Croft Carehomes Limited

The Croft Care Home

Inspection report

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Date of inspection visit:
08 February 2016
22 February 2016
17 March 2016

Date of publication:
10 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of The Croft Care Home was completed over three days, 8 and 22 February and 17 March 2016. We previously inspected the service on 4 November 2014, at that time we found the registered provider was not meeting the regulations relating to safe care and treatment, premises and equipment and good governance. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

The Croft Care Home is located in a residential area of Wakefield. The home provides accommodation for up to 29 older people, some of whom are living with dementia. The home has communal living areas on the ground floor and bedrooms are located on the ground and first floor. On the first day of our inspection 28 people were living at the home.

At the time of our inspection the service had a registered manager in post. 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.

Although people told us they felt safe, we saw examples of poor moving and handling and we found risk assessments did not fully address people's needs. In a bedroom where oxygen was in use, the bedroom door was wedged open. The window restrictors which were fitted were weak and would not be resistant to the use of force. People's medicines were not managed safely. Where people had lost weight, their risk assessment and relevant care plan did not reflect the level of risk and support they required. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were not adequately maintained. Some people told us they had no hot water in their bedrooms. A number of light bulbs were in need of replacement. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were not sufficient numbers of adequately deployed staff to meet people's needs and keep them safe from the risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence new staff received an induction to their role and staff received ongoing training and supervision.

Where people lacked capacity to consent to the care and support their received staff were not complying with the requirements of the Mental Capacity Act 2005. Capacity and best interest decision making were not clearly evidenced in care plans and Deprivation of Liberty Safeguards authorisations were not requested in a timely manner. This was a breach of Regulation 11 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's choices and personal preferences were not consistently respected. People were limited in their freedom to choose the components of their meals. People were not provided with the option of a hot drink with their lunchtime meal. People's dignity was not always respected and we could not clearly establish whether people received regular baths or showers in line with their preference. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, and we observed, there was little to engage people with during the day. The activities which did take place were not structured around people's individual preferences or previous interests. People's care plans were not person centred and lacked the necessary detail to ensure people who may have limited communication abilities or have memory impairment received the care they required and preferred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not stored securely. Accurate, complete and contemporaneous records were not maintained. Although some audits were completed by the registered provider and registered manager, these had not been effective and had not ensured the service was compliant with all the regulations. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not safe.

Moving and handling plans and risk assessments were not an accurate reflection of people's needs.

The premises were not suitably maintained.

Medicines were not managed safely.

There were not enough adequately deployed staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

A programme of staff induction, training and supervision was in place.

Where people lacked capacity we could not evidence staff were acting within the requirements of the Mental Capacity Act.

People's personal choices and preferences were not respected at meal times.

Risks related to people's diet and weight were not fully assessed or acted upon.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently treated with dignity and respect.

We could not clearly establish whether people received support to bath or shower in line with their personal preferences.

Records were not stored securely.

Is the service responsive?

Inadequate

The service was not responsive.

People were not engaged in person centred, meaningful activities.

People's care plans lacked the level of detail to ensure they received care which met their individual likes and preferences.

Verbal concerns were not formally recorded or investigated.

Is the service well-led?

Inadequate

The service was not well led.

People were not protected from unsafe or inappropriate care.

Audits were completed by the registered manager and the registered provider but they were ineffective and had failed to identify the regulatory breaches identified throughout this report.

The Croft Care Home

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 8 February 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and a specialist advisor. One inspector also visited the home on 22 February 2016, and again on 17 March 2016 along with a second inspector, both these visits were announced This was to ensure the registered manager would be available to meet with us.

Prior to the inspection we reviewed information we held about the service, such as notifications. We also spoke with the local authority and the infection prevention and control team. At the time of the inspection a Provider Information Return (PIR) was not available for this service. 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. On this occasion we had not asked the provider complete this document. We asked the registered manager to display a poster in the home to inform people and visitors that we were inspecting the service and inviting them to share their views.

During our visits we spent time in the lounge and dining room areas observing the care and support people received. We spoke with nine people who were living in the home and four visiting relatives. We also spoke with the registered manager, three senior carers, three carers and the cook. We spent some time looking at fifteen people's care plans and a selection of other records which evidenced the care and support people were receiving. We looked at three staff recruitment and training files and a variety of documents which related to the management of the home. We also viewed the communal bathrooms and a random selection of bedrooms.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said, "You're safe here, yes". Another person told us, "I feel safe". Relatives we spoke with also told they felt their family member was safe. One relative said, "They are not mistreated."

