Care Quality Commission

Croftacres Limited

Croftacres Residential Home

Inspection report

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Tel: 0114 234 0016

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The service was last inspected on 20 May 2014. At the last inspection we found the service was not meeting the requirements of the following two regulations: the management of medicines and records. As a response to the last inspection the provider sent a report to the Care Quality Commission of the action they would take to become compliant with the regulations. The provider informed us they would be compliant by February 2014.

Croftacres is a care home registered to provide residential accommodation for personal care for up to 25 older people. The building is purpose built. The service does not have a garden area but has some seating available at the front of the property. There is car parking available.

There was a registered manager for this service in post at the time of the inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Our observations during the inspection showed that there were not sufficient levels of staff to meet people's needs. We found that the provider did not have appropriate arrangements in place to ensure there were sufficient staff with the right mix of skills.

People told us they felt safe and were treated with dignity and respect. Our discussions with staff told us they were fully aware of how to raise any safeguarding issues and were confident the senior staff in the service would listen.

We observed staff treated people in a caring and supportive way throughout the inspection. However, on two occasions we observed two examples where a person was not treated with consideration and//or their privacy had not been maintained.

A pharmacist inspector from the Care Quality Commission inspected the service to check whether improvements had been made to the management of medicines and that these improvements had been maintained. We found improvements had been made and that the service had appropriate arrangements in place to manage medicines so people were protected from the risks associated with medicines.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The service was aware of the need to, and had submitted applications for people to, assess and authorise that any restrictions in place were in the best interests of the person.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people.

People spoken with told us they were satisfied with the quality of care they received and made positive comments about the staff. Relatives spoken with also made positive comments about the staff. Four relatives spoken with were satisfied with the care their family member had received. Two relatives of one person expressed concerns about the lack of continuity of the care provided.

There was evidence of involvement from other professionals such as doctors, optician, district nurses, physiotherapist and speech and language practitioners. We spoke with a district nurse who regularly visited the service. They made positive comments about the staff; they told us staff were very helpful and shared any concerns about people's wellbeing.

People gave us mixed views about the food provided at the service and they told us they were not always provided with a choice. During the inspection we did not see any availability of snacks and fresh fruit.

Staff told us they enjoyed caring for people living at the service. Staff completed induction, training and received ongoing support. Staff spoken with told us the registered manager was really supportive and listened to any concerns they may have.

We saw the service did not have robust arrangements in place to promote people's wellbeing by taking account of their needs including daytime activities.

The service had a complaint's process in place. We found the service had responded to people and/or their representative's concerns, investigated them and had taken action to address their concerns.

We saw evidence that checks were undertaken of the premises and equipment and action was taken to ensure people's safety.

We saw that the systems in place to monitor accidents and untoward occurrence to ensure any trends were identified and actioned was not robust.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we told the provider to take at the back of the full version of this report.

Summary of findings

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. During the inspection we found that people's needs were not being responded to in a timely manner due to the service not having sufficient staffing levels.

People told us they felt "safe". Staff were fully aware of how to raise any safeguarding issues.

At the last inspection we found the service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. At this inspection we found that sufficient improvements had been made, so that medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective. People made mixed comments about the food provided and told us that they did always have choice. We found the new menu had not been assessed to check it was nutritionally balanced.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The service was aware of the need to, and had submitted applications for people to, assess and authorise that any restrictions in place were in the best interests of the person.

Staff received induction and refresher training to maintain and update their skills. Staff were supported to deliver care and treatment safely and to an appropriate standard.

Is the service caring?

Requires Improvement

The service was not always caring. People told us they were treated with dignity and respect. However, we saw on two occasions where people were not treated with dignity or respect.

People and relatives made positive comments about the staff. We saw people were treated in a caring and supportive way.

Staff had attended end of life training to ensure arrangements could be put in place to ensure people had a comfortable and dignified death.

Is the service responsive?

Requires Improvement

The service was not always responsive. Our observations during the inspection told us that some people did not receive the individual care they needed.

