Croft Care Trust

The Croft Nursing Home (Barrow)

Inspection report

The Croft,
Hawcoat Lane,
Barrow In Furness
Cumbria LA14 4HE
Tel: 01229 8200 90
Website:www.croftcaretrust.co.uk

Date of inspection visit: 15 and 17 december 2015
Date of publication: 28/07/2016

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place over two days 15 and 17 December 2015. The inspection was unannounced. The Croft Nursing Home (Barrow), (The Croft) provides personal and nursing care for up to 46 people with a physical or learning disability some of whom have complex and challenging physical, medical and mental health needs.

The home is in its own grounds with easily accessible outdoor patio and garden areas. The front and rear gardens are well maintained and there are flowerbeds and patio areas for people to enjoy and use for recreation such as barbeques. All rooms are single occupancy and have ensuite facilities that are adapted to meet the individual needs of the people using them. The accommodation is on the ground and first floor of the main building and there is a passenger lift to assist

Summary of findings

people to access the first floor of the home. There are also four bungalows in the 'village' area of the home where people are able to live more independently. The home has a range of specialist equipment to promote mobility and independence for the people living there. At the time of our inspection the home was fully occupied.

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.

We found that there was a relaxed and inclusive atmosphere in the home and people had a good quality of life with high levels of engagement and activity. We saw staff spending time with and interacting with people in a very calm, positive and respectful manner and displaying empathy and compassion in these interactions. People using the service told it was a "good place to live". Surveys completed by people living in the home and relatives indicated people were very happy with the care, safety and support in the home. A relative told us, "We feel it's a very safe place" and professionals coming into contact with the service and the people living there commented that it was a "caring" home.

People living in the home were at the centre of the service and were treated very much as individuals. People and their relatives told us that staff understood their specific needs. People told us that staff "Are all my friends". We could see that staff had built up supportive relationships with people and were familiar with their life stories, goals and preferences.

We saw activities and leisure choices were personalised for each person and their plans were clear on how they wanted to live their lives and make their own choices. Staff were familiar with people's life stories and people's likes, dislikes, preferences and care needs and understood their different communication needs. We could see that staff knew how to respond and talk to each person to give them the support and care that they needed and wanted.

People's care and health plans were detailed, person centred and clearly described the individual care, treatment and support people needed and preferred.

Care plans had been written together with people to minimise risk but also to promote choice for the person and keep their independence. The care and health plans were regularly reviewed, the care evaluated and updated as required. The care plan format was pictorial to help people who used the service to understand them more easily. Individual plans of care included assessments and support for psychological, emotional and mental health needs and these were monitored closely so that appropriate support could be provided quickly if needed.

People were given time and the appropriate support they needed to take their medicines. People's care plans detailed any assistance or support that people might need to take their medicines safely and to best effect. Medicines were stored, administered, recorded and disposed of safely and in line with current National Institute for Health and Care Excellence (NICE) guidelines. Staff were trained in the safe administration of medicines and kept records that were up to date and accurate.

Staff levels were organised to make sure there were enough staff on hand to support people to follow their interests and go out or take part in chosen activities as they wished. Some people who used the service required one to one support and we saw this was provided. All the staff we spoke with told us they enjoyed their work and felt valued by the organisation. The staff we spoke with demonstrated a good understanding of the values and the philosophy of the service.

Staff received appropriate training to carry out their roles and they also had specific training to support people's different care and personal needs. This included training on diabetes, autism, epilepsy, swallowing difficulties, interactive communication and nutrition. Staff confirmed that their managers provided good support and supervision and encouraged their continual professional development. Some staff acted as 'champions.' They provided a resource to staff and people living there and gave additional support, advice and guidance. There were champions in privacy and dignity, health and safety, mental capacity and deprivation of liberty safeguards, medication and infection control.

A complaints procedure was displayed in standard and pictorial formats around the home. The registered provider had a pictorial complaints procedure which people told us they felt they were able to use. We looked at the procedures and records of complaints received and

Summary of findings

their investigation and resolution. All complaints received in the last 12 months had been resolved to the complainant's satisfaction and within the timescales stated in the home's procedures.

Staff had received training to recognise the signs of potential abuse and knew what action to take. They gave examples of what they needed to be aware of and what would give rise for concern. They said any concerns they raised were "always" listened to and looked into by the management team.

Staff had received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and they demonstrated a good understanding of these. Where people did not have the capacity to make decisions about their care, we saw that 'best interests' meetings were held. These included the people concerned, their relatives and health and social care professionals involved in their care. This helped to ensure that their individual rights were protected and that any decisions were made in their best interests.

The management team demonstrated strong values and a desire to learn about and implement best practice throughout the service. There was a strong organisational structure and all the people we spoke with were clear about their roles and responsibilities to the people living there. Surveys done showed that satisfaction with the care and support people received was high. One comment was "You offer an excellent service and [relative] always seems very happy in the Croft environment". Another comment was "[Relative] could not be in a better place, this is an outstanding care home".

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place.

Risks to people had been identified and risk assessments were centred on the needs of the individuals. People were supported to maintain their independence and lead full and meaningful lives.

There were always sufficient numbers of competent staff to ensure that people had their needs met promptly and safely. The service followed safe recruitment practices when employing new staff.

People's medicines were managed safely and appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines were in place.

Is the service effective?

Good

The service was effective.

There was a comprehensive training plan in place to provide continuous staff development and to update staff skills. Staff received all the training they needed to meet the needs of the people they cared for.

All staff had regular supervision and appraisal to support their practice and they told us they felt supported and valued by the management team.