Our inspection on 4 November 2014 found the registered provider was not meeting the regulations regarding safe care and treatment and premises and equipment. We also found evidence during this inspection that people were not always safe from the risk of harm.

Staff we spoke with told us they had received training in keeping people safe from the risk of harm or abuse and we saw certificates in each of the staff files we reviewed which evidenced the staff had recently completed this training. The registered manager told us they had also completed safeguarding training with the local authority. Staff were able to give examples of what may constitute a safeguarding alert, for example, physical and mental abuse or neglect. The registered manager was also able to give examples of incidents which may require a referral to the local authority safeguarding unit and they told us how the referral was completed. This showed us staff were aware of their responsibilities in keeping people safe.

During our inspection we observed poor moving and handling techniques from staff. On the first day of our visit we observed two incidents where staff did not use appropriate moving and handling techniques with people. On both occasions we saw staff used a moving and handling belt to support the person but then placed their arms under the person's axilla (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. We also observed staff place a moving and handling belt on a third person, staff placed their arms under their axilla to help the person to stand, we saw staff rotate the person 180 degrees to position them in a wheelchair. No equipment was used to ease the rotation, for example, a turntable. We brought these incidents to the attention of the registered manager. Following the inspection we were contacted by a health care worker, who was not employed by the service, who had also observed staff supporting a person using poor moving and handling techniques during their visit to the home. After the inspection we referred two of these incidents to the local authority safeguarding team, however, the local authority did not take any further action regarding this matter. We also asked the registered manager to monitor and review moving and handling of people at the home to ensure staff practices were safe and they were complying with relevant legislation and good practice guidelines. On our third visit we again saw staff use inappropriate moving and handling techniques with another person. We brought this to the attention of the registered manager and referred the incident to the local authority safeguarding team. Poor moving and handling techniques can cause harm to both the person being moved and staff.

We saw care plans contained a variety of risk assessments, for example, moving and handling, falls, skin integrity and nutrition. We noted they were not always an accurate reflection of people's care and support needs. We looked at the care plan for one of the people who we had seen being transferred using poor moving and handling techniques. The handling plan recorded they required only one person to stand but if this was not suitable then the hoist should be used. There was no risk assessment in place regarding the use

of the hoist and there were no details recorded as to the extent to which the person could participate in/cooperate with transfers, the specific equipment staff were to use, including the type of hoist and sling, sling size and which attachments were to be used. This meant care and support was not planned and delivered in a way that reduced risks to people's safety and welfare. This was brought to the attention of the registered manager on the day of the inspection.

We observed two staff supporting one person to move from an easy chair to a wheelchair. The review record in their care plan noted the person's mobility had changed during January 2016; we also saw another document within the care plan which recorded they now needed two staff to support them to transfer. We looked at the person's mobility care plan and saw this had not been updated to reflect the changes and still recorded the person was independently mobile around the home.

These examples evidence the registered provider had failed to ensure people's care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how accidents and incidents were logged and reviewed. We saw an analysis was completed by the registered manager, this included information relating to the location and time of accidents. This information enabled the registered manager to potential identify themes and trends.

During our first inspection day we noted a number of concerns relating to the premises and environment which put people at risk of harm. For example the door in the cellar leading into the laundry area did not close properly. We also saw three bedrooms doors wedged open, this included a room where oxygen was being used. This meant in the event of a fire, the doors would not be able to close and therefore would not provide the necessary level of protection for people. On our second visit the cellar door had been fixed to enable it to close properly and a 'doorguard' had been fitted to the bedroom door where oxygen was in use. These concerns were brought to the attention of the registered manager and we also notified West Yorkshire Fire and Rescue of our concerns.

Window restrictors were fitted to windows but these consisted of chains fastened to the window frame and openings. We were since told by the provider that these had been replaced.' The home had a passenger lift which operated between the ground and first floor. We observed the lift did not 'level' on the ground floor level which presented a trip hazard to people stepping in and out of the lift. We brought these concerns to the attention of the registered provider and registered manager to ensure these issues could be addressed promptly.

