Countrywide Care Homes Limited

Croft House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Croft House Care Home (called 'Croft House' by the people who live and work there) on 20, 22 and 26 July 2016. The first day of the inspection was unannounced. This meant they did not know we were coming. At the last inspection in November 2015 we rated the home as inadequate in every domain of care and inadequate overall and placed it in special measures. We also took enforcement action by serving the provider with notice of our intention to de-register and close the home if significant improvements were not made. This inspection was to see whether the issues we identified had been resolved.

Croft House contains four units over two floors. Downstairs are two nursing units, one with 18 beds and one with 12 beds. On the first floor there is a small residential unit with 12 beds and a dementia unit that has 24 beds. On the days we inspected there were 27 people in the units upstairs and 18 people in the units downstairs. There are stairs and lifts to the first floor. The home has dining and lounge areas in each unit, four conservatory areas downstairs and a large garden which is accessible to the people.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

After the last inspection a 'peripatetic' manager had been appointed; their role was to make improvements at the home while the provider recruited a new registered manager. At the time of our inspection the peripatetic manager was still in post and a new manager had been recruited; they were in the process of transitioning into the role from their current home. The plan was for the new manager to apply to register with CQC when they became the home manager full time in August 2016.

We took enforcement action after the last inspection. At this inspection we checked to see if improvements had been made in all the areas we identified. We found that all aspects had been addressed either fully or partially. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

As the previous inspection in November 2015 rated the home as inadequate we placed it into 'Special Measures.' At this inspection we found there had been improvements which were sufficient for the service to be rated as requires improvement overall with no inadequate domains. This meant the service could come out of special measures.

At the last inspection in November 2015 we identified issues with the accuracy of people's risk assessments. At this inspection the quality of risk assessment was mixed. Some were completed properly and others were not, and some were missing entirely. This constituted a continuous breach of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Recruitment records did not include prospective employees' full employment history and this was not investigated with them and recorded at interview. This was a breach of Regulation 19 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Although pressure area care and pressure ulcer management had improved, we found issues with the adherence to pressure ulcer treatment and prevention care plans. This was a continuous breach of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people about the food was all positive and we saw food and fluid care plans and risk assessments were much improved. However, we found issues with the recording of food and fluids for people either losing weight or at risk of weight loss. This was a breach of Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

There were ongoing problems with the quality and consistency of record-keeping in care files and in daily records. This was a continuous breach of Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Records showed the provider had greater oversight at the home since the last inspection. However, concerns remained around the potential sustainability of improvements due to the upcoming change in manager and previous issues with provider oversight.

Most aspects of medicines management were done well. However, we identified some issues with medicine protocols that lacked detail or were missing and records showed there had been problems when people's medicines had run out.

The recording and reporting of accidents and incidents was better, but not all reports contained the same level of detail.

We observed there were sufficient staff on duty to meet people's needs and this was supported by a dependency tool which incorporated the number of staff people needed to support them. Care workers told us there were enough staff, although feedback from the people and their relatives about staffing levels was mixed.

Progress had been made to ensure all people who lacked capacity to make their own decisions had been assessed and any decisions made on their behalf were done according to the relevant regulations. However, some best interest decisions we saw were generic or had not followed the correct process.

People said they felt safe at Croft House. Staff awareness of safeguarding, its prevention and reporting, was improved. Care workers could describe the forms of abuse and said they would report any concerns appropriately.

We saw cleanliness at the home was much improved. Issues with broken equipment and facilities identified at the last inspection had all been addressed.

Care workers received the training they needed to meet people's needs. Most staff had received supervision or an appraisal in 2016 and there were plans to ensure all staff would have one by the end of August 2016. Staff told us they felt supported by management.

Records showed people had access to a range of healthcare professionals. People said they could ask to see

a GP if they wanted to and relatives told us they were informed if their family members' health changed.

Environmental changes the home had made to become more dementia-friendly, particularly on the dementia unit, were impressive. Care staff had received dementia training and some had taken part in a dementia experience to help them empathise better with people who lived with dementia.

People and their relatives told us the staff were caring, promoted people's independence and respected people's privacy and dignity. Care workers felt the atmosphere at the home was much improved and staff were much happier.

People had access to advocacy services. Care files contained information on people's end of life care wishes if they and their relatives (if relevant) had been happy to discuss this area of care.

We saw care plans were much improved. They were detailed and person-centred and regularly reviewed and evaluated. The home had made an effort to try and obtain people's personal histories so care workers could interact with people better.

People now had access to meaningful activities. Their participation and enjoyment of activities was evaluated so care workers would know what people liked to do best.

The way the home recorded and responded to complaints had improved since the last inspection. We saw complaints received since the last inspection had been handled properly.

We received very positive feedback about the efforts of the peripatetic manager to improve the culture and atmosphere at the home. Levels of communication and team-working at the home had improved considerably.

An effective system of audit and quality assurance monitoring was now in place.

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.

Some issues with risk assessment identified at the last inspection had not been addressed fully. The home could not evidence a fully robust recruitment process.

Medicines management was largely done well, although we did identify some issues with medicines protocols that lacked detail or were missing.

The recording and reporting of accidents and incidents had improved, although some accident forms were not completed fully. Checks on the building and equipment used to support people had been done to ensure people were safe.

The cleanliness of the home was much improved. Our observations showed there were sufficient staff to support the people at the current level of occupancy and dependence.

Is the service effective?

Requires Improvement

The service was not always effective.

Pressure area care and pressure ulcer care had improved. However, we identified people with pressure ulcers who were not always supported according to their care plans.

People and their relatives were positive about the food at the home and we saw nutrition care plans and risk assessments were better. However, we identified issues with the recording of food and fluids for some people.

Compliance with the Mental Capacity Act 2005 had improved. However, we saw some best interest decisions contained generic information and one person was receiving covert medicine even though the correct process had not been followed.

People had access to a range of healthcare professionals to support their holistic health. Significant improvements had been made to the home in order to make it more dementia-friendly.

Is the service caring?

Good

The service was caring.

People and their relatives told us care staff were kind. We observed many warm and supportive interactions between people and care workers during the inspection.

People and their relatives were consulted about changes made to the home, such as improvements to the dementia unit and varying the times of meals. The home held regular residents' and relatives' meetings.