Staff handovers enabled information about people's wellbeing and care needs to be shared effectively and responsively.

Summary of findings

We found the service had responded to people's and/or their representative's concerns and taken action to address any concerns.

Is the service well-led?

Requires Improvement

The service was not always well led. We found that the provider did not have appropriate arrangements in place to ensure there were sufficient staff with the right mix of skills. This showed that the provider had failed to assess and monitor that the service had sufficient staff during the day and night to meet people's needs.

The service actively sought people's representative views. However, we found that people's views had not been regularly sought (including the descriptions of their experiences of care and treatment) to enable the provider to come to an informed view in relation to the standard of care and treatment provided to people using the service.

At the last inspection in May 2014 we identified a number of concerns relating to the records in place. Although there was no evidence to suggest that these concerns had negatively impacted upon people. At this inspection we saw that improvements had been made to records. However, we still saw a few examples where omissions had been made.

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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.

A scheduled inspection took place on 9 March 2015. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of one adult social care inspector, a pharmacist inspector 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 had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch had visited the service in February 2015. We also spoke with a district nurse who regularly visited the service.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eleven people living at the service, six relatives, the registered manager, a director, two senior care workers and a domestic. We looked round different areas of the service; the communal areas, bathroom, toilets, storage rooms and with their permission where able, some people's rooms. We reviewed a range of records including the following: four people's care records, seven people's medication administration records, three people's personal financial transaction records, three staff files and records relating to the management of the service.

Is the service safe?

Our findings

People spoken with told us they felt "safe" and had no worries or concerns. Their comments included; "'I do feel safe and comfortable here" and "it is very good here, I feel very safe". People told us staff responded to their calls for assistance but the time it took to respond was reliant on staff availability and how busy staff were. One person commented: "staff do come quickly when they are around but it's hard for them because they are so busy".

Relatives spoken with felt their family member was in a safe place and made positive comments about the staff. However, most relatives spoken with expressed concerns about the staffing levels within the service and said that there just weren't enough staff.

We found that a regular dependency assessment had not been completed by the registered manager. This is a tool manager's use to calculate the number of staff they need on each shift, to identify the numbers of staff and the range of skills needed to ensure people receive appropriate care and are safe. For example, the number of senior care workers and number of care assistants for each shift. We spoke with the registered manager who told us that the level of staffing at the service was decided by the owners and not based on the level of dependency of people. At the time of the inspection there were 25 people living at the service. The registered manager informed us that seven people living at the service required two staff members to support them with moving and handling.

The registered manager provided us with details of the care staff numbers. During the two day shifts there was one senior care worker and two care assistants providing support. During the night shift there was one senior care worker and one care assistant working. A domestic worked part time each day at the service. The registered manager told us that they worked Monday to Friday at the service and provided an on call service when they were not working. This showed that the service relied entirely on one manager being available 24 hours a day to provide advice and support to staff. We also noted that staff handover was not scheduled in staff rotas. This showed the service was reliant on staff good will to either come in 15 minutes earlier or to stay 15 minutes later for the handover to be completed.

Our observations during the inspection showed that the staffing levels within the service were not sufficient to enable staff to meet people's individual needs and to keep people safe. For example, we observed one person calling out for twenty minutes for support to go to the toilet in one of the lounge areas. A visitor went to obtain staff assistance for the person. At breakfast time we observed one person trying to navigate through one of the dining areas using a walking frame. There were no staff present as they were busy supporting people in other areas within the service. We observed the person picking up their walking frame and lifting it over chairs; this put them at risk of falling and/or accidently dropping their walking frame on other people still sat at the tables. This showed that there were not a sufficient number of staff to ensure people were safe and their health and welfare needs are met.

