Croft House Care Home Limited

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

Summary of findings

Overall summary

The inspection took place on 7June 2016 and was unannounced.

Croft House provides accommodation and personal care for a maximum of 29 older people and people living with dementia. It is an adapted property and accommodation is provided in single rooms some of which have en-suite facilities. The building has access for people with disabilities and there is a passenger lift to the first floor. At the time of the inspection there were 27 people living in the home.

The last inspection was in January 2014 and at that time the provider was compliant with all the regulations inspected.

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

People described the staff as caring, kind and compassionate and throughout the day we observed staff were attentive, kind and patient. People were treated with respect and staff knew about people's individual likes and dislikes. We saw staff took time to offer people choices and encourage them to make decisions about their day to day lives.

People living in the home told us they felt safe and people's relatives told us they had no concerns about people's safety. The staff we spoke with told us they would recommend the service to family and/or friends and they knew how to recognise and report abuse. However, we found that although safeguarding concerns were dealt with they not always reported to the relevant agencies and the actions taken were not always recorded.

We found that people's medicines were not always managed properly and safely. In addition, when people were having their medicines covertly, disguised in food or drink, the correct processes were not always followed to show when and by whom it had been decided this was in the person's best interests.

There were enough staff and people told us staff were available when they needed assistance. New staff did not start work until all the necessary checks had been done. This helped to reduce the risk of people being cared for by staff unsuitable to work in a care setting. Staff had induction training when they started work and we saw there had been training on topics related the needs of people living in the home. However, there was no system in place to show what training staff were required to complete or how often they should attend refreshers to make sure they were kept up to date with safe working practices.

The building was clean and well maintained. Improvements to the environment took account of the needs of people living in the home, for example an enclosed courtyard garden had been created to enable people

to go outside easily and safely. We found risks to people's safety and welfare were identified and dealt with in practice. However, the actions taken were not always reflected in people's care records.

People enjoyed a variety of food and drink and their individual needs and preferences were catered for. People who needed help to eat and drink were supported by staff in a sensitive and discreet way. However, we found there was a risk of people's nutritional needs being overlooked because of shortfalls in the record keeping.

People had access to the full range of NHS services to make sure their health care needs were met.

We found people's needs were assessed. People had individual care plans, however, although the approach to the delivery of care was person centred this was not reflected in the care plans which were lacking in detail. This created a risk people could receive care which was inconsistent or not in accordance with their wishes.

People and their relatives told us they were involved in care planning but this was not reflected in the care records.

People were offered the opportunity to take part in variety of activities which reflected their interests both inside and outside the home. An activities organiser was employed specifically for the purpose of spending time with people during the morning when other staff were busy. During the morning we saw some people benefitted from this. Throughout the day we saw staff engaged with people while supporting them to meet their needs.

People were given information about the complaints procedure. The provider operated an 'open door' policy and our review of the records and conversations with people confirmed concerns raised dealt with as they arose.

All the feedback we received about the management of the home was positive. People living in the home, relatives and staff were united in their praise of the leadership and management.

However, we found improvements were needed to the way the quality and safety of the service was monitored and to record keeping. This was to make sure people continued to experience consistently safe and effective care.

We found five breaches of regulations in relation to safeguarding, staff training, record keeping and monitoring and assessing the quality and safety of the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe and staff knew how to recognise and report any concerns about people's safety and welfare. Although concerns about safeguarding were dealt with they were not always recorded or reported to the relevant agencies.'

People's medicines were not always managed safely.

There were enough staff to meet people's needs and keep them safe and new staff did not start work until all the required checks had been done.

The home was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always protected because the provider was not applying the principles of the Mental Capacity Act to the use of covert medication.

People enjoyed a variety of food and drink which took account of their preferences and where necessary were supported appropriately by staff to eat and drink.

Although staff received some training there was no clear process in place to make sure they were kept up to date with training on safe working practices.

People had access to the full range of NHS services to make sure their health care needs were met.

The needs of people living in the home were taken into account when changes were made to the environment and/or the furnishings and décor.