People had access to advocacy services and the staff knew how to make referrals if people needed such support. People's end of life care wishes were recorded in their files where they and their families (if relevant) had been willing to discuss this aspect of their care.

Is the service responsive?

Good

The service was responsive.

Care plans had much improved since the last inspection. They were now detailed and person-centred and reviewed and evaluated regularly.

People now had access to meaningful activities. We saw they were evaluated by staff to identify people's personal preferences.

The process for receiving and dealing with complaints had improved. We saw each of the formal complaints received by the service since the last inspection had been documented and resolved properly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality and consistency of record-keeping was still an issue at the home. During the inspection, measures were put in place by the peripatetic manager to try and address this.

The culture and atmosphere at the home had much improved. Communication between the different units was better and staff worked well as a team.

An effective system of quality and safety monitoring was now in place at Croft House. People deemed at risk of deterioration

were discussed in regular cross-unit meetings so accountability for their well-being was shared.

Croft House 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 20, 22, and 26 July 2016. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the Provider Information Return (PIR) we asked the registered provider to complete before the inspection. This is a form that asks the registered provider to give some key information about the service, such as what the service does well and the improvements they plan to make.

We also contacted a range of organisations and stakeholders, including Healthwatch Wakefield, the local authority safeguarding team and the local clinical commissioning group (CCG). We did not receive any information of concern from Healthwatch Wakefield or the local authority and the CCG gave positive feedback about improvements they had observed during a visit in May 2016.

During our inspection we spoke with nine people who used the service and six people's relatives. We spoke with the peripatetic manager, the quality assurance manager and the regional director. We also spoke with the cook, three members of the domestic staff, the maintenance worker, two activities coordinators and nine members of care staff, including nurses and care workers who worked night and day shifts. During the inspection we spoke with one visiting healthcare professional and after the inspection we contacted two more for feedback about the home.

Some of the people using the service were living with dementia. We made observations during the three days we were there to try and understand their experience of living at the home.

As part of the inspection we reviewed 11 people's care files, five care workers' recruitment records, supervision and appraisal records, eight people's medicines administration records, audit and monitoring

records and other documents relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Croft House. One person told us, "I feel safe, yes." Relatives also said they felt their family members were safe at the home. One relative told us, "[My relative] is safe and well cared for."

At the last inspection in November 2015 we found risk assessments in some people's care files contradicted other information recorded about the person. At this inspection we looked at risk assessments for bed rails, skin integrity, mobility, falls, nutrition and infection control. Most risks had been assessed correctly and we saw care plans were in place to manage the risks identified. However, in some care files we noted risk assessments had not been calculated properly. For example, one person's nutrition risk was calculated as medium. We noted the person's difficulty with swallowing had not been taken into account even though they were on a soft diet and thickened fluids. Correct calculation would have made this person's nutritional risk high. The same person's infection control risk had also been incorrectly assessed as they had taken antibiotics for an infection recently and had a catheter in place, neither of which had been taken into account. We could see in this person's case the incorrect calculation had not affected the care the person had received as all the correct care plans were in place. However, this meant people's risk of harm was not always calculated by care workers properly.

Some of the people living at Croft House needed help to move and staff used hoists and stand-aids to assist them. We saw mobility and moving and handling risk assessments in people's files which stated which equipment was required to help them move; this included the size of hoist slings. However, we saw mobility care plans for two people which stated they needed a bath hoist in order to bathe safely but there was no risk assessment in place for use of a bath hoist. Another person had a risk assessment in place for bed rails. Part of this assessment asked if the person had dementia and we saw 'no' had been circled. According to this person's care records they did have a diagnosis of dementia. We raised the issues of poor documentation with the peripatetic manager. They agreed there was further work to be done in terms of the accuracy of documentation. However, at the time of our inspection some risk assessments were incorrect or missing from people's care files.

People at Croft House had personal emergency evacuation plans or PEEPs which were kept in an emergency file in the reception area so they could be easily accessed if needed. PEEPs contain information on how each person mobilises and how many staff members are needed to assist them. At the last inspection in November 2015 it was noted staffing levels at the home could not facilitate the evacuation of the people according to their PEEPs as too many people needed the assistance of two members of staff. At this inspection we saw that PEEPs had not been amended to make them useable in an emergency.

Issues with risk assessment constituted a continuous breach of Regulation 12 (1) and (2) (a) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

We checked recruitment records for five of the most recently employed staff members to see whether the home's recruitment process was robust. We found all the correct checks had been made, including the Disclosure and Barring Service, which assists employers to make safer recruitment decisions. Each staff

member had proof of their identity on file, copies of photographic identification, a completed application form and a record of their interview. We noted application forms did not record the full employment history of the prospective staff members and this had not been explored and documented by the manager who interviewed them. We saw a recent recruitment audit at the home had identified this issue and application forms which had asked for 10 years' employment history had been amended. They now asked for a full employment history, including an explanation for any gaps in employment. However, at the time of our inspection records showed staff had been employed when their full employment history was not known.

This constituted a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2015 we found a breach of regulation relating to the safe management of medicines. At this inspection we found most medicines were managed safely and observed they were administered in a person-centred way. One person told us, "I take my pills. They bring 'em round regular." A second person eating breakfast in their room was observed to have their medication on the table in front of them. As we spoke with them about this a care worker popped in to ask the person if they had taken their medicines. After they left the person told us, "They always check if you have taken them." A care worker we asked about medicines administration confirmed, "I always watch to make sure they've took it", and a second said they checked, "The right person, dose, medicine, time and route", every time.

We checked eight people's medicine administration records (MARs) and found they were up to date with staff signatures to show medicines had been administered properly. Records for controlled drugs, such as morphine, were kept correctly and stocks we counted tallied with levels recorded in the controlled drugs book. All medicines, including controlled drugs, were also stored securely, and room and medicine fridge temperatures were taken daily by staff. Records showed the temperature of one medicine room had been above the recommended 25 degrees Celsius. An air conditioning unit had already been brought into the room as the weather was very hot on and prior to our inspection.