This demonstrates the registered provider had failed to ensure people and others who had access to premises were protected from the risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people who lived at the home told us they did not have hot water in their bedrooms. One person told us they had been washing in cold water and another person said staff would say, "Sorry it's cold", before they washed her. When we spoke with a member of staff they confirmed they had, at times, had to wash this person with water that was not hot. When we checked a random sample of hot water taps we found of the 28 bedroom taps we tested, 13 either ran cold or ran out of hot water. The monthly water temperature checks recorded by staff at the home also documented, of the 28 bedrooms, eight in January and 11 in February 2016 recorded a hot water temperature below 40°, a total of seven recorded below 30°. If hot water is not at an adequate temperature this means safe hand and body washing cannot be maintained and therefore raises the risk of infections spreading between people who live at the home and staff.

In one bedroom we noted a bed head light was damaged and in another bedroom the light switch was broken and the en-suite toilet light was not working. Throughout the building a number of light bulbs needed replacing.

These examples demonstrated that the provider had failed to ensure the premises were suitably maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At approximately 10am on the first day of the inspection we entered a bathroom and found it had no paper towels or waste paper bin and the soap dispenser was empty. In a second bathroom we opened the cupboard under the sink and saw dried faeces on the wooden 'T' bar between the cupboard doors and on a pack of wipes stored in the cupboard. We checked again at 14.40 and found these issues had not been addressed. Two bedrooms we looked at also had a strong malodour. One of the bedrooms was unoccupied at the time of our inspection, but despite the window being open, the odour remained offensive. This evidenced people were not living in a clean and hygienic environment. Following our feedback to the registered manager the carpets were removed in these bedrooms and new flooring was laid.

As part of how inspection we checked to ensure medicines were managed and administered safely. A monitored dosage system (MDS) was used for some medicines while others were supplied in boxes or bottles. We checked one medicine which was stored in the controlled drugs cupboard. These are specific medicines which are classified under the Misuse of Drugs Act 1971 and where there are regulations regarding their management and administration. The stock tallied and each entry was completed and checked by two staff.

We observed a member of staff administering medicines to two people. We noted on the first occasion, when they left the medicines room to administer the medicine, they left the medicine keys in the medicine trolley with door open. They also failed to lock the door to the medicines room. On the second occasion they left the medicine trolley door open but removed the leys and locked the door to the medicines room as they exited. We spoke with the staff member about this and they told us they normally always locked the door to the medicines room but did not routinely lock the medicine trolley between administrations. This meant we could not be assured that medicines were stored securely with only authorised care home staff having access to them and that people were safeguarded against access to medication.

We reviewed the medicine administration record (MAR) for one person and saw one specific medicine was prescribed to administered at 'am' and '3pm'. We checked the MAR at approximately 13.20 and saw this medicine had already been signed as having been administered. We asked the staff member and they told us this medicine was routinely administered at 'about 12.30pm'. However, the staff member told us about another medicine which was administered to people at a specific time and they were able to tell us the rationale for this being done. This meant that not everyone who lived at the home was receiving their medicines in line with the written instructions of the prescribing health care professional.

We asked the registered manager and a staff member if PRN (medicine prescribed to be taken 'as needed') protocols were in place, they said they were not. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. When we returned to the home on 22 February 2016 the registered manager told us these had now been implemented. We looked at an example and saw that while some information had been recorded there was a need to ensure more detail was noted. The registered provider's medication policy recorded 'As required medication protocols should be in place for all as required medications that detail the medication, dose, quantity, frequency, when to refer to GP, reason for medication. The protocol should include the space between doses if the first dose

does not work, and the best times for taking the medication'.

One person who lived at the home had been prescribed a medicine to reduce anxiety. The direction on the medication administration record (MAR) was 'four times daily as required'. Both the registered manager and the senior care staff we spoke with told us they tried other techniques and they did not 'automatically go for medication'. However, on the two MAR's we reviewed, we saw the medicine had been given four times each day, there was no record of times to indicate the medicine had been given at a time other than the scheduled medicine round and there were no records to monitor the reason the medicine had been administered or to review its effectiveness.

Medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files for three staff files and saw candidates had completed an application form, notes were kept of the interview questions and responses and references had been obtained. Candidates had also been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We noted the DBS for one of the staff files was dated 2009. After the inspection we emailed the registered manager to ask if there was a more recent DBS check available for this member of staff and they told us there was not. However, they said they had now commenced an application for an up to date DBS. Ongoing monitoring of staff DBS checks helps to ensure staff remain suitable to work with vulnerable people.