Is the service caring?

Good

The service was caring.

All the feedback from people about the standard of care and the staff approach was positive. People described the staff as caring, kind and compassionate.

People were treated with respect and dignity. Staff knew people well and offered support in a kind and sensitive way.

Staff took time to explain things to people, offered choices and encouraged people to make decisions about how their day to day care was delivered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and there were care plans in place. Although the approach to care was person centred this was not reflected in the care plans which were lacking in detail

People and their relatives told us they were involved in care planning but this was not reflected in the care records.

People were supported to spend their time in meaningful activities which reflected their interests and abilities. While carrying out their duties all the staff made the most of every opportunity to engage with people.

People were given information about the complaints procedure. People's concerns were listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Everyone we spoke with had nothing but praise for the management of the home. People told us the management team were always available, were approachable and went out of their way to accommodate individual people's needs.

Risks to people's safety and welfare were identified and dealt with in practice but this was not always reflected in the records.

The processes for monitoring the quality and safety of the service and record keeping needed to improve to ensure consistently and to make sure people continued to experience safe and effective care.

Croft House Care Home Limited

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 7 June 2016 and unannounced.

The inspection was carried out by two inspectors.

During the inspection we spoke with five people who lived in the home, two relatives, six staff including the deputy manager, activities organiser and domestic supervisor, the registered manager and the company secretary. We observed people being cared for and supported in the communal rooms and observed the meal service at breakfast and lunch. We looked at six people's care records, medication records, staff recruitment and training records and other records related to the management of the home such as maintenance records and meeting notes.

We observed people being cared for and supported in the communal areas and observed the meal service at breakfast and lunch. We looked around the home at a selection of bedrooms, bathrooms, toilets and the communal rooms.

Before the inspection, we reviewed the information we held about the provider such as notifications and any information people had shared with us. We contacted the local authority commissioning and safeguarding teams to ask them for their views on the service and whether they had any concerns.

Following the visit we reviewed the information in the Provider Information Return and considered this information when making our judgements. This is a form that asks the provider to give some key

information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

We looked at how people's medicines were managed within the service. The provider had a copy of the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes' (March 2014). However, we found this guidance was not always implemented which placed people at risk of not receiving their medicines safely and as prescribed.

We looked at the medicines with the deputy manager. We found some medicines were not always stored securely or safely. The medicine fridge was in the kitchen and contained prescribed medicines. We found it was unlocked which meant people not authorised or trained in medicines management had access to prescribed medicines. We found some medicines were stored in an internal room. Although the medicines were secured the room was very warm there was no thermometer to measure or monitor the room temperature. NICE guidance recommends medicines should be stored below 25°C to ensure the potency of the medicine is not affected by adverse temperatures.

The provider told us senior care staff had been trained to administer and manage medicines. However, they confirmed at night there were no senior care staff on duty. The provider told us some night care staff had received medicines training and said if pain relief was required Paracetomol would be left out at night for staff to give. This was unsafe practice because it was not in line with NICE guidance.

We looked at a sample of medicine administration records (MARs) and found overall they were well completed. However, there were no individual photographs on some MARs although the deputy manager told us these had been provided to the pharmacist but had not been included on the printed MARs.

We saw where medicines had not been administered the reason why was not recorded. For example, one person's MAR showed a prescribed laxative had been 'withheld' or 'destroyed' on several occasions. Although the deputy manager gave valid reasons why the medicine had not been given, this was not documented.

We saw topical medicines such as creams and ointments were not always dated upon opening and found the application of creams was not always recorded. The MARs showed the topical medicines prescribed but the deputy manager told us care staff applied the creams and completed separate topical MARs. We asked to see the topical MARs for two people, one who was prescribed a pain relieving gel and the other a steroid cream. The deputy manager was unable to find any records to show us these creams had been applied. Although we saw body maps for some people showed where creams should be applied, there were no body maps for these two people. This meant we could not be assured people were receiving their medicines as prescribed.