The staff and managers understood the requirements of the Mental Capacity Act 2005 (MCA) 2005 and the Deprivation of Liberty Safeguards (DOLs), their responsibilities under this legislation and acted confidently to put this into practice. People's liberty was not being unnecessarily restricted and people living there were being fully supported to make choices in their lives.

Staff always had contacted healthcare professionals and specialist services when people had needed this to make sure that appropriate support, advice and treatment was accessed promptly. They had sought to provide high standards of care, treatment and support by identifying and implementing best practice.

People were involved in deciding on the menus in the home and were provided with range of homemade nutritious food and suited to their needs and preferences.

Is the service caring?

Good

The service was caring.

People told us that they felt well looked after and we saw that the staff treated people in a supportive and respectful way and that their independence, privacy and dignity were promoted.

Staff knew the people they were caring for and supporting, including their personal preferences, interests and personal likes and dislikes.

Summary of findings

People were supported to express their views. People had access to advocacy services. This helped make sure others who knew them well were able to speak up on their behalf.

Is the service responsive?

Good

The service was responsive.

On-going improvement and evaluation of care management was seen as essential. The service strived to achieve high standards in providing person centred care based on best practice.

The service was flexible and responsive to people's individual needs and preferences, finding creative ways to enable people to participate in planning their care and to live as full a life as possible.

People were able to lead fulfilling lives because they were fully engaged in hobbies and activities that they enjoyed and were meaningful to them. The arrangements for social activities and work were tailored to people's individual needs and preferences.

Concerns and complaints were always taken seriously, used to learn from and explored thoroughly and responded to in good time.

Is the service well-led?

Good

The service was well led.

The philosophy of care and values of the service were person-centred and staff understood and practiced these values and made sure people were at the heart of the service.

People living in the home, their relatives and the staff were extremely positive about the way the home was managed and commented upon the open and inclusive management of the service.

Systems were in place to thoroughly monitor the quality of the service people received and to get people's views on the way their home was run. There was a broad range of robust audit systems in place to measure the quality and effectiveness of the services and care provided.

The service worked in partnership with other organisations, local network meetings and online provider forums to make sure they were following current practice and providing a high quality service.

The service strived for the highest standards of individualised care through continuous consultation, research and reflective practice.

The Croft Nursing Home (Barrow)

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.

The inspection took place on 15 and 17 December and was unannounced. This meant the provider or staff did not know about our inspection visit. It was carried out by an adult social care inspector. The last inspection had been in July 2014 and there had been no concerns.

We spent time speaking with and observing people and staff within the home including the dining rooms and lounge areas. We spoke with nine people who lived in the home, two relatives, four registered nurses, six care staff and three ancillary staff, including laundry and domestic staff. We spoke with the registered manager/Chief Executive, the general manager, the clinical nursing lead, the care coordinator for residential care, the catering manager, the administrator, deputy chief executive/finance manager and the chairperson of the Board of Governors.

Some people living at the home were not able to communicate verbally and others could not easily give us their views and opinions about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us better understand the experiences of people who could not easily talk with us. This helped to assess the quality of interactions between people who use a service and the staff who support them.

We looked at care records and plans and at eight people's care plans and case tracked these. We looked at medication records and risk assessments in detail to see how their care was being planned with them and delivered. We looked at records relating to the ordering, management, use and storage of medicines. We looked at the staff rotas, recruitment, staff training and supervision records and records relating to the maintenance and the management of the premises and the equipment in use. We looked at records that related to how the home was being managed and how quality and effectiveness was being monitored.

We reviewed information we held about the service including statutory notifications sent by the registered manager about incidents and events that the service must send to us by law. We looked at our information on referrals made to the local authority safeguarding team, any concerns raised with us and any applications the manager had made under Deprivation of Liberty Safeguards (DoLS). We contacted the local authority and health and social care professionals who came into contact with the home to get their views. We used this information to decide which areas to focus on and to help plan the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give us key information about the service, what the service does well and any improvements they plan to make. The registered manager completed this in considerable detail.

Good

Is the service safe?

Our findings

All of the people who were able to speak to us who lived in the home told us it was "a good place" and "nice to live in" and they "always" felt safe. Relatives we spoke with told us that they were "In and out of the home all the time" and were able to visit as they wanted and were made to feel welcome. We were told "We are very happy with everything here. We feel it's a very safe place, they're (staff) all very pleasant and they seem to be on the ball so we have no worries". Surveys completed by people living in the home and relatives indicated people were happy with the safety and support in the home.

Systems were in place to make sure people living there were protected from abuse and avoidable harm. Staff had received training in safeguarding adults and training records confirmed this. The nursing and care staff we spoke with could tell us what may constitute abuse and how to report it. All the staff we spoke with were confident that any concerns they might raise would be followed up by the management team and that prompt action would be taken to make sure people were kept safe. There were whistle blowing procedures for staff to raise concerns. Staff we spoke with said these had been used and that staff, acting in good faith, had been well supported when they had reported an issue of poor practice.

When there had been any safeguarding incidents at the home the registered manager has referred incidents to the appropriate agencies promptly. A member of the senior management team reviewed all incidents and accidents and completed a review of these. The outcomes were recorded and improvements made if needed to promote people's safety.

We found that all the people who lived at The Croft had their needs and risks fully assessed and regularly reviewed. There was information and guidance to staff on how to manage and reduce any identified risks to people. This helped to make sure that people received the support they needed to live the lives they wanted and to stay safe. People's care plans included risk assessments for swallowing problems, behaviours, skin and pressure area care, falls, moving and handling, mobility and nutrition.