We identified some issues with medicines. Records showed there had been problems with people's medicines running out. One person had been without a diabetes medicine for two days and another person had run out of pain control patches. We spoke with the peripatetic manager about these incidents. They told us problems had occurred when medicines were not prescribed in accordance with the monthly cycle which meant they ran out in before the end of the month. Records also showed a bottle of a person's medicine had been smashed accidently and a replacement had not been obtained for several days due to communication issues within the home and between the home and the GP. The peripatetic manager explained how they had worked with the GPs the people at the home were registered with to resolve this problem. They had also created a weekly medicine audit that included checking medicine stocks to ensure they would not run out. Records we saw showed this audit was carried out every Sunday on each unit. This meant issues with availability of medicines had been addressed by the peripatetic manager.

We saw medicines errors that had occurred were documented correctly and the peripatetic manager had taken steps to prevent further problems. All care workers administering medicines had been checked for their competency since the last inspection. We saw and staff told us the medicines errors had been discussed in supervisions with staff and at a team meeting, where lessons learned were considered. The peripatetic manager had also worked hard to improve communication with the GPs the people at the home were registered with. This meant the home had taken appropriate action when medicine errors had occurred and staff were encouraged to reflect on incidents in order to learn from them.

Not all medicines prescribed 'as required' had person-centred protocols which told staff when they should

be administered. 'As required' medicines are taken by people when they feel they need them. For example, one person on the dementia unit did not have a protocol for a pain relieving medicine. Another person on the dementia unit had a protocol for a medicine which could be administered if they became distressed; we saw their prescription had changed on 01 July 2016 but the medicine protocol was dated January 2016 and had not been updated with the new prescription. Other people did have protocols in place for medicines such as pain killers and laxatives, however, they lacked detail. When people live with dementia or have problems communicating and cannot ask for medicines verbally, medicines protocols should contain information about body language or behaviours people may show when they need their 'as required' medicines. We brought this to the attention of the peripatetic manager who said protocols for medicines prescribed 'as required' would be reviewed and updated as soon as possible. However, this meant at the time of our inspection, not all medicines prescribed 'as required' had protocols.

At the last inspection in November 2015 we found accidents and incidents had not been recorded and investigated properly and had not been reported to the local authority or to the Care Quality Commission (CQC). At this inspection we saw accidents and incidents had been reported to the local authority and to CQC appropriately. We also saw the peripatetic manager had implemented a new 'post falls pathway' which set out a procedure to be followed if a person had a serious or unwitnessed fall. This included making regular checks at set times after the fall, including blood pressure and neurological observations. We checked the 15 most recent accident and incident forms and found that whilst the majority were completed fully and in appropriate detail, there were issues with the quality of the information recorded on four of them. We raised these issues with the peripatetic manager who agreed the forms we highlighted were not completed fully. They said more work needed to be done to ensure care staff completed documentation properly.

Care staff we spoke with could describe the forms of abuse people using the service might be vulnerable to. One care worker said they would watch out for changes in a person's behaviour which might indicate they were not happy. All the staff we spoke with told us they would report any concerns to the member of staff in charge or to the peripatetic manager. Senior care staff could explain how safeguarding referrals were made to the local authority. All of the care staff we spoke with had received safeguarding training in 2016. We noted there was a monthly safeguarding audit at the home; this involved checking staff knowledge and analysing any incidents that had occurred. In addition, the peripatetic manager had implemented a feedback system for safeguarding incidents that happened at night or weekends so they would be made aware of them. This meant care staff were aware of the safeguarding risks to people and how to report them, and the peripatetic manager had oversight of incidents that had occurred.

Safety checks had been made on all of the equipment and facilities used to support the people at the home or keep them safe. This included checks of water temperatures, fire extinguishers, moving and handling equipment, the fire alarm and the lift. Fire drills had been done on a monthly basis and the fire alarm was checked weekly. Risk assessments were in place for various aspects of the building, including a fire risk assessment, and the home had a contingency plan should there be a fire, flood or loss of utilities. This meant the appropriate checks and assessments had been undertaken to make sure the building and equipment at the home was safe.

At the last inspection in November 2015 we found the home was not clean and various equipment and facilities were broken. At this inspection we found the home to be clean and there were no odours present, except in one person's room. We asked the peripatetic manager about this person's room and they told us the provider had been updating two people's rooms every four to six weeks during 2016 and this person was due to have their carpet replaced with a surface which would be easier to clean. The home had been inspected by the local authority's infection control team in June 2016 and had been rated as 81% compliant

with their standards. We saw the peripatetic manager had been provided with an action plan which they were working their way through. During the inspection we checked the equipment and facilities that were broken at the last inspection and found they had all been fixed or replaced. People, their relatives and care staff commented on the changes since the last inspection. One person told us, "Cleaners are in all the time", and a relative said of the home's cleanliness, "Yes, it's better now." A care worker said, "It's improved a lot", and a second said, "It's changed loads. I've worked here for [number] years and it's the best it's ever been." An inspection in May 2016 by the Clinical Commissioning Group had also concluded that, 'Cleanliness was much improved.' This meant the provider had responded to concerns and the home was now clean and broken facilities had been fixed.

At the last inspection in November 2015 we found a breach of regulation relating to staffing as there were insufficient care workers and they were poorly deployed. In addition, the dependency of the people was not factored in when calculating the number of care workers required as staffing levels had been based purely on the occupancy of the home. Over the three days of this inspection we observed there were sufficient care staff on duty to meet the needs of the people at the current level of occupancy and dependency. A dependency tool had been used which incorporated the level of support people needed. This showed the home had a staffing level which was greater than that required for the number and dependency of people currently in residence.

People and their relatives had mixed opinions as to whether there were sufficient care staff at the home. People told us, "If I press my buzzer they come straightaway", "There isn't enough staff for the number of residents really", and, "If I need anybody (care staff), they come". Another person commented, "Sometimes they've (the people) to wait a little bit longer, sometimes it's ok", and then added, "A lot of people are in their bedrooms so staff are in there." One relative we asked if there was sufficient staff on duty replied, "Probably not because they're all so busy all the time", but then went on to say of their relative who was nursed in their room, "People (care staff) come when we buzz." Another relative told us staffing levels had definitely improved and a third said, "Yes, they seem to have (enough staff)", whereas a fourth said, "Sometimes you can't seem to find a member of staff when we come." A fifth relative told us, "No they don't have enough (staff), just my observation. At lunchtime so many people need help, they could just do with another one (care worker)"; we asked this relative if staffing levels affected the care their family member received and they said no. A sixth relative said, "I'd say there's enough staff."