During lunch time, we saw staff were very busy supporting people in the dining rooms. We saw two people had chosen to eat their lunch in one of the lounges. Both people expressed that lunch was late and that they were still waiting for a drink. They were served their lunch by a member of staff but they did not have any cutlery. They also did not have a drink. The staff member who had served the meal called out repeatedly to other staff to bring in some cutlery but the other staff were busy supporting people in the dining room to eat. The staff member left the lounge and returned a couple of minutes later with the cutlery. The two people had started eating their meal when another staff member came in and asked the two people what they would like to drink. One person who had decided to have lunch in their room told us that staff had forgotten to bring their dessert. They commented: "I've had to press my buzzer because I wanted some pudding and they'd forgotten me". This showed that there were not a sufficient number of staff to ensure people received appropriate care.

Later during the day we noticed two bins full of incontinence pads that needed emptying. We also found that they were causing an unpleasant odour. We saw that the service was reliant on care staff emptying bins when the domestic finished working during the day. It is important to have sufficient staff available to maintain the cleanliness of a service.

We also found that the level of activities provided to people in the service was based mainly around staff availability and provided on an ad hoc basis. For example, one person

Is the service safe?

was required to be supported to go for a walk regularly. We looked at their activity sheet for week commencing 2 March 2015. We saw that they had not been supported to go for a walk during the week. We spoke with the registered manager; they told us that staff did not always have time to support the person to go for a walk. The walk was substituted by providing an alternative activity like reading. The service did not have a garden area for people to access so this activity allowed the person to go outside regularly. This showed that there was not a sufficient number of staff to enable this person's health and welfare needs to be met.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous visit in May 2014 and we had some concerns about the way medicines were managed and administered within the service. We asked the provider to take action to address these concerns and to send us a plan of how they intended to do this. At this visit we found that the required improvements had been made and maintained.

We spoke with the registered manager and two care workers responsible for the management and administration of medicines and we observed part of a medication round. We reviewed records relating to the management of medicines within the service, including medication administration records (MARs) and other records for seven people living in the service.

Medicines were stored securely and there were adequate stocks of each person's medicines available with no excess stock. Having good stock control helps to reduce the amount of medicines stored and potentially wasted.

The service had policies, procedures and systems for managing medicines and copies of these were available for care workers to follow. Medicines records were clear and accurate. We checked a sample of seven people's medicines against the corresponding records. The medicines could be accounted for easily and showed that they had been given correctly.

We observed part of a medication round and saw that people were supported to take their medicines safely. The care worker administering medicines explained what she was doing clearly and was kind and patient.

We spoke to a visitor who told us they had noticed that sometimes care workers handled medicines without gloves and left the trolley open and unattended in public areas. Whilst we did not see this happen during our time in the service, we passed these concerns on to the registered manager who agreed to take action to ensure this type of poor practice was not repeated.

Some medicines, such as painkillers, were prescribed to be taken only 'when required'. Many people living in the service could ask for these medicines when they needed them, although some people with poor communication skills were unable to do so. Although information had been prepared for care workers to follow to enable them to support people to take their medicines safely, this was not always as detailed and personalised as it needed to be in order to have due regard to people's individual needs and preferences.

Medicines were only handled and administered by trained care workers. Having well trained staff reduced the risk of making mistakes with medicines.

We looked at how medicines were audited (checked) to make sure they were being handled properly. The registered manager carried out regular checks and took action when necessary to further improve medicines management within the service.

People spoken with did not raise any concerns regarding the cleanliness of the service. We noted that there were malodours in two people's rooms. Although the rooms looked clean, the malodours showed the rooms had not being sufficiently cleaned. We spoke with the registered manager who assured us they would take action to address these areas. They also told us that the provider was looking at different options for the floor covering in bedrooms.

We saw that the service had a range of cleaning schedules in place including the following: hoist cleaning, medicine cupboard cleaning and kitchen cleaning. Hand gel was available in communal corridors. We noted some areas needed attention to maintain the cleanliness of the service. For example, quilts and pillows were being stored on the floor in the linen storage room, two bins in two of the toilets were broken and the flooring in one of the ensuites needed replacing. We spoke with the registered manager who told

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us that they had identified these areas needed attention and showed us a copy of a recent infection control audit. This showed that the service was taking action to address these concerns.