Where people were prescribed medicines to be taken 'as required' there were no protocols in place to guide staff about how to identify when people were in pain. We also saw staff were not recording the time when 'as required' medicines had been given. This is important as some medicines such as pain relief tablets require a minimum time gap between doses.

We checked the stock balances of three medicines and found discrepancies with two. One person had seven tablets left when according to administration records there should only have been six. This suggested one tablet had been signed for but not given. Another person should have had 144 pain relief tablets in stock, yet when we counted there were 170 tablets, which also suggested the person had not received their medicines as recorded on the MAR.

This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

We saw the senior care staff member administering medicines in the morning. We saw the staff member was patient and kind with each person giving them support where needed and staying with them until the medicines had been taken. We saw people were asked if they required any pain relief.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of one CD and it was correct.

We looked at a selection of maintenance records which included fire safety, gas, water and electricity. They showed the provider had suitable arrangements in place to make sure the premises and equipment were safe and properly maintained.

The registered manger told us an external agency carried out a health and safety audit of the premises every year. When we looked around we saw the premises was well maintained and it was evident there was an on-going programme of redecoration and refurbishment.

People told us they felt safe in the home. When we asked one person if the felt safe they replied, "Most definitely." Relatives we spoke with were also confident people were kept safe.

Four of the five staff we spoke with said they had received safeguarding training, although two staff told us this had been a couple of years ago and one staff member said they had not received any safeguarding training. However, all staff we spoke with understood the different types of abuse, were aware of the safeguarding procedures and felt confident any concerns they reported would be dealt with appropriately. Staff were aware of whistleblowing and knew external agencies they could contact if they felt concerns had not been addressed.

However, we saw a report in the care records which showed a safeguarding incident had occurred in April 2016 between two people who lived in the home. Although the registered manager described the actions they had taken in response to this incident to keep people safe, they had not recorded these actions or identified this as a safeguarding incident or made a referral to the local authority safeguarding team. This demonstrated a lack of understanding of the local safeguarding policy and procedures.

This was a breach of Regulation 13(3) the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People we spoke with told us there were enough staff to meet their needs. One person said, "Staff here are excellent and there's always plenty of them around." Another person said, "If I need help they're here quickly."

We spoke with two relatives who were regular visitors to the home and they also felt the staffing levels were

sufficient. One relative said, "There's always lots of staff around." The other relative told us they visited at different times and days and found there was always a 'high proportion of staff'.

In the PIR the provider told us the registered manager and deputy manager reviewed staffing levels on a monthly basis. In addition to occupancy this review took account of the needs of people living in the home. They told us they had lower than average staff turnover and this helped to keep people safe. The registered manager told us there were usually five care staff on duty during the day, this included a senior care worker or deputy manager. The registered manager was not included in the staff numbers and separate staff were employed for activities, housekeeping, catering and maintenance. Overnight there were two staff on duty and one of the management team was on call. However, the home did not always have a senior care worker on duty at night.

The provider told us in the PIR they carried out criminal records checks with the Disclosure and Barring Service (DBS) and obtained at least two written references for new staff. This was confirmed by the records; we looked at the staff files of three newly appointed staff.

In the PIR the provider told us they had an external infection control audit in June 2015 and scored 98%. When we looked around we found the home was clean and free of unpleasant odours. We saw staff used aprons and gloves to help reduce the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us there were no DoLS authorisations in place. However, 12 DoLS applications had been submitted to the local authority in June 2015 and were awaiting an outcome. Our discussions with staff showed although they had received training they had a limited understanding of the MCA and DoLS.

We saw staff explained to people what they were proposing to do and ensured they had their consent before proceeding. However, there was no evidence in the care records to show that people had consented to their care and treatment, including medicines.

The deputy manager told us five people received their medicines covertly, which meant the medicines were hidden or disguised in food or drink. We saw letters from the nurse practitioner which showed they had given permission for the person's medicines to be given covertly.

However, there was no evidence of a mental capacity assessment for these decisions or a best interest meeting. There was no information in the care plans to show which medicines were to be given covertly or how this was to be done. This showed the service was not complying with the MCA or the NICE guidance for managing medicines in care homes.