Emphasis was placed on ensuring the environment in the home was safe and appropriate. The service received government medication alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and health and safety updates from the Health and Safety Executive and The Institution of Occupational Safety and Health (IOSH). The service has two staff qualified to the National Examination Board in Occupational Safety and Health (NEBOSH) standard. This training covered the main legal requirements for health and safety in the UK and the identification and control of workplace hazards. This helped the staff involved to manage risks more effectively and work with other staff members to make sure they were also aware of any risks.

There were clear procedures and guidelines about managing infection control. An infection control lead nurse took responsibility for ensuring systems were in place to manage and monitor the prevention and control of infection. We found all areas including the laundry, kitchens, bathrooms, lounges and bedrooms were clean, pleasant and odour-free.

Policies and procedures were in place and a comprehensive business continuity plan to guide and inform staff on what to do in the event of foreseeable emergencies. There were emergency contact numbers easily available to the nurse designated in charge of the premises to use in managing any foreseeable situation. These practices indicated to us that the provider could show how they would respond to emergencies and had a proactive approach to finding ways to keep people safe from harm.

Effective systems were in place to make sure new staff were only employed if they were suitable and safe to work in a care environment. Recruitment records of the most recently recruited staff had all the checks and information required by law had been obtained before the staff were offered employment in the home. Checks had been made to ensure that the nurses working in the home were registered with their professional body and fit to practice and were checked at least annually.

The probation period for new staff had been increased to six months to allow the management, other staff and people living there time to fully assess performance and abilities and to give feedback. This indicated that a broad range of information was looked at and the views of people living there were valued and respected. For example, key

Good

Is the service safe?

workers were involved in getting people's feedback on new employees as people were familiar with their keyworkers and trusted them. Staff told us that the registered manager asked people how new staff were doing.

Staff told us there were "always" enough staff on duty to allow them to spend the time with people they needed and "do my job properly". More staff had been recruited to make sure there were always enough staff on duty when people needed them. Rotas indicated that staffing levels and skills were continuously monitored and organised to provide additional staff for one to one activities, at evenings and at weekends when people wanted to follow their own interests or participate in activities and hobbies they enjoyed.

To provide higher expertise to support people with a learning disability four Learning Disability (L/D) registered nurses had been employed and also mental health trained nurses. The clinical nurse manager told us that a range of clinical and nursing skills were needed to meet the diverse needs of the people living there and help in "picking up on problems and anxieties quickly". Care staff told us these staff brought expertise to help increase their knowledge and awareness of particular conditions or behaviours.

A new role of 'breakfast assistant' had been introduced to make sure people received their breakfast when they were ready for it and help them if necessary to eat their meal. Nursing staff told this allowed them time to concentrate on medicines administration during the busy morning period without interruption. Care staff told us that it helped them as they could concentrate more on helping people get up, washed, dressed and get ready for their day.

People's medicines were being safely stored and managed and this was done in line with current National Institute for Health and Care Excellence (NICE) guidelines and included medicines liable to misuse, called controlled drugs. The service had a clear medication policy in place that staff understood and followed. We spoke with a member of nursing staff who was responsible for management, stock checks and audits they talked us through the processes in place for ordering, reconciling and disposing of medicines. The systems in use helped to prevent any accumulation of medication and reduced the risk of errors occurring. To keep up to date with best practice with medication staff attended monthly pharmacy meetings and participated in an online provider forum on this. Clinical room and refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges. This helped to make sure that the medicines were in good condition for use.

Good

Is the service effective?

Our findings

People received effective care from nursing and care staff that had the knowledge and skills they needed to carry out their roles and responsibilities. People living there, relatives and health care professionals coming into contact with the service were able to confirm this to us. One person living in the residential part of the home said "I am really happy with everything, I like my room, I like living here, I like the food very much". Others told us "I love my meals, especially the puddings, they [staff] know my favourites" and another said "They [key worker] are my friend and get things done". A relative told us, "They (staff) are on the ball here, if anything happens with [relative] health it is followed up right away and we are kept up to date".

Health and social care professionals we spoke with told us that the staff made appropriate referrals and contacted them promptly if there were any concerns or support required. We were told that the staff acted on specialist advice and made changes to people's care and support, following consultation, when it had been needed. They had worked closely with staff to support complex new admissions so the process was "smooth" and "all was ready". The healthcare professionals who responded to our requests for their views about the service agreed that this was a person centred service that engaged well with other services to get people the support they required.

People's care plans were clear about their preferred communication approaches and details of any aids and equipment they required to aid communication. The nursing and care staff knew the people living there well and knew how they liked to be supported with their hobbies and what activities they enjoyed and how each person liked to receive their personal care. There were clear individual management plans in place on how staff should offer support to help people with different behaviours and in different situations. The plans included people's own descriptions of what they needed to help them and how they saw their own behaviours. Staff talked through with us what they would do if people became restless or agitated or if they were unhappy and needed comfort.

Staff training records and the training programmes were in place that used a variety of delivery methods depending on the topic. This included face to face and classroom based training, individual mentoring to assess competence and skills, e- learning to update knowledge and distance learning for more individualised courses of study. The management team evaluated the delivery methods to establish the most effective and as a result the care certificate training was part classroom based and part practical to allow staff to apply the theory into their practice. Staff completed relevant work books, answered set questions and took tests that required a pass mark to help in the evaluation of their learning. New staff were paired with senior staff to work with for a minimum of two weeks as part of their induction and during vocational training until they had been formally assessed as competent to work unsupervised.