During our visit we observed that staff wore gloves and aprons where required and we saw these were readily accessible throughout the service. However, relatives spoken with told us that staff did not always wear their gloves and aprons. Whilst we did not see this happen during our time in the service, we passed these concerns on to the registered manager who agreed to take action to ensure this type of poor practice was not repeated. We also saw that clinical waste bags were not always being used by staff. We spoke with the registered manager who assured us they would speak to staff regarding the importance of using the appropriate waste bags.

At the last inspection, the registered manager informed us that the service had requested a Disclosure and Barring Service (DBS) check to be undertaken for all the staff working at the service. We looked at two staff files and saw evidence that these had been obtained. We looked at the recruitment records of a staff member who had recently started working at the service. We saw that a robust recruitment procedure had been adhered to and appropriate checks had been completed to ensure people were cared for by staff who had been assessed as being safe to work with people. For example, a reference had been obtained including one from their most recent employer.

Care records were reviewed regularly and contained information about people's support requirements and preferences and how these were to be met. Individual risk assessments were in place in order to minimise and manage risks to people.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues. We saw the service had a copy of the local authority safeguarding adult's protocols to follow to report any events and safeguard people from harm. We saw evidence that the registered manager had followed these protocols and reported concerns to the local authority. However, we found that the registered manager had not notified the Care Quality Commission of these concerns, which is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered manager submitted these notifications to the Care Quality Commission following the inspection.

We spoke with one of the services director's; they showed us the system in place to manage people's spending accounts. The service paid for example the hairdresser and chiropodist and then invoiced the individual or their representative. We looked at three people's financial transaction records and saw they were correct. The amounts invoiced to each person were correct. This showed there was a robust system in place to safeguard people from financial abuse.

We saw evidence that a range of checks were regularly undertaken of the premises and equipment. For example, fire system checks, hoist checks, pat testing, scale calibration checks, emergency lighting checks, lift checks and call bell system checks. We saw that the call bell check had not ensured that a call bell lead was in place in each room. For example, in two people's room we saw that a call bell lead was not in place; a lead enables the call bell to be positioned so the person can call for staff assistance. We spoke with the registered manager, they told us that both people knew how to use a call bell and they assured us that a call bell lead would be put in place.

The service had a process in place for staff to record accidents and untoward occurrences. However, we saw that there was not a robust system in place to monitor accidents and untoward occurrence to ensure any trends were identified.

Is the service effective?

Our findings

People spoken with told us they were satisfied with the quality of care they had received. During the inspection we observed staff explaining their actions to people and gaining consent.

In people's records we found evidence of involvement from other professionals such as doctors, optician, district nurses, physiotherapist and speech and language practitioners. The service had a written and verbal handover at the end of a shift. We spoke with a district nurse who regularly visited the service. They made positive comments about the staff; they told us staff were very helpful and shared any concerns about people's wellbeing.

People gave us mixed views about the food provided at the service and they told us they were not always provided with a choice. One person commented: "the food is very good but some people aren't given enough so I give them some of mine. I don't always like the food. I'm not keen on beans and chips but they've never asked if I want something else. If I don't like it, I just leave it". We observed at lunchtime that two people said they didn't want either option (sausages and/or liver with mashed potatoes and vegetables) but they were not offered any alternative. This told us that people's preferences were not being met.

During the inspection we did not see any availability of snacks and fresh fruit. When the tea trolley was brought round in the morning there was no offer of anything other than a drink. We spoke with the registered manager; they told us that people's menu choices were obtained at the beginning of each day by the kitchen assistant and if people did not like what was on the menu an alternative was offered. They also told us that people could ask for snacks during the day. People living with dementia may forget orders made before so having a choice of food at meal times can help promote choice. Also having snacks on offer during the day provides choice and a visual reminder to people of foods that are available to eat.