This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

Staff we spoke with told us they had received training but said some of it was 'a while ago' and acknowledged they needed refresher training. For example, two senior staff members told us they had received medicine training 'a couple of years ago'. The training records showed the most recent medication training had taken place in October 2014 and consisted of a half day internal training on medication recording and administration.

We looked at the training records for other areas of safe working practices and saw a similar picture. For example, the records showed the most recent training on safeguarding had taken place in September 2014 but this had not been attended by all the staff. In the case of two senior members of staff there was no record of them having attended safeguarding training since 2007.

We were not able to establish from the records what subjects the provider deemed to be mandatory training and how often training updates should take place. The registered manager confirmed there was no system in place to identify when training updates were due.

Staff told us they had received appraisals but had not received any formal supervision. The registered manager told us one of the deputy managers was responsible for staff supervision which should take place six times a year. They said the deputy manager had records of the supervisions they had undertaken but they could not be found during the inspection. We saw one supervision record for a member of staff which had taken place in October 2015. However, this was a record of an observation of practice rather than a one to one supervision. One to one supervision is designed to give staff the opportunity to meet with their line manager or delegated senior staff member to discuss their role and any support and/or training needs they have.

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

The records showed new staff had received induction training when they started work. The registered manager told us they tried to recruit staff with existing qualifications such as National Vocational Qualifications (NVQ). They said they would support new staff to complete the Care Certificate if they did not already have a qualification in care. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.

We saw some training had taken place on topics related to the needs of people living in the home such as dementia awareness, mental health awareness and the prevention of pressure ulcers.

People told us they liked the food. One person said, "The food's good. You get a choice and if you don't like what's on the menu they'll make you something else." One relative described the food as 'brilliant'.

We saw people had breakfast as they got up throughout the morning and were asked what they would like. People were provided with a choice of hot and cold drinks throughout the day and could also help themselves from a water dispenser in the lounge. We saw homemade biscuits were offered with drinks mid-morning, which people said were 'lovely'.

We had lunch with people in the dining room and found it was a relaxed and sociable occasion. Music was playing softly in the background which meant people were able to have conversations with one another. There was one main choice for lunch, although there was a choice of two desserts. We saw the main meal was brought ready plated from the kitchen which meant people were not offered a choice of portion size or whether they wanted all the components of the meal. However, this choice was offered with dessert which was served in the dining room and people were asked what they would like. People were offered a choice of cold drinks with their meal.

We saw where people required assistance with their meals staff sat with them and chatted to the person as they helped them.

Care records we reviewed showed people had access to a range of NHS services and we saw the involvement of GPs, the nurse practitioner, district nurses and opticians. The registered manager told us the nurse practitioner visited weekly which gave people regular access to medical advice and ensured people's needs were reviewed in a timely manner.

People's needs and preferences were taken into account when the premises was adapted, furnished or decorated. The home had an enclosed courtyard with seating and raised flower beds which had been created with the needs of people living with dementia in mind. The courtyard was accessible from one of the lounges and from a corridor and some people's bedrooms opened onto the courtyard. Throughout the day we saw the courtyard was well used with some people going in and out and others sitting outside enjoying cold drinks. Inside the home we saw visual signs were used which helped people living with dementia find their way around independently. We saw the home had a variety of arm chairs in different styles, sizes and colours. The provider told us they had considered the different needs of people living in the home when they had sourced the furniture rather than take a 'one size fits all' approach.

Good

Is the service caring?

Our findings

When planning the inspection we looked at an external website which provides information about care services. We saw Croft House had received consistently high reviews. This was consistent with the feedback we received from people during the inspection.

People we spoke with were unanimous in their praise of the care provided and the kindness of staff. One person said to us, "I read this was the second best care home in the country. I would say it's the best - definitely. Staff are brilliant." We asked another person what they thought about the staff and they said," You couldn't get better. They're very good." We asked a further person what they thought of the home and the staff. They said, "I like it here. They're all lovely and very good to me."