The training programme incorporated the Care Certificate for care staff. Three new staff were currently doing this and they each had weekly face to face meetings with senior staff to work through the course. The Care Certificate is a recognised qualification from the training organisation Skills for Care. It is the new minimum standard that should be covered as part of induction training of new care workers. Other care staff had already completed qualifications in health and social care such as the National Vocational Qualification in Levels 2 and 3. The nursing and care staff said that the registered manager was very supportive of staff development and encouraged it.

Staff had done essential mandatory training in moving and handling, health and safety, infection prevention and control, safeguarding adults, medicines management, food hygiene, first aid, equality and diversity, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff had undertaken training to support people with specific conditions, such as diabetes, autism and epilepsy. A carer told us, "If we need more training to be able to understand a condition or be able to help someone, we get it. It is never an issue. I had diabetes training which helped me understand it more but it also meant I could help [person] understand too and do some things for themselves". Another staff member told us "I am always learning and finding out more about what I need to do to really help people, it makes my job so much better and I see the importance of little things".

Additional training had been introduced on supporting people to live with dementia. It was recognised that as people living there grew older they would need greater support and deeper understanding from staff. The service recognised that staff needed to continuously enhance their skills as individuals living there grew older and as their

physical as well as mental health altered. Discreet signage had been introduced around the premises to help people who were living with the early stages of dementia move about the home and orientate themselves more easily.

Some nursing and care staff had received additional training to be able to become 'link nurses' or 'champions' in particular areas of care. Their role was to provide a resource to staff and people living there and give additional support, advice and guidance. There were link nurses in privacy and dignity, health and safety, mental capacity and DoLs, medication and infection control. The 'link nurse champion' for infection control had identified that improvements were needed to make sure that all hand washing facilities within the home promoted best practice in infection prevention. The equipment identified had been provided so that staff had better access to safer hand washing.

The home had its own staff trained to deliver moving and handling and personal care training and act as a resource for staff. One of the learning disability nurses was the link nurse for advocacy and as such maintained close links with people's advocates and Independent Mental Capacity Advocates (IMCA). The registered manager and nursing staff told us that this system continued to be developed as staff were identified who wanted to take up these enhanced roles.

Records showed all staff had regular supervision. Staff told us they felt they were being helped with their own development and understanding of people's needs through having regular supervisions. The nursing team carried out clinical supervisions with the care staff they worked with. The registered manager told us this was done to ensure that the registered nurses carried out supervisions and clinical observations with care staff they worked with and to enable them to 'lead by example'.

Continuous professional development for nursing staff was being promoted by participation in the Cumbria Learning and Improvement Collaborative (CLIC). This training was aimed at registered nurses and was a collaborative educational approach to learning across different health care settings in Cumbria. The project had been developed in nursing homes in collaboration with the University of Cumbria and with specialist nurses to promote communication across the nursing teams by improving networks and developing further learning opportunities. Staff had used CLIC workshops to provide clinical skills training in areas such as pain management, diabetic management, communication and tissue viability. This helped nursing staff to stay up to date and widen their knowledge base.

The service took nursing students on training placements and had been audited as an effective learning environment for student nurses by the Faculty of Health and Science within the University of Cumbria. Nursing staff supporting students had received training to mentor and support students coming to the home. This was to make sure that student nurses were well supported during their placement.

The approach being taken to staff training, support and professional development showed that the service was continuously looking for ways to help their staff to improve their skill and progress professionally. Time and resources were made available for mentoring and supervision to help make sure that what staff had learnt was put into practice to improve people's lives. Staff took pride in their work, their job satisfaction was high and their continuous learning and development was addressed comprehensively by the management team, leading to positive outcomes for people using the service.

The Mental Capacity Act 2005 (MCA) gives a legal framework for making decisions on behalf of people who may lack the mental capacity to do this for themselves. People's care records indicated that consent to care and treatment was being sought in line with legislation and guidance. People were being supported when they had been unable to make an important decision, such as about medical treatment. Management and staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and how to put this into practice. The service had clear procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests.

Information was available for people living within the home on the MCA, what is was and what it meant for them. This was written in 'easy read' and large print formats so that it was easier for people to understand and how they could be helped to plan ahead for their future for example with powers of attorney. Powers of Attorney (PoA) state who has legal authority to make decisions on a person's behalf

when they cannot do so themselves. We saw in people's care plans that where a person had someone who held power of attorney this was clearly stated and if this power was for finances and/or care and welfare.

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 procedures are called the Deprivation of Liberty Safeguards (DoLS). The staff outlined the purpose of this legislation to us, how it was used in practice and its potential impact on the people they were caring for. Applications had been made to relevant supervisory authorities for deprivation of liberty authorisations. These had been requested when necessary to restrict people for their own safety and were as least restrictive as possible. For example where their daily living might constrain them in some way, such as lap belts to prevent people slipping from wheelchairs. Advocates had been involved to give support and also relatives, health professionals and social services to make sure decisions were made in that person's best interest.

Policies were in place regarding giving people medicines without the person's knowledge or 'covertly' if needed for their health. The planning for this was done on an individual basis around a person's condition and behaviours. The management plans showed that this had only been done following a detailed assessment to be sure that the person was not able to understand the consequences of not taking their prescribed medicines. This involved a person's GP and included consideration of alternative administration methods. These decisions were made involving advice and assessment from other healthcare specialists, such as the pharmacy, consultant psychiatrist and community mental health team and with input from relatives and key workers.