We saw people who needed a specialised diet and/or soft diet had been provided with one at lunch time. We saw one person had a very poor appetite and we saw staff trying to encourage them to eat. We spoke with the registered manager regarding the menu available at the service and whether it had been nutritionally assessed. The registered manager told us that the menu at the service had recently been changed but it had not been assessed to ensure it was nutritionally balanced. We also found that people's views had not been sought with regards the food available at the service. The registered manager assured us that they would review the menu to ensure it was nutritionally balanced.

There was some seating at the entrance of the building which people could access with staff support but we saw the service did not have a garden area. The benefits of a garden can change for people through the stages of dementia, at first providing opportunities for gardening activities and later promoting stimulation of the senses and awareness outside of the self (National Institute for Health and Clinical Excellence / Social Care Institute for Excellence, 2007). Getting outside also allows people to exercise in fresh air at the same time as benefitting from sunshine and daylight. Spending as little as 10 to 15 minutes of activity a day outside can be very beneficial to the health of people living with a diagnosis of dementia.

We saw that the decoration of the communal areas on the ground floor had improved since the last inspection. We saw there was a lack of clear signage to support people living with dementia to navigate around the service. We saw that some people had fully personalised their rooms. Their room reflected their interests, their personality and their personal interests. However, we saw a few people's room showed little evidence of personalisation. We spoke with the registered manager who told us that they were arranging to improve the signage within the service. They also told us that the owners were planning further improvements within the interior of the service.

The registered manager had a copy of staff training matrix on the wall of their office so they could monitor the training completed by staff. We saw there was a robust system in place to identify when staff required refresher training. Staff had completed a range of training including the following: safeguarding vulnerable adults, dementia awareness, managing challenging behaviour, infection control, food hygiene and fire safety. We looked at three staff files and saw staff completed training that was relevant to their role. For example, senior care workers had completed medicines management training.

We saw evidence that staff had received regular supervision and an annual appraisal. Supervision is the name for the regular, planned and recorded sessions between a staff member and their line manager. An

Is the service effective?

appraisal is an annual meeting a staff member has with their line manager to review their performance and identify their work objectives for the next twelve months. All the staff spoken with told us they felt supported by the registered manager and encouraged to maintain and develop their skills. One staff member commented: “any small problem you can talk to her about and she always takes things on board”. Another staff member spoken with described the range of training they had completed since the last inspection which had included supporting people who may have behaviour that could challenge others.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The provider had policies and procedures in relation to the MCA and DoLS. The service was aware of the need to and had submitted applications to the DoLS supervisory body who are the responsible body to consider and authorise where they deem it necessary that any restrictions in place are in the best interests of the person.

Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently.

Is the service caring?

Our findings

People spoken with made positive comments about the staff and told us they were treated with dignity and respect. Their comments included: “staff are very kind”, “the staff are really good” and “people [staff] are very respectful”. All the relatives spoken with made positive comments about the staff and felt their family member was treated with dignity and respect.

We observed staff treated people in a caring and supportive way throughout the inspection. For example, we observed a staff member supporting a person who was refusing to eat. The staff member used lots of interaction and encouragement and the person ate a good portion of their lunch. However, on two occasions we observed two examples where a person was not treated with consideration and//or their privacy had not been maintained. For example, we observed a staff member shouting to a person in a corridor saying “[name], do you want to go to the toilet before lunch” and then shouting “shut the door before you go”. We shared this information with the registered manager; they assured us they would speak with staff about maintaining people’s dignity and treating people with respect. We also saw one person telling staff during lunch that they could not eat their meal but the person was ignored.