Relatives we met were equally positive. One relative said, "It's a super place. I visit every week and I've no worries - the care is very good. The girls here are so nice and (the registered manager/owner) is excellent. I can't speak highly enough of the place." Another relative said, "The care here is unbelievable. (The owners) are wonderful and care so much about people. The staff are fantastic and they really do care. That's what makes it so different from all care other homes I've been to - the staff genuinely care." Relatives told us they could visit at any time and were always made to feel welcome.

We spoke with a visiting entertainer who told us they had been coming to the home for three to four months. They said, "I visit lots of care homes and this is the best one I go to." When we asked them what made it the best they replied, "The staff. They're very attentive and really care about people. They're always friendly and welcoming."

We saw staff knew people well and engaged with them at every opportunity. Staff were caring and considerate with people. We saw they listened to what people had to say and were patient and kind. There was a warm and friendly atmosphere and we saw people were relaxed chatting and laughing with staff and each other. People looked clean, comfortably dressed and well groomed.

People care records contained information about their life history including people important to them such as family and friends as well as any interests and preferences. We saw staff used this information to initiate conversation and have discussions with people.

The provider told us they supported people to keep in touch with family and friends. For example, they used Skype to help one person whose family was overseas to keep in contact.

The provider told us they were always looking for new and better ways to support people, particularly those living with dementia. For example, they said they encouraged the night staff to wear pyjamas to help orientate people and create a 'night time' atmosphere to promote rest and sleep.

In the PIR the provider told us people living in the home were involved in decision making by means of regular residents meetings. The most recent was on 31 May 2016. The items discussed included activities

and the menus. The meetings were chaired by one of the deputy managers and the registered manager followed up any actions needed. For example, they told us people had expressed a wish to have some Indian food and they had arranged for them to visit a local Indian restaurant. In addition they said they consulted with people and their relatives on an individual basis about their care and treatment.

The provider told us in the PIR all the DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) were reviewed annually. They also told us they had identified planning for end of life care as an area where they planned to make improvements. They said they were liaising with the palliative care team and exploring ways of making it easier for people and their families to engage with planning for end of life care.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care they needed and we saw staff knew the care and support people required and provided person-centred care. Relatives also told us they were involved in decisions about people's care. However, none of this was reflected in the care records we reviewed.

We found care plans lacked detail about the support people needed and how and when this was to be provided. For example, one person's care records showed they were incontinent and were unable to communicate verbally. Yet there was nothing in the care plan to show the support the person needed in accessing the toilet or how often this should be offered/provided. The records showed this person 'wanders around a lot which can upset some other residents', yet there was no information to show what support was required from staff in managing this situation. Another person's care records showed they had a medical condition, yet there was no care plan to show how this was managed.

In another person's records we saw they had been discharged from hospital with specific treatment instructions. There was no care plan in place to ensure this information was readily available to all staff.

We had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient. For example, one person's weight records showed they had lost 5kgs between January and May 2016. There was no malnutrition universal screening tool (MUST) assessment in the care file. The nutritional care plan was dated 3 January 2016 and identified the person had a medium appetite, was to be weighed weekly and the MUST to be completed monthly. We saw monthly reviews since January 2016 showed the person's appetite had reduced but made no reference to this person's continued weight loss or showed the action that had been taken in response to this.

We looked at the food and fluid charts for this person. The fluid charts showed in the four days leading up to the inspection the person had received a total daily fluid intake of between 450mls and 900mls. There was no information on the charts or in the person's care plan to show what the daily fluid intake should be and no evidence to show the charts had been monitored or reviewed by staff. Similarly the food charts showed little food taken on some days and no evidence of review by staff. For example, the daily intake recorded on 5 June 2016 was half a Weetabix, three mouthfuls of chicken and vegetable and three mouthfuls of sponge and custard. We discussed this with the registered manager who acknowledged the shortfalls in recording and said these would be addressed. They assured us the person was receiving sufficient to eat and drink, although this could not be evidenced in the records we saw.

