them. The activity organiser does 1:1 with people and [name of person] enjoys playing football with you."

We saw a pre-admission assessment had been completed prior to people being admitted to the home. This is an initial assessment used to determine people's care and support needs as well as how the service proposed to meet those needs.

People had a care plan and a separate file in their bedrooms where staff recorded peoples care and support on a daily basis, including personal care and pressure relief. We reviewed a file for one person who required staff to record a regular entry as to the person's location. We saw this reflected the times the person was observed by staff and did not contain pre-set times. This meant the record was an accurate reflection of

their observation.

On Cedar unit the file in people's bedroom contained a 'profile mapping' document. We saw this provided a simple overview of what the person enjoyed. One persons recorded 'really good at sport, cricket, football, snooker'. Another person's profile map gave a potted history of their life story This was a basic tool which provided staff with a summary of the person's needs, preferences, likes, dislikes and interests.

The records we reviewed contained care plans regarding the care and support people needed as well as care plans which were relevant to people's specific health conditions, for example, a previous stroke, diabetes or care of a percutaneous endoscopic gastrostomy (PEG) feeding tubes. Records also included a sleep care plan which recorded the care people needed during the night.

Each of the care plans we reviewed was person centred and recorded information which enabled staff to know what people's preferences were. For example, '[person] prefers to wear socks with no shoes or slippers for comfort', '[person] likes to sleep with their face covered and likes to use the duvet for this' and '[person] suffers knee pain and will let staff know by rolling their trouser leg up and pointing to their knee'. One care plan referred to the person having a teddy bear and we saw staff had ensured they had this. Another care plan referred to the person needing a splint to be applied to their hand, we checked and saw they were wearing the splint. Having accurate and detailed information is important as some people who lived at the home had memory impairments and were not always able to communicate their preferences. However, we did observe one person was dressed in trousers although their care plan noted 'prefers to wear skirts and not trousers'. This person required staff to support them to dress and therefore had not chosen to put the clothes on of their own accord

There was a document in the front of peoples care plans which recorded whether people and /or their families wanted to be involved in the reviews and updates of their care plans. We saw evidence in one of the care plans we looked at of the family members input into the review of their relatives care plan. Care plans were reviewed on a single document but these provided a summary of the previous months care and support needs. A senior carer told us where people's needs changed, they made an amendment to the care plan and then the care plan was re-typed by the administrator. Regular reviews help to ensure care records are up to date and reflective of people's current needs so that any necessary actions could be identified at an early stage.

During our discussions with people and relatives, no-one raised any complaints regarding the service they received other than a concern regarding personal laundry items going missing. We saw the registered manager kept a record of any complaints raised at the home. There were 10 complaints or concerns logged from January 2017 and a summary sheet which recorded the date, details of the complainant, the issues raised and the action taken to address the issues. This showed there was a system in place to respond to, and monitor concerns raised about the service.

Requires Improvement

Is the service well-led?

Our findings

When we asked people about the management of the home, they told us, "Absolutely fantastic, hard pressed to find better" and "I like all the staff, they are interested in your needs, they want to see us happy." Relative's comments included; "Management do listen - I always manage to see them when I visit", "The managers are great" and "Extremely helpful bunch." A visiting healthcare professional said, "[Names of registered manager, clinical lead and nurse] are always here and I can talk to them. They are very nice and helpful."

A member of staff said "I love it here." Another staff member said "We are caring and compassionate with people." another staff member said, "[Name of registered manager] is lovely. You can speak openly to her and she is approachable. Firm but fair." They also told us the director of care visited the home on a regular basis and they felt confident in being able to talk to them and raise any concerns they may have.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

There was a system in place that was currently under further development to monitor the quality of the service people received. A number of audits were completed at the home and the registered manager told us a number of new auditing tools were also being introduced. We saw internal audits already in place were completed on a variety of areas including the environment, equipment and various records relating to the quality of the care provision.

The registered manager told us the director of care completed regular visits to the home and provided verbal feedback of their findings to the registered manager. They told us the registered provider had also engaged the input of an external consultancy to assist them in improving the governance systems throughout the organisation. The registered manager told us the consultant had completed an in-depth audit of the home in January 2017 and they also visited the home on alternate months to monitor and review progress, the most recent being April 2017.

We reviewed the audit dated April 2017 which had been completed by an external consultant. The audit recommended that mental capacity assessments needed to be decision specific and best interests decisions also need to be recorded in people's files. The report noted this had also been a recommendation following their visit in January 2017 and had not yet been addressed. A health and safety audit had been completed in January 2017 by an external organisation. One of the points raised by the auditor was in regard to not all slings being LOLER checked.

Following the inspection the registered manager provided us with a copy of their action plan for Croftlands Care Home which included issues raised in the two external audits we had reviewed. The action plan recorded the matters as 'ongoing' with no date recorded as to when they would be completed to a satisfactory standard.

These examples demonstrate that although issues are being identified and action plans implemented, areas requiring improvement are not being addressed in a timely manner. And, as evidenced within our report there are areas of improvement needed in regard to people's safety and welfare. These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how they ensured the service they provided followed current good practice guidance. They told us attended good practice events provided by the local authority and they also told us they were to be included in pilot scheme in the local area. This was about trying to reduce hospital admissions and where a hospital admission was unavoidable, to improve the safety and effectiveness of the admission.

There were systems in place to gather the views of staff and people who used the service.

Both staff and the registered manager told us meetings were held on a regular basis, pre-arranged nurses meeting was held on the second day of our inspection. We saw minutes of meetings dated February, August and September 2016, January 2017 and April 2017. The meetings in 2017 had been held at three separate times throughout the day to enable staff working different shifts to attend.

People told us regular resident meetings were held at the home. One person told us, "We have meeting's every month and the activity co-ordinator always speaks to us about activities." We reviewed the content of minutes from meetings in July and October 2016 and January 2017 and saw they included feedback from people who attended the meetings. Subjects discussed included activities, trips, staffing, and safeguarding and infection control. We saw a copy of the most recent meeting minutes were on display in the lounge on Cedar unit.

The most recent relative's survey had been sent out in April 2016. The registered manager showed us a summary of the results. We saw 43 surveys had been sent out and 20 completed surveys were returned and the majority of feedback was either positive or contained minor suggestions for improvements. The registered manager said a new survey was due to be sent out; it had been delayed while a new format was developed.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection was on display within the home and the rating, along with a link to the CQC report was also available on the registered provider's website.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not always provided in a safe way. The management of medicines was not always safe.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems of governance were not effective.

The enforcement action we took:

We served a Warning Notice on the Registered Provider.