On the day of the inspection we saw a few people had chosen to stay in their rooms. We looked at one person’s care plan and saw that their care plan reflected that they liked to get up later in the day. However, two people spoken with felt that the choice to stay in their rooms was not available for them. One person commented: “they [staff] like everybody to be up before 9am. They [staff] wouldn't let me have a lie in” and “I have a lovely bedroom but they [staff] don't like me going into my bedroom during the day. They [staff] like me to be in the lounge so that they can keep an eye on me”. We spoke with the registered manager who told us they would speak with people to ensure they were aware that they could choose to get up later or choose to stay in their room.

There was information about the advocacy services available for people to contact in the reception area. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

The registered manager told us there was a member of staff who was the “dignity champion” at the service. Two of the key aims of the dignity champion was to influence and inform colleagues and to stand up and challenge any disrespectful behaviour rather than just tolerate it. We also saw that the topic of maintaining people’s dignity had been discussed at the staff meeting in January 2015.

It was clear from our discussions with staff that they enjoyed caring for people living at the service. One staff member: “I really enjoy working here looking after the residents, there is a really good team working here”.

The care worker administering medication was patient and gave encouragement when supporting people to take their medicines. People were able to take their medicine at their own pace and were not rushed.

We also observed that staff adapted their communication style to meet the needs of the person they were supporting. For example, kneeling down and speaking with the person on their level in a chair. When staff were available we saw staff chatting to people about events of the day or if they were planning to go out for a day with relatives.

In one person’s care plan there was a pain tool that staff could use to help the person tell them the level of pain they were experiencing. Care staff had attended end of life training to ensure arrangements could be put in place to ensure people had a comfortable and dignified death.

Is the service responsive?

Our findings

People told us staff responded when they called for assistance or used their call buzzers to call for assistance during the day or night. Two relatives spoken with told us they were not satisfied with the quality of care provided at the service. They said the staff were caring but there was a lack of continuity of care. For example, staff were very busy so there was not always a staff member available in the communal areas to provide assistance to people. They said their family member needed to be encouraged to drink and their fluid intake monitored to ensure they did not become dehydrated.

We reviewed four people's care plans and found that some people's care plans did not have an account of the person, their personality and life experience. This could lead to an increased focus on the person's condition rather than the person. We saw that each person's individual needs had been assessed and any risks identified. However, we found one person had complex needs and they needed a health and medication review. We spoke with the registered manager who assured us that this would be arranged with the person's GP and they would speak with the person's representative.

Our observations during the inspection told us that some people's needs were not being met in a timely manner and that some people did not receive the individual care they needed. For example, one person who was visually impaired needed support to enable them to drink regularly and to reduce their risk of dehydration. We saw that a drink had been placed on a window sill behind the person. The explanation given by the registered manager for the placement of the drink was to allow it to cool. However, we saw that the drink was not offered to the person, even after it had been left on the window sill for at least half an hour. We spoke with the registered manager; they assured us that arrangements would be put in place to ensure the person was appropriately supported to drink regularly.

During the inspection we observed one person being supported to move from a chair to a wheelchair using a rotunda in the lounge area. The person was supported to move by one staff member although their care plan stated that two staff members were required to make sure the person was safe. The support provided by the staff member was inappropriate and put the person at risk of harm. For example, the staff member had supported the person to stand by pulling their trousers and the person had been placed right on the edge of the wheelchair. Staff spoken with were aware that the person required two staff members to assist the person and were unable to give an explanation other than staff were busy supporting people in other parts of the service. We observed another person being supported to transfer from a chair to a wheelchair by one staff member. The person was using a walking frame to support their weight. During the transfer we noted that the staff member was highly conscious of maintaining the person's safety by providing verbal instruction to the person. However, we saw that the presence of two staff members would have minimised the risk of the person falling. We spoke with the registered manager who told us they would speak with staff. They also told us that they were arranging for all the care staff to attend refresher training in moving and handling.

We also found the level of staffing in the service impacted on the services ability to promote people's wellbeing by taking account of their needs including daytime activities. There was no programme of activities at the service. Healthwatch had visited the service in February 2015 and also found that there was a lack of meaningful activities within the service. All the people spoken with were unable to describe any activities provided at the service except where they had been taken out by a family member. We spoke with the registered manager who told us that the service did not have an activities worker and that care staff provided activities when they had the time. However, we saw the service did not have a sufficient number of staff to enable them to encourage meaningful activities, occupation and stimulation.