Care plans contained information on specific dietary needs, preferences and intolerances. Everyone had an individual nutritional assessment and a weekly or monthly check on weight. If people found it difficult to eat or swallow then advice had been sought from the dietician or the speech and language therapist (SALT).

Five people living in the home were taking pureed diets due to swallowing difficulties. We asked the catering manager and staff how they supported these particular dietary needs and made the pureed foods appetising for people. The catering manager had attended training on food preparation for people with swallowing difficulties and had put what he learnt into practice. Pureed and thickened foods were individually prepared by piping the food onto people's plates as separate foods. This kept the food tastes separate as they would be if the food had not been pureed and allowed for attractive presentation.

The catering manager had done an advanced nutritional consultancy course and this training had helped them be in improving menu planning and providing a more varied menu for those on 'special' diets such as diabetic and gluten free. The menus always had two vegetarian options, nutritional and allergen information and pictorial formats of the meals to help people choose.

The staff and catering manager had liaised with the hospital dietician when reviewing the menu options with the people living there. Menus and food choices were discussed at meetings and new menu items were 'taste tested' by people living there. The catering staff told us that the support they received from management when planning meals had been "amazing". They said that any training or equipment for food preparation they needed to keep developing the catering service they got "without question". The local authority had awarded the highest five stars for hygiene and food preparation at its last environmental health inspection.

We saw that the environment was subject to continuous assessment and there was a programme of work to amend, adapt and update the premises. For example altering bathrooms into wet rooms because people had said they preferred this and found it easier to use. Overhead hoists had been fitted in all of the bedrooms in the nursing section of the home to improve the assistance that could be given to help people mobilise. A new clinical room was being created to provide more room and storage and this had air conditioning to ensure that the room temperature could always be controlled. The registered manager told us "Our philosophy is to alter the environment to suit the needs of the person and what they need to get on with life".

Good

Is the service caring?

Our findings

We observed staff as they spent time with people and saw that people were relaxed with staff. We saw that staff showed kindness, sensitivity and compassion in their interactions. One person living in the home told us that the staff "Are all my friends". We saw they interacted in a friendly and positive way with people and were attentive, listening and responding to people, laughing and joking with each other and giving comfort and reassurance if needed. From speaking to staff and observing interactions we could see that staff had built up supportive relationships with people and were familiar with their life stories, families and interests. A relative told us "The care here is very good, very personal, they really do care here". We were also told by a relative "It is very homely".

Surveys completed by relatives also indicated a very high level of satisfaction with the care their family members had received. One comment was, "As a family we are more than happy with the great care and attention (relative) receives and we know they are being very well cared for and are happy". A relative told us, "They (staff) have done all they can do to keep (relative) independent, they have their room just how they want it." We were also told that the home "Feels like a real community, it's (relatives) home, there is always something going on and (relative) does all the things they enjoy". We saw the survey responses sent out to healthcare professionals to get their views. These also indicated that the service was caring. One comment said, "Excellent care" and another "Very caring". All the staff we spoke with told us they enjoyed their work and that it was a "happy" place to live and work in. One told us "It's a lovely place to work; you can really make a difference here". Another person told us "It's a good place to live, I would be very happy for anyone of mine to live here. Everyone here loves the work they do and get a lot back from the people they look after".

In the residential part of the home there were four bungalows where people lived with support from the care staff. We asked some of the people living in there what it was like there. One told us "I love my room, I like having my own room and space". They told us they did some of their own cooking and also baking with help from the activities coordinator. There was another separate bungalow where one person lived more independently with only supervision from staff. We found that where possible people were being helped to stay as independent as they could be. We saw that risk assessments were in place to encourage people's independence in ways that mattered to them. This included everyday activities such as making their own drinks, baking and preparing food as well as their own plans for getting to and attending their work or leisure activities.

Care plans were clear about how people wanted to be helped and what was a good or a bad day for them. Staff asked people what they wanted to do during the day and helped or found someone who could help to make any arrangements such as activities or visits. Staff explained how they gave people choices each day even if they only seemed small, such as what they wanted to wear or eat or where they wanted to spend their time while in the home. People living there had a good quality of life full of engagement and activity inside and outside the home. People could attend the church of their choice if they wanted to and be supported to do so. People had also supported to attend family weddings, religious celebrations and attend funerals. We saw how one person had been given support and guidance when they had to come to terms with a personal loss involving appropriate professionals in devising support plans. This helped to provide consistent support to help the person express how they were feeling.

Where possible the staff supported people when they went into hospital. This was to help people when they went into a new environment and aid their admission. Everyone had a hospital passport so staff in the hospital had all relevant information about that person but it was understood that admission could be distressing for people. Therefore it was seen as important to give support.

The nursing and care staff understood about the importance of person-centred care. The clinical nursing lead told us, "All the staff here bring different things to their role and different perspectives and knowledge, all are very important to create the holistic and supportive approach we want. Everyone we spoke with felt they were part of the care team; this included the maintenance and kitchen staff and the housekeeping staff. All were involved with people on a daily basis, knew them well and received training to help understand their needs and to safeguard them.

We saw that people who could not easily express their needs received the right level of support, for example, in moving around the home and in managing their food and

Good

Is the service caring?

drink. We saw situations where people did become distressed and saw that staff intervened and used appropriate techniques, including listening and distraction skills to help people deal with this. It was evident that staff had knowledge of the person's condition and had the right skills to sensitively manage such situations when they arose.