Care staff we asked about staffing levels all agreed there were sufficient staff on each shift. Care workers told us, "There's more than enough staff", "The number of residents is less so the staff to residents ratio is better. There wouldn't if we were full", "There is on a night now (enough staff). It's increased", and, "Yes at the moment (there are enough staff) but if we get more service users then we would need more staff." Our observations, the home's records and feedback obtained at this inspection showed there were sufficient care workers to meet the needs of the people at the current level of occupancy and dependency.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in November 2015 we found issues with pressure area care and pressure ulcer management. Wound care was not appropriate and there was no evidence people with restricted mobility were being assisted to reposition in order to prevent pressure ulcers from developing. At this inspection we looked at the care files of two people with active pressure ulcers and one person at risk of pressure ulcers. We saw they each had the appropriate skin integrity risk assessments in place and wound care plans. Records showed a specialist nurse had been involved with each person who needed wound care and both wounds were currently healing. The specialist nurse had also provided wound care training to some of the nurses.

We checked the daily records kept for each person to see if they were supported to reposition in order to promote healing and prevent further ulcers. People had repositioning records in their rooms which showed they were assisted to reposition according to their care plans most of the time; however, some records had omissions. For example, the repositioning charts of one person at risk of pressure ulcers were blank between 12pm and 7pm on 14 July 2016 and 3pm and 7pm on both the 18 and 19 July 2016. Care plans for a person with an active pressure ulcer stated they should only be positioned on their back for meals and for 30 minutes afterwards. Their repositioning records for June and July 2016 showed they were regularly lying on their back for more than six hours per day, although not consecutively. We raised concerns with the peripatetic manager who agreed record-keeping and adherence to care plans was not as it should be. By the second day of inspection the room charts for people who needed assistance to reposition had been updated with the specific instructions from their care plans. The peripatetic manager had also implemented a new system whereby senior care workers had to check repositioning charts at the end of each shift and either sign them off as complete or investigate any omissions. However, at the time of our inspection although wound care was much improved, there were still some issues with practice and record-keeping.

This constituted a continuous breach of Regulation 12 (1) and (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2015 we found a breach of regulation relating to meeting the nutrition and hydration needs of the people at Croft House. This was because people who needed foods and fluids with a certain consistency for safe swallowing did not always receive a choice of foods, people with diabetes were not supported to have a low sugar diet, people who had lost weight had not been referred to their GPs or a dietician and people did not always have access to drinks and snacks.

At this inspection feedback from people and their relatives about the food was positive. People told us, "I can eat all the food, the quality is good. I can't put 'em wrong about the food", "The food's all right. You do get a choice", "It's beautiful. I had a cooked breakfast today", and, "The food is very good". Relatives commented, "[My relative] always liked the food and enjoyed it", and, "[My relative's] put weight on since [they've] been here."

At this inspection we found there had been an improvement in this aspect of care. The care files we looked

at contained risk assessments and care plans for nutrition and hydration, which included the support people needed with swallowing safely, diabetes and weight loss. Care plans also stated how often people were to be weighed by care staff. During the three days of inspection we noted people had access to hot and cold drinks and snacks between meals. The peripatetic manager explained the home was trialling a new mealtime system whereby people nursed in their rooms received their meals first followed by the people using the dining room second. The peripatetic manager explained how the idea had been discussed with people, their relatives and staff; the aim was to ensure there were sufficient staff available to support all those who needed assistance to eat and drink.

We observed mealtimes at the home during the inspection and saw people who needed support received it in a timely way. The mealtime experience in the dining room was relaxed and sociable. People chose their meals the previous day. On one unit we saw people were offered the food they had selected and then other choices if they had changed their minds. On another unit we observed some people were given their food and not offered the opportunity to change their minds. In some cases they were not told what the food was, for example, the type of sandwich or flavour of soup. We raised this with the peripatetic manager who said all people should be offered a choice, and those with mental capacity problems shown picture cards or plated food in order to help them decide. The peripatetic manager said they would ensure staff were reminded by senior care workers and at the next staff meeting.

Care and kitchen staff knew which people had special diets and how their food and drinks should be prepared. Care staff could describe the process for monitoring people's weight and when and how referrals must be made if individuals experienced weight loss or had problems swallowing safely. We saw in people's care files that GPs, dieticians and speech and language therapists had been involved in the care of some people at the home. This meant the home had improved how people were supported to meet their nutrition and hydration needs.

However, we did identify some issues with documentation relating to people's food and fluid intake. People who had lost weight or who were at risk of weight loss had food and fluid charts which were to be completed after each meal, snack or drink. We checked food and fluid charts of people on different units of the home. Neither person's forms were completed fully. For example, one form was blank for 10, 13, 14 and 19 July 2016. The other form was better as food and fluids were recorded, but not always the exact amounts. We raised concerns with the peripatetic manager who amended the forms by the second day of our inspection with instructions to direct staff on how to complete them fully. A new system was also implemented whereby senior care workers had to check food and fluid charts at the end of each shift and either sign them off as complete or investigate any omissions.

We also identified issues with some people's weight records. Two people had rapid weight loss recorded in their files which had not triggered a concern at that time. For example, one person had a recorded weight loss of nearly 16kg between September 2016 and January 2016 and another person whose weight was stable between November 2015 and June 2016 suddenly appeared to lose nearly 10kg by July 2016. We raised this with the peripatetic manager who asked care workers to reweigh the people concerned during the inspection. Neither person's weight was of concern; in fact one person had gained weight. The peripatetic manager said care workers were not using the weighing equipment properly and did not always recognise weight loss as it was measured in kilograms rather than pounds and stones. During the inspection the peripatetic manager retrained the staff on how to use the weighing equipment properly and how to recognise the significance of weight loss in kilograms in order to prevent further problems. However, at the time of our inspection there were ongoing issues with the completion and accuracy of documentation at the home.