We asked relatives of people who used the service if they felt there were enough staff on duty to meet people's needs. One relative said, "As you can see, there's loads of staff around, there always seems to be." Another relative commented "They don't have enough but these places never do." A person who lived at the home said, "Sometimes there are not enough (staff) to go around, they are pushed, but I can wait." Another person said, "They don't have time to give you a bath." Four staff told us they felt there were not enough staff. One said, "Not always, it depends on the mood of the residents, sometimes people need more 1:1." We asked one staff member if they had time to spend with people, they replied, "No you don't, but it's the same everywhere." We asked the registered manager if they felt there were enough staff to meet people's needs, they said they did.

The registered manager told us four staff were on duty during the day and two staff at night. The care staff were supported by a cook, a domestic and a laundry assistant, although they said the laundry assistant post was currently vacant. The cook finished their shift mid-afternoon and the registered manager told us a member of care staff went into the kitchen at tea time to serve people's meals. We asked the registered manager how staffing numbers were decided, for example if a dependency tool was used to ensure staffing was proportionate to people's assessed needs. They told us they had a dependency tool but they did not use it. We asked how they knew there were enough staff to meet people's needs. They said they could see by monitoring and observing they had enough staff.

During the period of our inspection we identified a number of occasions where people needed staff support and staff were unavailable. For example, we observed one person, who was at high risk of falls, get up from the chair and mobilise without the use of their aid. We also observed this person outside the home, on the decked area adjacent to the lounge, although staff responded promptly when they became aware of the situation, to bring them back into the home. We observed tea time on two of the days we visited the home. We saw one of the staff had to come out of the kitchen where they preparing and serving people's teas to assist with someone who needed the toilet. We also saw staff had to break from serving meals to answer the

door bell or the telephone. These examples demonstrate the registered provider had not ensured sufficient numbers staff were available to ensure they could meet people's assessed care and support needs.

On our third visit we saw one person did not eat their soup, ate only one sandwich and declined a pudding saying they were 'full'. Four different staff had been involved in serving or taking away plates from this person. This meant staff may not have been aware of how little this person had eaten. When we reviewed the weights for this person we saw they had lost 2.9kg between January and March 2016. We discussed this matter with the registered manager on the day of the inspection.
These examples evidence there were insufficient numbers of adequately deployed staff available to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

One staff we spoke with told us they had received an induction when they commenced employment at the home. They said this consisted of a review of policies, an introduction to people who lived at the home and a period of shadowing a more experienced staff member. Two of the staff files we reviewed were for staff who had been employed for less than 2 years. We saw evidence in both files of the induction process they had completed. This showed new staff were supported in their role.

Most of the staff we spoke with told us they received supervision with their manager but one staff member said they could not recall having had supervision. Staff said if they had any issues or concerns they could speak in confidence with the registered manager. We saw supervision records in each staff file we reviewed and a contract which noted staff received supervision on a quarterly basis. The registered manager told us they completed the supervision for all the staff employed at the home and this consisted of a mixture of 1:1 and group supervisions. The registered manager told us training was a mixture of online and practical training and this was echoed by the staff we spoke with. We saw evidence of training certificates in the three staff files and the training matrix recorded the training staff had completed. Ensuring staff receive regular training and supervision provides assurance that staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) as described in MCA schedule A1 together with any conditions on authorisations to deprive a person of their liberty set by the supervisory body as part of the authorisation. The registered manager told us three people who lived at the home were subject to a DoLS authorisation.

In each of the care plans we reviewed we saw people or their relatives had signed to consent to their photograph for information held about them by the home, being shared with other relevant health care professionals. If people lack the mental capacity to agree to this for themselves, this decision should be made by the care home as a best interests decision under MCA section 4: as part of this process, relatives must be consulted but do not themselves become the decision-maker, unless they have been authorised to do so legally through award of power of attorney.