People's privacy and dignity were maintained and saw that doors were closed when any personal care was being given. A member of staff was a privacy and dignity link nurse and had addition training on this. They gave additional support and guidance to staff to promote best practice. Throughout the home information was provided for people in easy read formats that could aid their access to the information and understanding. This included emergency information, people's care plans, their health action plan, information on medication people took, the in house activities programme, CQC reports, mental capacity information and their newsletter. Everyone living there had an assigned key worker and a link nurse if receiving nursing care that supported people to make their wishes known

We saw in care planning that people were able to say what their preferred place for end of life care was and what was important to them. People had received independent advocacy support when they had needed to help in making more complex decisions such as around care or treatments. The service had links with the local hospice and the community palliative care team. Some staff had received training in the 'Six Steps to Success'' (Six Steps) end of life care programme. The 'Six Steps' programme is a training programme developed to enable care homes to be implement the organisational changes required to deliver the best end of life care.

Family members we spoke with told us that they were made "very welcome" when they came to the home and that they could visit at any time of that suited. A relative we spoke with told us that they appreciated the open policy on visiting and said staff always gave them "a cup of tea and biscuits". The staff and management team told us they had an "open culture", with the board of governors being involved on a regular basis.

We spoke with the Chairperson of the Board of Trustees who visited weekly and was well known to the people living there and staff. They told us that they did regular quality checks and discussed projects with the management team and staff involved. They told us that most importantly they wanted to speak to and spend time with the people living there and relatives. They told us they were an outside presence able to see how the day went and to make sure people were "Enjoying their time and getting the most out of life". They told us that everyone was so used to them being about that they had become "part of the furniture" and people who lived in the home felt comfortable with them as a person visiting in their home.

Good

Is the service responsive?

Our findings

One person living at the service told us it was important to them to be able "Get out and to meet new people and make new friends". They told us, "I like to go shopping for my own things" and "I like going to my work". We saw that there was a clear plan in place to allow them to do these important things and when they needed help to achieve these things and when they did not. We saw that one to one support was available seven days a week to allow people to go out and take part in chosen activities like swimming, line dancing and daily tasks like choosing where they went to do their shopping and when.

We found that after consultation with the people living in the home at meetings and group discussions the onsite craft workshops had closed. This change had been done to promote greater access to the wider community where people could go out and mix more broadly locally and to attend outside work, craft and training opportunities. This helped to promote greater social inclusion and encourage people to form friendships outside the home with a wider group of people, if that was what they wanted. People told us "It's good being out, I like my friend at home and I like my friends when I am dancing" and " I go out with[support worker] for coffee". We saw that some people who could not easily tell us about their day were also out into the town with support staff for shopping and coffee. They were at ease with the people going out with them and their pleasure in the activity was evident from their laughter and anticipation.

For more individualised activities and choice an activity coordinator role had been recruited to work with people living in the home. There was a planned programme of activities in addition to people's individual preferences. The weeks activities were discussed weekly and also any arrangements for meals out and trips and some to plan holidays when these were being considered. Over the Christmas period there were parties and discos and meals out, some involving families, lunches and musical and pantomime visits. We found that all year people were supported to regularly attend functions and shows within the local communities, such as concerts, musicals and dance shows in the evenings. It was up to the person to decide whether or not they joined in on these occasions.

Twice a year the home held 'open days 'when families, friends and the local community helped to support Croft Care Trust. The grounds and garden was set up stalls and activities. We were told by a relative that staff and people living there worked hard all year towards presenting these events. People who lived there confirmed this was an event they enjoyed organising and taking part in.

People had their own computers, games consoles and internet use and also some had chosen to have 'Sky' installed for their televisions. There was a 'Club House' on site if people wanted to do crafts or meet socially and also a large screen television for films and major sporting events. We were shown some art work that had been done by people living in the home and this had been put on display, with the person's agreement, in the home.

A joint decision that had been made by the people living there and the registered manager that the onsite 'tuck shop 'should close. The 'tuck shop' meant that people had not had to leave the home for general items of shopping and people now wished to do this. This was so people could choose where and when they wanted to do their own personal shopping rather than accept the limited items in the tuck shop. The staff and management team had worked hard to consult and discuss this at meetings and to get regular verbal feedback from people and families. This was done to make sure that people living at the home were part of planning these changes. It also allowed people to consider how to make the local community more accessible to them in other aspects of everyday life.

There was transport available for people to use and one new bus was entirely wheelchair accessible so people living in the nursing part of the home could easily use it. The residential part of the home had different vehicles suited for use by people who were more mobile. The management team had worked with people living there to decide on the type of vehicles they wanted for their social life and trips out. There was no signage on any vehicles used indicating the name of the home. The management team was very clear that they did not give free advertising on their own cars and the people who lived there said they did not want to either as they went out in their cars.

Staff looked for ways to involve people in the way the home was run and asking them what they thought. The cooks and catering manager did 'taste tests' with the people in the home. When new menus were being discussed residents tasted samples of the proposed menu items to get their views. People had marked the samples out of 10

and the best were incorporated in the revised menus. The catering manager said it had been very useful and also fun and meant the people living there made the choices not the cooks or management.

Everyone who lived at the home had highly personalised and individual plans of care in place and these showed how risks had been individually assessed for example when using equipment such as wheelchairs. We saw in care plans that physiotherapists, occupational therapists and an Autism specialist had been involved in assessing people for the use of specific equipment and furnishings and advising on safe working practices. For example getting specialist seating to suit a person's particular physical condition and developing individual physiotherapy regimes with community physiotherapists for staff to carry out with people.