Issues with record-keeping constituted a continuous breach of Regulation 17 (1) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

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

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

At the last inspection in November 2015 we found a breach of regulation relating to the need for consent as people who lacked mental capacity whose files we looked at had not been assessed for their ability to make decisions. Some people who lacked capacity had signed consent forms and only four DoLS applications had been made for the entire home. In addition, people's liberty was restricted by a lack of staff to support them to get out of bed or mobilise and by a lack of suitable seating.

At this inspection we found there had been a significant improvement. DoLS applications had been made for all people who lacked capacity to consent to living at the home or were otherwise restricted. There were more care staff and new chairs had been purchased so that people who needed seated support could get out of bed. Care workers' knowledge of MCA and DoLS was also much better, and they could give examples of how they supported people to make choices. One care worker told us, "It's keeping them safe from harm in the least restrictive way", and a relative said, "I'm sure they understand [my relative's] capacity to make decisions." The care files of people who lacked capacity contained mental capacity assessments and records of best interest decisions made on people's behalf. These included people's ability to consent to care and treatment, to be resuscitated in the event of a cardiac arrest and to be supported by staff with equipment, for example, a hoist.

However, we did note MCA assessments were rather generic and those for the use of safety equipment did not specify what equipment would be used. We also checked documentation relating to the use of covert medicine for three people living with dementia who would sometimes refuse the medicines they needed to stay healthy. We found one person did not have an MCA assessment and best interest decision recorded for this. There was a GP letter on file agreeing to the use of covert medicines for this person, but the MCA process had not been followed fully. We brought this to the attention of the peripatetic manager who agreed person-centred assessments should be in place for decisions people lacked the capacity to make. They stated the audit and improvement of MCA and DoLS documentation was 'work in progress' and would be completed within four weeks of our inspection.

People and their relatives told us staff were well trained and had the right skills to support them. One person told us, "I think the staff know what they're doing." A relative we asked if staff were well trained told us, "Yes, I would say so now." A second relative said of training at the home, "They're definitely on the ball with that."

Staff we spoke with said they had received a lot of training since the last inspection, some of which was online and some face-to-face. One care worker told us, "We have all had so much training. It has done so much for my confidence." The training matrix for the home showed over 90% of staff were up to date with mandatory courses, including safeguarding, fire awareness and manual handling. Nurses at the home had attended specialist training courses on venepuncture and catheterisation since the last inspection. Records

showed staff newly recruited to the home were enrolled on the Care Certificate and had a week-long induction which involved shadowing experienced staff when they started. This meant care workers received the training they needed to meet people's needs.

Most care staff we spoke with had received supervision since the last inspection; they also said they felt supported by senior care workers and managers, the peripatetic manager in particular. Care workers told us, "There's a massive difference since last November. The management is better, and the support", and, "You feel like you can approach them (managers) if you've got any problems." However, records showed not all care workers had received regular supervision since the last inspection or an annual appraisal in the last year, although this had improved in the weeks preceding this inspection. We asked the peripatetic manager about this. They explained the focus since the last inspection had been on improving other aspects of the home, such as on the care provided, care plan quality and training. This meant supervision and appraisal had not been as high a priority. The peripatetic manager emphasised how staff had been supported in other ways, such as via staff meetings which we saw had happened regularly in 2016, and by their open door policy. One care worker told us, "We have meetings where we can discuss how we feel. [The peripatetic manager] is open to suggestions." The supervision and appraisal matrix showed every staff member would receive either supervision or appraisal by the end of August 2016. This meant not all care workers had received regular supervision and appraisal at the time of our inspection. However, supervision dates were booked in for all staff, and care workers we spoke with said they felt supported by management.

Records showed people had access to a wide range of healthcare professionals to help support their holistic health, for example, GPs, podiatrists, speech and language therapists, the dietician and dentists. People told us they could request a GP if they wanted one and relatives said they were updated when the health of their family members changed. Relatives told us, "They have the GP to [my relative] if there's any problem. They ask the nurse to see [them] from here", and, "I have a word with the nurse each time I come and this keeps me up to date."

The peripatetic manager said there had been communication issues between the home and the two doctors' practices where most of the people were registered but they had worked hard to fix this. One initiative had been to coordinate how calls were made to request a doctor to attend. In the past each unit would call the doctors' practice separately, so one GP might get four calls on the same day from the home. The new system was coordinated by the senior care workers and involved them contacting each unit daily to ask if a GP was required so one phone call was made. The peripatetic manager had also created a new form upon which a person's health details and observations, such as blood pressure and temperature, were recorded and faxed to the doctors' practice in advance of their visits. One visiting healthcare professional told us, "They give us observations before we come now. It's much better." Another told us, "Overall, recently things have much improved." This meant the home had put measures in place to improve communication with, and people's access to, the wider team of healthcare professionals.

At the last inspection in November 2015 we found the home was not dementia-friendly. At this inspection we noted the positive changes that had been made throughout the home, but in particular in the dementia unit. Picture signage was evident to help people find bathrooms and toilets, people's doors had been painted different colours, new seating had been purchased and heating added to the conservatory areas which had been cold. On the dementia unit there was a large bus stop mural with a wooden bench underneath, to encourage people who liked to walk around to have a rest. The kitchen and dining areas had been subdivided using 'rummage boxes' filled with vintage objects, like shower hats and gloves, to promote reminiscence. There was also a garden room that contained wooden benches, artificial grass and a garden wall mural so people on the unit could feel like they were outside on days when the weather meant this was not possible. A dedicated activities coordinator had been recruited to the dementia unit since the last

inspection and the home had been visited by the 'dementia bus', an interactive training environment which simulates what it is like to have dementia for care workers. One staff member said of this, "[The trainer's] feedback to us was quite inspiring. It was great, a real eye-opener." This meant significant improvements had been made at the home in order to make it more dementia-friendly for the people who lived there.

Good

Is the service caring?

Our findings

People told us the care workers at Croft House were caring. One person said, "It's a lovely place to live, the girls (care workers) are lovely and can't do enough for you." Relatives agreed. They told us, "I think what they do for [my relative] is fantastic", "There's some that go above and beyond", and, "I think the attitude of the staff is lovely. [My relative] loves it here."