The care plans we reviewed contained a mental capacity care plan. For example, one person's care plans care plan recorded they had capacity to make daily decisions but they would require family and social work support for bigger decisions. Their care plan also referred to staff acting in the person's best interests. During

our observations of this person we noted their capacity to make decisions fluctuated but the care plan did not record how staff should support the person with their decision making on a day to day basis. This level of information is important as it ensures staff understand the decisions people have the capacity to make and how staff can support people in this process.
The entrance door to the Croft Care Home was locked door and there was a coded lock to prevent unauthorised entry or exit to the home. This was to keep people safe from harm, however this also meant that people who lived at the home who lack capacity might not be free to leave'. To ensure this restraint was lawful, where people lacked capacity to consent to this restriction, there should be records documented, including those of a best interests decision founded on a 'reasonable belief' that the person lacks mental capacity to consent to, or refuse, this intervention. One person had been living at the home since January 2016 and lacked capacity to make this decision however, no capacity assessments had been made and there was no evidence of best interests' decision making in their care plan.
We reviewed the DoLS authorisation document for one person. This recorded that they needed staff to prompt them to their personal care, change their clothing and take their medicines. We saw a mental capacity care plan in place for this person. However, there was no evidence of capacity assessments regarding these tasks and no evidence of how staff would support them to make these daily decisions. This person had been admitted to the home during 2014 as The Croft Care Home front door had a coded lock in place and they were vulnerable if they left the home without support. The registered manager told us they had only applied for a DoLS authorisation in recent weeks. Requesting DoLS authorisations in a timely manner ensures that where people are deprived of their liberty this is lawful and the person's rights have been protected.

Staff we spoke with told us they had completed training in MCA but two staff said they would like more information about this topic and said further training had already been arranged. When we spoke with the registered manager about these issues they acknowledged they lacked understanding of this legislation and acknowledged they required more training.

These examples evidence the registered manager and staff were not aware of their responsibilities under the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This also demonstrates that people were deprived of their liberty for the purpose of receiving care without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
There was a board in the dining room with pictures of the food offered at the home although this did not reflect that day's menu. At lunchtime people were offered a choice of two meals. We saw staff tell people what the choices were and we heard people choosing the meal they preferred. We saw that people who were not sat at the dining table for lunch were not offered condiments and no one was offered a hot drink at lunch time. A relative told us people were never offered a hot drink at lunchtime and a member of staff said hot drinks were not offered until after the staffs' shift changeover at 2pm. We saw the only drinks offered to people were a choice of two dilute squashes. We heard one person ask for a drink of tea at lunchtime but they were given a drink of squash. Another person asked a staff member if they could have their pudding and they were told they would have to 'wait for everyone else'.

We saw staff give lunch to two people but they failed to speak to the individuals or describe to them what they were eating. At tea time on the third day of our inspection we saw staff offer people soup however, no one was told what flavour the soup was. Most people were offered a choice of sandwich although we saw staff give a plate of sandwiches to one person without offering any choice. The sandwiches were all on white bread and we did not see or hear people being offered the opportunity to have brown bread. Two people declined the sandwiches at tea time and we did not observe staff offer them any other alternative. Neither did we observe them eat any food other than their dessert.

This demonstrated not all staff consistently respected people's personal preferences and choices. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found records of people's weights were recorded in care plans and a 'weight book'. On our visit, 17 March 2016, the registered manager told us one person had been identified as losing weight and was being weighed weekly. They said this had commenced 'two to three weeks back' but there was no record in the care plan or weight book of a weekly weight check.

We observed a person at lunchtime eat very little and receive no staff support. Their care plan recorded 'staff to be in close proximity' to enable them to receive appropriate support to eat and drink. We checked their weight records and saw their weight was recorded as 53.6kg in July 2015 and 46.1kg in February 2016. We saw their nutritional risk assessment had only one entry dated 27 November 2015 which scored them as medium risk and their nutritional care plan, dated 9 February 2016 recorded their weight was stable. Another person's nutritional care plan, dated 6 October 2015 recorded they had a 'stable weight' but a 'poor appetite'. The weight records detailed they had lost 4.1kg in less than a month. The nutritional risk assessment was reviewed in October 2015 and scored them a medium risk.

One person told us they had to have a soft diet due to a health problem; they said they had been given stewed steak for a previous meal. At lunchtime we saw they were given a normal diet. They told the staff member they needed a soft diet and the staff member mashed the contents of the plate for them. We also noted they were offered sandwiches at tea time, which they declined. We spoke with the registered manager and a senior carer about this person. They said the person would sometimes not choose a soft option at meal times and they had the mental capacity to make these decisions. We asked if they had taken medical advice from the person's GP or completed a risk assessment regarding this aspect of their care but neither of these had been done.