Before people came to live at The Croft the senior care and nursing staff met people and families and carried out a comprehensive assessment of their care needs and conditions to be sure they could meet their needs before offering a place to them. During the initial assessment process, information was gathered from a variety of sources so staff could get to know as much as possible about the person and their life and background. This helped to make sure there could be a smooth transition for the person into the home. Staff had asked people and their family and friends for details of their life so they could build up 'picture' of the person and their own life journey to date.

Staff had undertaken work with one person and their family to make sure they had been able to visit and stay before they made their move so it could be managed in a phased way for the person. It allowed key workers to make sure they had all the information required to help them support the person in the move and to be well prepared to provide all the care they needed. Additional training had been provided so all staff had the right skills to give consistent support to meet the person's complex physical and healthcare needs. There had been close liaison with the community learning disabilities team and the speech and language therapist on behaviour management and communication approaches for one person who needed specific support in these areas.

Specialist nursing staff had also been involved with people and advised and visited, for example, to provide specialist diabetes support for complex diabetic needs. There were clear instructions for blood monitoring, dietary intake and medication and specific training had been provided for staff to make sure they could respond correctly to the management of the condition. One person was being very involved in the management of their condition and all their care information was in easy read formats that they found easier to understand. This had been well planned and the person had been empowered to have more control over the management of their condition.

This care plans we examined were thorough and comprehensive in their scope and reflected people's needs and their expressed choices and preferences. People's changing care needs were being identified at frequent reviews and daily updates. People's care plans detailed any assistance or support that people might need to take their medicines safely and to best effect. This included instructions on the safe positioning of people and any precautions and checks required. Everyone who lived in the home had access to their own care and health records and health care plans and it was made clear in their care plans that this document was their property and confidential.

The management and staff had good professional relationships and communicated well with other agencies and external professionals. This included the involvement of the behaviour intervention, community mental health, autism specialists and learning disabilities specialist teams. There were up to date records in care plans of these visits and those to and also from doctors, consultants, district nurses, dentists, chiropodists and the outcomes for people. People had annual health checks with the own doctors, also eye tests and regular dental check-ups. At one person's health check it had been noted that there was a weight gain that could affect their health. The staff had worked with the person and the practice nurse to devise a health action plan to help them reduce weight gradually. A copy of this individual plan was in the person's own care file and had been discussed with them.

Specific methods were being used by staff to talk and communicate with people and these suited the needs of each person. Sometimes pictorial formats were used that people could point to and make choices. Staff tailored their approach to suit each person based upon individual assessment and their knowledge of them and how to ask. We saw that actively staff listened to what people had to say and they gave them time to express themselves and did not try to hurry them.

Good

Is the service responsive?

Staff had handover meetings between shifts to share information about people living there and to help make sure any changes that affected people's wellbeing or health were passed on. These approaches helped maintain consistency because staff had the most up to date information about people.

The service had a complaints procedure that was displayed in standard and pictorial formats in the home. We looked at the records of complaints that had been received and of the investigation and resolution of the six complaints received in the last 12 months. The complaint records were well organised and had been addressed promptly as required by the home's own procedures. The manager tracked all concerns, incidents and complaints to assess if there were any common themes so that improvements could be made to systems or address any weakness in practice. In the satisfaction survey one relative said "Whenever I have raised an issue the service has worked with us to address it".

Good

Is the service well-led?

Our findings

People living at The Croft were being actively involved in discussing and developing their service. People told us about regular monthly meetings, chaired by the activities staff, with management and catering staff being involved when requested by the people living there. Smaller, more informal meetings took place as needed for general discussions about trips or meals out and group activities.

Feedback collected from relatives was overwhelmingly positive and this had been recorded by the service. Surveys done recently showed that satisfaction with the care and support people received was high. The collated survey information showed that 100% of the responding family and friends surveys said they felt their relative's needs were being met. One comment was "You offer an excellent service and [relative] always seems very happy in the Croft environment". Another comment was "[Relative] could not be in a better place, this is an outstanding care home"

The home had a statement of purpose that was made easily available in the home setting out the service's aims and philosophy. This was to provide a safe and caring environment for residents as long as it is needed, to seek to maximise the development of each individual within their own potential and to provide individual care of the highest possible standard based on current knowledge and research and that promotes privacy, dignity and respect".

People living there, their relatives and staff said that the managers were approachable and supportive and they could speak to them whenever they wanted to "about anything". Feedback was being sought from people verbally on a daily basis and more formally by using easy read surveys and relatives and professionals were also asked to provide regular feedback. There were also 'feedback stations' within the home so people could make a comment or say what they thought at any time. These were used by the people living there and also for anyone visiting the service to give their views.

The registered manager told us that effective communication was "vital" to having an effective team and a happy home. There were regular staff meetings with monthly nurse's meetings and a weekly manager's meeting to monitor service provision and plan ahead to help the service run smoothly for the people living there. Staff told us that the registered manager and the department managers did not "just stay in their office" but were out and about in the home. We saw that they all spent time chatting with people and at reception opening the front the door to let people in and out and taking the opportunity to chat to relatives and other visitors.

The senior managers had quarterly meetings with the Board of Governors and reported back on quality assurance and progress against the business plan and agreed annual objectives. Records showed that the service's accounts were filed with Companies House and the charities commission for audit and scrutiny. The management team also produced a monthly cost analysis to ensure their work was managed within agreed budgets which were calculated annually by the management team. There was an agreed project fund so all service development work and improvements were fully resourced. For example the capital expenditure to pilot and implement digital care planning and medication systems, for new vehicles to suit people's needs and to upgrade the sensory room.