At the last inspection in November 2015 we found a breach of regulation relating to staffing, as staff were often too busy to support people, and care assistants and nurses were not working well as a team. At this inspection, as noted earlier in this report, we saw there were sufficient staff on duty to meet the needs of the people at the home's current level of occupancy and dependency.

During the inspection care workers told us the atmosphere of the home was much improved as were the attitudes of staff and the willingness to work as a team. One care worker told us, "Staff are more smiley when they come to work." This care worker emphasised how the attitudes of staff impacted on the people, stating, "However you are reflects on them." Another care worker said there had been friction between day and night staff previously, but this had improved; they told us, "The staff do seem a lot happier now." Relatives said of the care staff, "They've always got a smile on their faces", and, "The ethos of the carers is that this is people's home." Another relative described how care workers had attended a fayre at the home on their days off. The relative said of this, "I thought wow! That's good." This showed us the atmosphere at the home had much improved and staff were happier.

At the last inspection in November 2015 we found a breach of regulation relating to dignity and respect, as people were not involved in decision-making at the home and staff were not always respectful of people's privacy and dignity. At this inspection we saw records of residents' and relatives' meetings which had taken place at the home. They were not always well attended so the peripatetic manager was considering ways to promote attendance, such as offering refreshments. People and their relatives were also sent an annual questionnaire so they could feedback about the service. This happened in July each year, so there were no results available that included the time since the last inspection. People and their relatives had been consulted about the change in mealtimes, as discussed earlier in this report, and the switch of the main meal from the middle to the end of the day. Meeting minutes showed they had also been consulted over changes to the dementia unit, such as the garden room, the subdividing of the lounge and dining areas and the installation of a wet room. At the time of the inspection the home was consulting with people and their relatives over the naming of each of the units at the home. Some people we spoke with had been involved in reviewing their care plans, as had their relatives. Relatives had been invited by letter to care plan review meetings and had also been sent 'my life history' documents to complete about their family members. This information had been used to create one page profiles we saw displayed in people's rooms, so care staff could learn more about the people they supported and provide better person-centred care.

Care workers could describe how they promoted people's independence and respected their privacy and dignity. One care worker said, "I ask them what they'd like to do, what they'd like to wear", another described encouraging a person to zip up their coat themselves and a third said they made sure people's

modesty was protected during personal care by only uncovering the part of the body they were assisting the person to wash. Care workers told us, "I treat them as I would my own mum", and, "These people are like your family. We spend so much time with them." Throughout the inspection we observed only warm and supportive interactions between care workers and the people they supported. People appeared clean and well-dressed. We did not hear staff discussing confidential information in front of people or their visitors and staff knocked on people's doors before entering their rooms. People's rooms were clean and tidy, and they and their families had been encouraged to personalise their rooms with furniture, pictures and ornaments. This meant staff respected people's privacy and dignity and treated them as individuals.

At the last inspection we found a breach of regulation relating to person-centred care as people with terminal illnesses or nearing the end of their lives had no care plans or end of life wishes recorded in their care files. At this inspection we saw end of life wishes were recorded in the care files of people who had been willing to engage in a discussion around this area. People's relatives, when appropriate, had also been involved in these discussions. One relative described being approached with their family member by the home about end of life wishes. They told us, "I'm sure they'll involve us at that time and review what we discussed." The local hospice had provided end of life care training to some of the care staff and more was being organised for the remaining staff. The peripatetic manager also showed us a person's care file which had been modified as they approached the end of their life to focus on providing comfort and pain relief. This meant the home had much improved their provision of end of life care.

Information was available on advocacy services in the reception area of the home. We asked the peripatetic manager if any of the people at the home had the support of an advocate at the time of our inspection. They said all of the people at the home had family who advocated for them, but gave an example of a person who used the home for respite since the last inspection who was referred to an advocate to help them decide where they wanted to live. Care staff had received training on advocacy as part of their Mental Capacity Act 2005 course. One care worker described how they would try and support a person to make decisions by offering choices, but would refer them to an independent advocate if it was a big decision, such as whether to refuse resuscitation, or involved their money. This meant care workers understood the purpose of advocacy and the service referred people to advocates when they needed them.

Good

Is the service responsive?

Our findings

At the last inspection in November 2015 we found a breach of regulation relating to safe care and treatment as risk assessments used to inform the content of care plans were not completed accurately. In addition, the information contained within people's care files lacked detail and was at times, incorrect and contradictory. At this inspection we found people's care plans had been improved and were now detailed and person-centred. One relative told us, "It's better, definitely. The care plan is better", and a second relative described how the home was adjusting their family member's care plan to see what worked best. One care worker commented, "The care plans are a lot better. They're more person-centred." We observed people received care according to their care plans. For example, people at risk of developing pressure ulcers were assisted to reposition, people who needed food and fluids of a specific consistency to help them swallow received them and people with mobility issues got the support they needed to move from staff. Care files had a contents page at the front and we found they were easy to navigate. One visiting healthcare professional agreed, stating, "I can find the information that I need in care plans", and another told us, "You can find what you need now in the care files."

A new assessment process for prospective admissions to the home had been implemented by the peripatetic manager. One care worker explained, "We do care plans and evaluate them weekly for the first four weeks to make sure they're right." We saw a new admission checklist which covered all aspects of care to be assessed and planned was used. This included tasks such as booking in medicines, finding out any dietary needs and weighing the person, with timescales for completion. Progress with the admission checklist was reported weekly to the provider's quality assurance manager and regional director so they had oversight of the admission process. This meant the home had much improved the way the care of people admitted to the home was assessed and planned.

We sat in on 'handover' meetings during the inspection, when staff finishing their shifts updated staff starting their shifts about people's well-being, gave reminders for appointments and passed on any outstanding tasks. The meetings were detailed and informative as to people's needs and changes in condition. There was also a diary in use which contained people's appointments that staff checked at the start of each shift. We asked care workers how they would meet the needs of a person newly admitted to the home. Care workers told us they would speak to the senior care worker for a detailed update, read the person's care plans and get to know the person to find out their preferences.