These examples evidence the registered provider had failed to fully assess the risks to people and had not ensured that all that is reasonably practicable to mitigate any risks had been identified and acted upon. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the staff we spoke with told us the home had a good relationship with the local GP practice. We saw documented evidence in people's care plans that they received input from other healthcare professionals, for example, the G.P and district nursing team.

There were bedrooms, bathrooms and toilets to the ground and first floor. Communal areas were on the ground floor. Toilet and bathroom doors were painted yellow; this can help people who are living with dementia to locate toilets and bathrooms more easily. Bedroom doors were painted different colours and many had the room number and the name of the occupant. In the communal area there was an orientation board and this was updated to ensure the correct day and date were on display and the information regarding the weather was relevant. There was no directional signage to help people navigate from their bedroom to the passenger lift, the communal areas or the toilets. We recommend that the service finds out more about dementia-friendly environments in relation to the specialist needs of the people who were living at the home.

Requires Improvement

Is the service caring?

Our findings

Most people told us staff were caring and kind. One person said, "Yes, the staff are good to everyone. They listen to you". Another person said "Oh yes they are all kind." A relative we spoke with told us their parent was 'well looked after'.

During our inspection we observed people to be relaxed in the company of staff. One person knocked their walking stick on the floor and a staff member promptly picked it up and placed it within their reach. We heard one staff member speaking discreetly with a person about their need to use the toilet. One of the staff we spoke with said, "Each person is somebody's mum, dad or grandparent, I look after them how I would look after my own family member."

Many of the care plans we reviewed referred to people being able to make their own decision regarding their daily lives; for example what they ate and the clothes they wore. One staff we spoke with explained how they supported people to choose the clothes they wanted to wear each day. Throughout the inspection we saw examples of staff offering people choices, for example, asking people if they wanted to sit at the table for meals, if they wanted an apron on and if they wished to participate in a game of skittles.
We also saw examples where staff attitudes were not as caring. For example, one staff placed a moving and handling belt around a person without any form of explanation as to what they were doing. This person was transferred to an easy chair by staff and left with their jumper pulled up exposing their abdomen. An inspector adjusted their clothing to cover up their body and the person smiled and thanked them. While waiting for lunch to be served, we saw two staff stood at the front of the dining area watching people who were in the communal area. Neither staff used this opportunity to engage with people. When the music finished, staff switched the television off without any consultation with people as to what they may prefer to watch or listen to.

We a saw a life history document had been completed in most people's care plans. One had answers to most of the questions but the majority of answers consisted of one word and lacked detail. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences. Life history can also aid staffs' understanding of individuals' personalities and behaviours.

One relative told us some staff were 'abrupt'. Another relative told us they often found other people's clothes in their family member's wardrobe. Their relative was a gentleman and they said the items of clothing were sometimes ladies clothing. They also complained to us that items of clothing went missing.

We saw one lady whose personal grooming needs had not been attended to, her hair was dishevelled and we observed that her nails were soiled. We -informed the registered manager about our concerns and they told us the person would not always allow staff to support them with their personal care. When we observed this person at tea time we noted they had remained as we had initially found them.. One person who lived at the home commented to the person sat next to them, "Your hair is stuck up; it's not been done (combed) this morning." We saw one person still had a hospital wrist band on even though they had been discharged from hospital ten days earlier.

Most staff told us people had a choice over whether people had a bath or a shower; one staff member told us they only offered people a shower. One person we spoke with said they would prefer a bath, "It is just showers." When we looked at their life history it recorded 'do you prefer a bath or a shower – bath in the morning'. Their personal care plan recorded 'quite happy to have a shower when asked'. Another person's life history document recorded 'do you prefer a bath or a shower – both'. We found records relating to the care people received with their hygiene needs were confusing and erratic. Many records only referred to the person's first name and not surname, some records did not have the month to which they referred to written on. As a result we could not evidence people received support with their hygiene needs in line with their personal preferences.

This demonstrated staff did not consistently treat people with dignity and respect. Not all staff consistently respected people's personal preferences and choices. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was also a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate, complete and contemporaneous records were not maintained regarding people's hygiene needs.