The annual business plan summarised Croft Care Trust's organisation's aims and objectives. It contained detailed planning strategies that we could see these were being implemented. For example with the environmental work that was taking place to make the home environment better suited to meeting people's individual needs and medicines storage. The clear organisational structures and the proactive approach to organisation planning helped the management team to focus on continuous improvement. We saw this reflected in the efforts made to constantly seek opinions and gather ideas on how to make the service better for the people living there.

The management team had conducted their own audits against the key questions we ask at inspections and had looked at ways to improve in line with these lines of enquiry. The managers also confirmed to us that they read the inspection reports from other care services as an audit tool to help them identify where they could improve the service. Staff we spoke with were very positive about the way changes had been made to continue to improve the service and move it on. One told us "They [management team] have been great and made a lot of very useful changes, not just for the sake of change or to look good, it must benefit people like with the staffing and activities. Now I get to spend much more time with my key residents".

Good

Is the service well-led?

The manager's looked for ways to keep up to date with what was happening locally and nationally in the care sector and attended monthly pharmacy meetings, local network meetings and online provider forums in order to do this. We could see managers had researched on the internet what was available through different kinds of training approaches and providers. This was to try to make sure they could provide the right training for their staff based the conditions and needs of people living in the home.

The registered manager told us in the PIR that "Quality assurance was integral to monitoring the way service was run". We looked at their latest quality assurance questionnaire from people living there, health care professionals and family members. The comments made and the overall results showed that the staff and management were meeting their expectations of a person centred care service. The management team kept survey formats under review to make sure they were 'user friendly' and encouraged people to engage with the process. We saw that the management team had improved their quality assurance questionnaires in use to better reflect the characteristics of the Key Lines of Enquiry (KLOE) used by CQC. This was to help make sure they were asking the right questions to reflect the perspective of the people living there or visiting the service.

We found quality monitoring systems and processes to be thorough and consistently good. There were well established systems for gathering, recording and evaluating accurate information about the quality and safety of care and the treatment and support the service. The management and senior nursing and care staff did monthly audits of accidents and incidents in order to identify any trends, for example environmental hazards. Medicines audits were done monthly and stock checks weekly and the temperature and environment for medicines storage was closely monitored. Monitoring had identified the need for better clinical facilities for medicines and hence a new medicines room with air conditioning was in the process of completion.

Health and safety audits and internal checks were well established such as, health and safety, premises, fire safety, water temperature checks and service maintenance checks, nutrition and weights, care planning, complaints and safeguarding. Health and safety reviews were done quarterly and followed up with action. For example, following their regular review soft door guards had been fitted throughout the home. This was to reduce the risk of any injury to people should a fire door close suddenly in an emergency situation.

Catering records showed that food safety and temperature audits were being done. Monthly cleaning audits and checks on cleaning schedules throughout the home were being completed and checking bathrooms, communal areas and bedrooms. One such audit had identified the need for more frequent high dusting and cleaning of taps. This had been put in place and was being monitored. There were laundry audits to monitor laundry practices and environment. Following an audit the laundry had been redecorated and reorganised to improve the flow of clean and dirty laundry. These audit programmes had enabled the registered manager to monitor the quality of the service and make prompt improvements or changes to systems or practices where necessary. We saw that where change was needed a structured plan was developed so that progress could be monitored and evaluated by the management team.

Staff in all departments told us that the registered manager and the management team were very visible in the home, led by example and encouraged people and staff to make suggestions about how the service could be improved for those living there. The nursing and care told us that the management team allowed them to develop their ideas and to take projects forward that could benefit the people living there.

Staff were confident about raising any issues that affected people living in the home. They said they knew from their previous experiences that they would be listened to and addressed in a "professional way" and that their actions were "valued" by management. Staff members said when they had raised concerns about poor practices observed inside and outside the home that had affected the people these had all been reported to the appropriate agencies and investigated by the home. Due to these being taken seriously, staff we spoke with said they knew they would be listened to. Staff said they were encouraged to be open about any errors they made and knew these would be handled in a "professional" way and used to learn from not "Just to try and blame someone". Nursing staff told us that

Good

Is the service well-led?

as a team they were encouraged by the managers to reflect on their practice, what they might need to change and to consider different options. This helped to make sure that all concerns and events were reported and investigated.

Staff said the managers were always available day and night and that they could rely upon them if they called out of hours. They said that the managers worked with them all the time that it was an "open culture" and they knew "everything that was going on" and they felt it was up to "all of us to improve things". We were told by staff that "Management here is very good, there is a total commitment to the people living here, we are like a family".

Staff were clear about their roles and responsibilities and confirmed to us that they received regular constructive feedback about their performance. We looked at the organisational structure within the home that showed a clear line of support and accountability within the service. Staff we asked told us that responsibilities and roles were reinforced by the managers in their regular staff and departmental meetings.

The management team had detailed policies and procedures in place covering all relevant aspects of the service. These were reviewed at least once a year and following changes in legislation or good practice. When we began our inspection we asked for the policies and procedures in use and a wide range of records and documents needed to assess their performance. These were all provided promptly for our use. We found all the records and paperwork we looked at to be clear, legible and organised in a logical and structured way that made them easy to use and find current information.

Staff were aware of these aims and everyone we spoke with felt they worked together to meet them. People's experience both verbally to us and via surveys was that staff were meeting these aims. The service also has a track record of providing a high standard of care and of consistent improvement. We could see, and relatives told us, that staff 'went the extra mile' and invested their own time in helping people live full lives, make their own choices, and be part of the local community. We found staff and management to be passionate about and dedicated to their work.