On the afternoon of the inspection a musician from a local church played religious music to people in one of the lounges. Staff told us that they came to play once every fortnight. However, we saw this did not take into account people with other religious/cultural backgrounds and beliefs or those who were not religious.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

The complaints process was displayed in the reception area. We reviewed the service's comments and complaints log. We found the service had responded to peoples and/or their representative's concerns, investigated them and taken action to address their concerns.

People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff or a family member.

Is the service well-led?

Our findings

The registered manager was visible at the service; people and relatives knew who the registered manager was. In the reception area the service had displayed their mission statement. The service's mission statement recognised that the following values were needed to contribute to a high standard of care and quality of life; privacy and dignity and fulfilment.

During the inspection we noticed that some staff were not adhering to the service's dress code and/or not wearing a name badge as stipulated in the employee handbook. Staff wearing a name badge can assist people who have a memory impairment who cannot always remember staff names. It also allows visitors to the service to identify the staff member they have seen or spoken with. The feedback received from Healthwatch's visit was that they also found that staff were not following the service's dress code and staff were not always wearing a name badge.

The manager understood that as part of their role as the registered manager that they were required to submit notifications to the Care Quality Commission. For example, the notification of an unexpected death or serious injury. However, we found the registered manager had not been aware that they should have notified the Care Quality Commission regarding any safeguarding concerns. The registered manager assured us they would submit these notifications in the future.

During the inspection we spoke with one of the directors (one of the owners of the service), they told us the three directors regularly visited the service. We saw that two of the directors had attended the residents and family meeting on the 21 May 2014. This showed that the directors of service were actively involved in the management of the service.

Our observations during the inspection showed there were not sufficient levels of staff to meet people's needs. It is important that staffing levels are regularly assessed and monitored to make sure they are flexible and sufficient to meet people's individual needs and to keep them safe. We found that the provider did not have appropriate arrangements in place to ensure there were sufficient staff with the right mix of skills.

We reviewed the minutes of two resident and families meetings held in May and November 2014. We noted that people living at the service had not attended either meeting. We saw that a range of topics had been discussed including the following: activities, laundry, interior decoration and maintaining people's hydration levels. At the meeting held in November 2014 a member of the care home assessment team had attended to talk about dementia care. The registered manager told us they had completed a survey with people living at the service in May 2014. During the inspection the registered manager told us the menu had recently been changed at the service but we found the views of the people living at the service had not been sought. It is important that the provider regularly seeks the views (including the descriptions of their experiences of care and treatment) of people using the service to enable the provider to come to an informed view in relation to the standard of care and treatment provided to people using the service.

At the last inspection in May 2014 we identified a number of concerns relating to the records in place at Croftacres. At this inspection we saw that improvements had been made to records. However, we saw that on occasion some details had not been completed. For example, in one person's care plan the consent form for photographs had not been signed.

All staff spoken with made positive comments about the staff team and registered manager working at the service. The registered manager told us that the service held staff meetings to review the performance of the service. We looked at the senior staff meeting minutes held on the 6 January 2015. We saw that a range of topics had been discussed regarding the performance of the service. These topics included: the use of mobile phones by staff, medication audits and ensuring all care workers were assigned time to read care plans. We also reviewed the minutes of the care staff meeting held on the 7 January 2015. A range of topics had been discussed including: maintaining service user dignity, laundry, topical cream charts, training and staff roles and responsibilities.

There were planned and regular checks completed by the registered manager and senior care workers within the service. The checks completed included: medication audits, infection control audits and care plan audits. These checks were used to identify action to continuously

Is the service well-led?

improve the service. We also saw evidence that the registered manager had completed an action plan as the result of an inspection completed by the NHS and the local authority in September 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.