We saw people's care plans were reviewed and updated on a monthly basis. Daily notes evaluated the support people received and were written by senior care workers each shift; they were sufficiently detailed and evidenced people had been supported according to their care plans. The daily notes we saw focused on tasks and were rather clinical in nature. The peripatetic manager agreed with our observation and told us of a recently implemented initiative at the home. Care workers had been encouraged to capture non-task related interactions or 'moments' they had with people, particularly those people nursed in their rooms, such as activities people said they enjoyed or jokes that had been shared. The purpose was to learn more about the people they supported and to emphasise to staff that people's support should not consist solely of the completion of tasks. The records we saw evidenced the social interactions people had with care

workers and one relative told us, "They're (the care workers) very attentive and interactive. They pop in for a chat with [my relative]." A second relative said, "If they're passing they'll come in and have a nice chat", and went onto describe a care worker sitting with the person and other family members to look at old photographs. A third relative said, "[The activities coordinator] makes a fuss of [my relative]. The other staff do too." A care worker said, "It's nice to spend more time chatting and getting to know people." This meant the home had tried to ensure social interactions between care workers and people were as important as support interactions.

At the last inspection in November 2015 we found a breach of regulation relating to person-centred care as people did not have access to meaningful activities, particularly those people nursed in their rooms. At this inspection we found there had been an improvement in people's access to activities. The home had employed a second activities coordinator who worked exclusively on the dementia unit. The home had a trolley which one of the activities coordinators ran as a mobile shop, with all proceeds going to an activities fund. With this money the coordinator had bought items for people, including adult colouring books and pencils, puzzle books and sewing kits. Relatives told us how much their family members had enjoyed using these. Activities coordinators evaluated peoples' engagement and enjoyment of the activities they took part in and we saw each person had a socialising care plan, which detailed the activities they preferred.

People said of the activities at the home, "Monday after tea we have bingo", and, "I like to be in my room but you can go downstairs. They have things on downstairs." Relatives said of the activities, "[My relative's] done bingo and done singing. They know what [my relative] likes", "Activities are really good", and, "The gardens are kept well. They had a little fayre at the weekend with stalls and things." Care workers we asked about the activities at the home said, "They like playing bingo, it's quite popular", "The Friday quiz is fun", and, "They're doing a lot more (activities) now. It's a lot better."

A board in the reception area listed the activities for the week and we saw there was something planned for each morning, afternoon and evening every day, including weekends. Activities for the month were displayed in various areas throughout the home. During the inspection we observed people taking part in an exercise session and a quiz, playing cards, chatting with care staff and enjoying the garden. One care worker described having an idea to improve people's access to activities and the garden by supporting people from the upstairs residential unit to use the downstairs facilities during the day. The peripatetic manager was supportive of the suggestion, the people were consulted and the idea was trialled. Feedback from the people was positive, and we saw people from the upstairs residential unit spent time downstairs with people from the nursing unit during the day. The care worker told us, "It's much better now. If they want to have a walk in the garden they can." This meant the home had much improved people's access to meaningful activities.

At the last inspection in November 2015 we found a breach of regulation relating to how complaints were received and acted upon. At this inspection we looked at the complaints the home had received since the last inspection. Seven formal complaints had been received in writing. Records showed the peripatetic manager had documented, investigated and resolved each complaint in line with the company's complaints policy. Of the people and relatives we spoke with, only one said they had made a verbal complaint; they told us, "[My relative] complained and was happy with how it was resolved." We asked people if they would make a complaint if they needed to. People told us, "I'd take it up with a carer, for advice", and, "I'd report it to the boss if I had a complaint." A relative told us, "If I had a complaint I would tell them." We saw the complaints policy had been discussed at a residents' and relatives' meeting so that people and their relatives would know how to complain if they needed to. This meant the process for acting upon and receiving complaints was much improved at the home.

Requires Improvement

Is the service well-led?

Our findings

We took enforcement action after the last inspection and placed the service in special measures. The service had not had a registered manager since before our last inspection. After the last inspection, the provider had appointed a peripatetic manager to start making improvements to the home while a new manager was recruited. When we inspected this time the peripatetic manager had been in post since January 2016 and a new manager had been appointed and was starting in August 2016.

At the last inspection in November 2015 we found a breach of regulation relating to good governance as there was a lack of leadership and team-working at the home, record-keeping was poor, audit was sporadic and the provider lacked oversight of the problems at the home.

As discussed earlier in this report, we found issues with the quality of record-keeping in some of the care files we inspected. These included the way risk assessments were calculated and the quality and consistency of daily records. Some risk assessments were missing entirely. Most best interest decisions we saw recorded for people lacking mental capacity were generic and one person was being administered covert medicines without the correct decision-making documents in place. We asked the peripatetic manager about the audit of care files and they explained that all of the care files had been revised and updated since the last inspection, and a systematic audit of one file per unit per month was to start the following month. They also agreed improvements were needed. By the end of our inspection the peripatetic manager had already held meetings with many of the staff to emphasise the importance of record-keeping. In addition, documents kept in people's rooms were amended to state very clearly the information staff were to record and a new checking process had been implemented to ensure documents were completed fully and in a timely way. The peripatetic manager also planned to add record-keeping as a discussion item to the next team meeting agenda and to the upcoming round of staff supervision and appraisals. However, this meant at the time of our inspection we found there were ongoing issues with the quality and accuracy of record-keeping.

Issues with record-keeping constituted a continuous breach of Regulation 17 (1) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

A factor which had exacerbated the issue with record-keeping was the use of agency nurses at the home. For example, we noted the majority of incident forms not completed properly were done by agency nurses. We asked the peripatetic manager what had been done to improve the situation while recruitment of permanent nurses was ongoing. The peripatetic manager described how care workers had been trained to support and remind agency nurses to complete their allocated daily tasks, we saw a list of expected tasks was displayed prominently in each nurses' office and the handover document which nurses completed each shift went to the peripatetic manager for them to check. The peripatetic manager had also requested the same staff whenever possible from the agency for consistency; we met agency nurses at the home who had worked there regularly since the last inspection. The peripatetic manager also fed back to agency nurses at their next shift if the allocated daily tasks had not been completed on their last shift and had reported back to the agency when relatives had complained about a particular agency nurse. The peripatetic manager said the home was in the process of recruiting more nurses and the reliance on agency nurses was reducing. A

visiting healthcare professional we spoke with agreed. They told us, "There was an issue with agency (nurses). That has tailed off significantly." This meant the peripatetic manager had identified issues with task-completion and record-keeping caused by the use of agency nurses and had put measures in place to try and address them.