We asked staff what steps they took to maintain people's privacy. One staff said they made sure doors and curtains were closed and used towels to keep the person covered up as much as possible. Another staff member said they made sure the shower curtain was put around people and they waited outside if the person was able to shower themselves. A record was kept in care plans of people's preference regarding locking their bedroom door and having a key to their bedroom door.

People's records were not stored confidentially. On the first day of our inspection we saw a large pile of records in the cellar on top of a filing cabinet. The registered manager told us the records were waiting to be transferred to the head office for archiving. They were removed later that day. On each of the days we visited the home we saw two files were kept on the window ledge in the communal areas. These contained people's daily records, daily care charts and observation records. This meant people's records may be accessed by individuals who did not have the authority to do so. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We asked people what activities they took part in. Comments included; "Once you have eaten you sit in a chair", and another person said, "There is the odd game of bowling". A relative said, "They are left to fester on a chair, there is nothing to do, people are sat for hours." Another relative said, "They do activities but not what (family member) would do. Some ladies could do with more."

During the period of time we spent at the home we observed people spent significant lengths of time sat in their chairs with little to occupy them other than the television or listen to the music that was playing. We observed a number of people spent their time walking up and down the corridor. The information on display regarding activities noted there was an activity provided each morning and afternoon over seven days. On Monday, the activities were listed as music and sing a long in the morning and baking in the afternoon. Neither of these activities happened during the first two Mondays we visited the home although a game of skittles did take place on the first Monday of our inspection. On our first day a staff member asked people if they wanted to play skittles, some people said they did but the staff member had to break off the game to support someone to go to the toilet. On the third day of our inspection we saw a staff member sitting with a small group of people, painting.

The registered manager told us the activity timetable did take place but activities changed to what people wanted to do. They also said many people did not want to participate in the activities offered. They said that no-one was specifically employed to provide activities for people and this was provided by the care staff as part of their role. A member of staff said, "We try to get people involved, skittles and bingo are popular." We asked what social engagement people who remained in their rooms received and they said, "It is difficult when we are busy." They told us about one person who was in their bedroom; they said they had chatted to the person when they went in their room to put some laundry in the room. Another staff member said, "We try to follow the activity timetable, but we don't always. If someone wants the toilet, if phone or doorbell goes, we get broken off." We asked another staff member when staff had time to spend with a particular person, they said they could not remember the last time anyone spent time with this person other than when it was part of a task related activity. This meant this person was at risk of social isolation.

Both the registered manager and the staff we spoke with told us people chose not to participate in activities. When we reviewed people's activity records we found the activities did not reflect their personal interests. For example, one person's records noted they used to enjoy football and gardening, they also liked to read the Castleford Express and watch rugby. Their socialising care plan detailed 'is reluctant to join in with others'. Another person's socialising and communication care plans noted 'regularly plays dominoes with another resident'. We looked at the activity records for them for a three week period and saw no reference to playing dominoes. A staff member told us they had no recollection of this person playing dominoes.

This demonstrated the registered manager had not ensured that people received person-centred care and support that was appropriate, met their needs and reflected their personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was also a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 as there were insufficient numbers of adequately deployed staff available to support people to engage in meaningful occupation.

People's care plans were not person centred and did not accurately reflect people's needs. For example, four people's care plans noted 'may decline showers but with gentle encouragement from staff may reconsider'. Only one of the records detailed why the person may decline, '(person) is not keen on them' and none of the four care plans recorded the person's preferences regarding taking a bath. The personal care plan for one person recorded they needed the support of two staff with hygiene and dressing but there were no details as to the level of support required or that the person had preferences regarding lotions, perfume, make up or jewellery.

The communication care plan for one person referred to the person at times becoming frustrated and shouting. The record advised staff to use distraction techniques but there was no detail as to what these techniques were. This meant staff did not have a written record they could refer to which would ensure staff were providing consistent care which met the individual person's needs. Staff told us about a person who liked to have their bedroom door open all the time and the reason for why this was. When we looked in their care plan, this aspect of their care was not recorded in their care plan. We also noted people's nutritional care plans referred to people them making their own choices but lacked detail as to how people made their choices or what support staff may need to provide to enable people to make individual choices. People's dietary likes and dislikes were not recorded within their individual care plans.