At this inspection we received very positive feedback about the impact the peripatetic manager had had at the home, in terms of providing leadership and improving the atmosphere and culture at the home. Staff said of the peripatetic manager, "The manager has really put the life and soul into the place. [They've] been very supportive", "Any problems at all we can ring [the peripatetic manager] and it gets answered straightaway", "[The peripatetic manager's] really nice, willing to listen", and, "The home has improved 100% since [the peripatetic manager] has been here. Morale was rock bottom; had so many managers and that." A visiting healthcare professional said of the peripatetic manager, "[Name] is really approachable and very keen to make changes." We saw the peripatetic manager was visible around the home during the inspection; they spoke in a familiar way with people and their relatives and it was clear they were well known by those they spoke with. One person said of the peripatetic manager, "[They] walk around a lot and say hello", a relative commented, "She is pretty good", and a second relative said, "[The peripatetic manager's] lovely, very approachable. I have also met [the new home manager] too."

The new home manager was due to start at Croft House in August 2016 but had already been working at the home one day a week and had covered the peripatetic manager's two week holiday in July 2016. The plan was for the new home manager and peripatetic manager to overlap until the middle of September 2016 prior to the new home manager taking charge fully. Feedback about the new manager was positive. Staff told us, "[The new manager] that's coming is a very experienced manager. [They] were manager of the year at the recent (provider) awards", "We've already been introduced to [the new home manager] and we've got to know [them]", and, "I think [the new home manager's] going to be really good."

At the last inspection in November 2015 we found audits of the service to ensure safety and quality were sporadic. At this inspection we saw various checks and audits were completed on either a daily, weekly, monthly or quarterly basis. These included daily health and safety walk arounds, weekly medicine audits, monthly safeguarding audits and quarterly dining audits. We saw records of provider visits since the last inspection. Audits had been undertaken on behalf of the provider by the quality assurance manager on a monthly basis, and had included monitoring of the premises, care files and any complaints made, as well as speaking with people and their relatives directly for feedback. The peripatetic manager gave us examples of how audits had been used to make improvements at the home. These included the implementation of a weekly medicine audit as the monthly medicine audit showed issues with medicines running out. The peripatetic manager said once the weekly medicines checks became embedded as part of normal home practice, they would revert to monthly-only medicine audits. An audit of hoist slings had shown people did not have their own sling and had been forced to share with others, so more slings had been purchased. The dining audit had been used to consider the best system at mealtimes to ensure people ate well and got the support they needed. This meant the comprehensive system of monitoring now in place at the home was used to make improvements to the way people were supported.

The peripatetic manager had worked hard to improve the culture and atmosphere at the home and to promote team-working across the various units. This included 'flash meetings' held on Mondays, Wednesdays and Fridays, which were attended by the heads of the various units, and included maintenance, the kitchen and housekeeping. After the meetings, attendees would cascade pertinent information to staff within their unit or area. One member of staff said of these meetings, "I can ask questions and get support", and another said, "Communication is 100% better." Another tool implemented since the last inspection was the resident at risk register. This document was added to during the month as

issues arose and discussed at flash meetings. On it were listed those people with pressure ulcers, those who had lost weight, people with infections, incidents of suspected or actual abuse and people with serious changes in their condition. Discussion of this document at flash meetings meant accountability for people's well-being was shared by all staff at the home.

The atmosphere and communication within the home had also been improved with regular staff meetings. We saw these promoted a two-way dialogue whereby the peripatetic manager asked staff for their ideas and input as to what improvements they would like to see at the home. Staff not on duty at the time of staff meetings were paid to come in to attend them and separate meetings were held for day and night care workers to maximise attendance. Care workers told us, "I'm proud of all the staff and how we've been supported since the last inspection", "The atmosphere has 100% improved", "We do get asked for ideas", and, "Everyone gets along. Staff are welcoming." This showed us the culture was much improved at the home, staff were happier and worked better as a team.

We saw representatives of the provider had attended the home regularly to support the peripatetic manager to make improvements since the last inspection. These included the quality assurance manager, senior quality assurance manager, regional director and human resources manager, all of whom had visited at least monthly. The peripatetic manager told us, "I did get a lot of support from them." We wanted reassurance the provider would maintain a sufficient level of oversight at the home to prevent a deterioration of standards in future so we asked the peripatetic manager, quality assurance manager and regional director what lessons had been learned since the last inspection. The peripatetic manager told us, "People are more aware of being more aware. There's more monitoring and action." The quality assurance manager said, "We're looking at making the quality audit tools more robust and to make managers more accountable." They also told us any concerns were now reported to the senior quality assurance manager and operations director so they could follow them up, commenting, "It's a more open and transparent system." The regional director praised the new home manager and told us, "We need to consolidate the changes and focus on continuous improvement", and, "I'm very confident that [the new home manager] will continue to take them forward." The regional director also confirmed they would continue to make weekly visits to the home for the six weeks following our inspection to support the new home manager as they settled in. This meant the provider had improved their oversight of the home and had plans in place to support the new home manager when they started in August 2016. However, at the time of our inspection there remained uncertainty as to the sustainability of the improvements made to the home due to the planned change in manager and issues with poor provider oversight in the past.

At the last inspection in November 2015 we found staff could not explain what the vision and values of the service were, so we asked them again at this inspection. One care worker said, "To make somebody's life comfortable and safe, and like they're cared for and happy", and a second care worker told us, "To look after them the best I can. To make sure their needs are met. I like to come away feeling I've done something good." The interactions we observed between the care workers and the people showed us care workers understood the vision and values of the service and put them into practice when they supported the people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always calculated properly. Regulation 12 (1) and (2) (a) Daily records showed people with pressure ulcers were not always supported according to their care plans. Regulation 12 (1) and (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment records did not include details of employees' full employment history. Regulation 19 (3) (a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were ongoing issues with the quality and accuracy of care documentation. Regulation 17 (1)

The enforcement action we took:

Warning notice