The lack of detail, combined with the fact that a number of people were living with dementia and may not be able to fully communicate their needs, put people at risk of receiving care and support that was not in line with their personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us there were two recorded complaints in July 2015 and there were no current complaints at the home. We asked if verbal complaints were logged and they said they were not as they were 'dealt with there and then'. We saw an incident report in one of the care plans we reviewed dated 14 January 2016 which referred to the relative not being satisfied happy regarding the laundry service their family member received. We asked the registered manager if this matter had been dealt with as a complaint. They told us it had not. During the inspection we spoke with this relative and they told us they were still dissatisfied with the laundry service at the home. This showed the system for identifying, receiving, recording, handling and responding to complaints was not robust.

Inadequate

Is the service well-led?

Our findings

Our inspection on 4 November 2014 found the registered provider was not meeting the regulations regarding good governance. On this visit we checked and found that satisfactory improvements had not been made.

The Croft Care Home had an experienced registered manager in post; they began working part time at the service in November 2014 and became full time at the service from January 2015. They told us their vision for the home was to provide a caring home that was warm and friendly. The registered manager was supported by a team of senior carers, care staff and ancillary staff.

One of the relatives we spoke with told us the registered manager was visible and was often seen throughout the home. Staff told us the registered manager was approachable and one staff member said, "Any issues, there is always someone you can ask or talk to." Another member of staff said they felt there was an open culture and they had no qualms about raising any concerns they may have.

During the inspection we found evidence of two incidents which, although they had been reported to the local authority safeguarding team, the registered manager had not submitted a statutory notification to the Care Quality Commission (CQC). However, we were satisfied that this was an oversight as we had evidence of other matters previously being reported in line with the 2009 regulations.

The registered manager told us they completed a number of audits each month which included the environment, medicines and infection prevention and control. They said they had not commenced audits of care records as the care plans had all been updated in October 2015. We saw the registered manager had a monthly audit file which contained the audits they had completed each month. Audits had commenced from March 2015 and included medicines, accidents and complaints. One of the senior care staff we spoke with told us the registered manager provided feedback about any issues the audits had raised. They told us the registered manager had recently reminded staff about the importance of completing daily care charts and showed us a note on the white board in the medicines room which confirmed this. The registered manager told us the registered provider visited the home on a regular basis. We saw an audit completed by the registered provider in August 2015 and following the inspection the registered provider emailed us a further two audits dated October and December 2015.
The regulatory breaches highlighted throughout this report evidence that the systems of governance carried out by the registered provider and registered manager were neither effective nor robust. This was evidenced by the number of regulatory failings identified during our inspection. For example, we observed a number of examples of poor moving and handling, risk assessments in people's care plans did not fully address people's needs and we had concerns about the safety of the premises. There were inadequate numbers of suitably deployed staff to meet people's needs and the home was not compliant with the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. The provision of activities was very limited for people and care records lacked the level of detail to ensure staff had the knowledge to enable them to provide person centred care for people
This evidence illustrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 because the original breaches we had found at the last inspection had not been rectified through effective quality oversight and monitoring.

The registered manager told us staff meetings were held regularly throughout the year and a member of staff confirmed staff meetings were held regularly. We saw a record of staff meetings which had been held in June, August and September 2015. We also saw hand written notes from two recent meetings held in January 2016. Meetings are an important method of monitoring the service, identifying potential problems and gaining the views and opinions of staff.

We asked the registered manager how they gained the feedback of people who used the service. They told us they held resident and relative meetings. We saw minutes from a meeting held in November 2014 and the agenda for meetings scheduled for May and December 2015, the record for both these meetings noted no-one had attended. They said a survey of people who lived at the home and their relatives had been completed in April 2015 and was due to be sent to people again in April 2016.

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager had not ensured that people received person-centred care and support that was appropriate, met their needs and reflected their personal preferences.

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's personal preferences and choices were not consistently respected .

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not provided in a safe way. People were not protected from the risk of harm. The Registered provider had failed to fully assess the risks to people and had not ensured that all that is reasonably practicable to mitigate any risks had been identified and acted upon. People's medicines were not managed safely

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	People were deprived of their liberty for the purpose of receiving care without lawful authority.

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure the premises were suitably maintained.

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from unsafe or inappropriate care as the quality of services provided were not robustly monitored or audited. Accurate, complete and contemporaneous records were not maintained.

The enforcement action we took:

Notice of Proposal to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of adequately deployed staff available to meet people's needs.

The enforcement action we took:

Notice of Proposal to cancel