In another person's records we saw a care plan about diet and nutrition dated 31 January 2016 which had last been reviewed on 30 April 2016. The care plan stated the person's dietary intake should be monitored by completing food and fluid charts. However, when we checked there were no fluid and food charts in place. The records showed that while the person's weight fluctuated by 2 or 3kg from month to month they had maintained a Body Mass Index (BMI) of 20, which is within the healthy range, since September 2014.

This was a breach of Regulation 17(2)(c) the Health and Social Care Act 2008 (Regulated Activities 2014)

Regulations

When people were assessed as needing particular equipment to maintain their health and/or safety we saw this was in place. This included equipment to help reduce the risk of falls such as profiling beds, height adjustable beds, sensor mats and movement sensors. Other examples included equipment to reduce the risk of developing pressure sores such as special mattresses and cushions.

The provider told us they had a special portable inflatable cushion to help people back to their feet after a fall. This helped to reduce people's distress by enabling staff to help them safely and quickly.

People told us there were activities taking place which they could participate in if they wanted. During our visit we saw people playing dominoes with staff, reading newspapers, listening to music, watching television and chatting with staff and each other. It was a hot sunny day and many people chose to sit outside in the garden and were kept supplied with drinks. Parasols were available for those who wanted to sit in the shade and staff ensured those who were in the sun had sun cream applied.

In the afternoon we saw people enjoyed listening and watching an entertainer who sang for them.

The provider told us they had recently employed an activity co-ordinator who worked from 9am until 12 midday. They said this was because they had recognised there was little to occupy people in the morning as most activities took place in the afternoon. The activity co-ordinator was present during our inspection and we saw how people benefitted from this staff member's input. For example, we saw one person having an animated discussion with the activity co-ordinator about the music they were listening to which was from a well known musical. We saw the activity co-ordinator used an iPad to find the answers to questions the person asked and showed them photographs of the stars who had been involved in the musical. The person was very interested and it generated a long conversation. We saw throughout the morning the activity co-ordinator initiated and encouraged discussions with people and there was a lively buzz in the lounge. We saw people smiling and laughing and those who chose not to actively participate were watching and smiling.

We spoke with the activity co-ordinator who was enthusiastic about their role. They told us how they ensured everyone benefitted from their input and made sure they spent time with people who chose to stay in the rooms. They told us about the activities people enjoyed which included quizzes, reminiscence and games. They also said there were regular trips out.

There was a complaints procedure in place. Information about the complaints procedure was made available to people in the Statement of Purpose and was also displayed in the home.

The provider told us they operated an 'open door' policy and encouraged people to talk to them about any concerns they had so that they could be dealt with there and then. We saw evidence of this in the records. The provider told us they found this approach was effective and said they had not received any formal complaints in the last 12 months. One person who lived at the home told us, "I've got no complaints; they look after you very well".

Requires Improvement

Is the service well-led?

Our findings

People living in the home, relatives and staff were unanimous in their praise of the leadership and management of the home. Staff said they felt supported in their roles and said they would have no hesitation in recommending Croft House as a good place to work. Staff also told us they would be happy for a relative of theirs to be cared for in the home.

The provider told us they sent survey questionnaire annually to people who used the service, their families and other stakeholders. We saw most of the responses were positive and suggestions for improvements were taken seriously and whenever possible acted on. We saw people were given feedback to let them know about changes the provider had made in response to their comments.

The deputy manager told us they carried out regular medicine audits, however when we asked to see these they told us they were not recorded. The registered manager told us an audit had recently been carried out by the pharmacist who supplied them with their medicines; however they said they had not received a copy of their report. Following the inspection the provider sent us a copy of the report, it was dated 2015 but did not state in what month the audit had been carried out. When we looked at how people's medicines were managed were found a number of concerns which we have detailed in the safe section of this report. In addition, we found the provider was not following their own policy or the principles of the Mental Capacity Act in relation to the use of covert medications.

We saw the registered manager monitored risks to people's safety and welfare every month, this included monitoring falls, nutrition and the risk of pressure sores. However, when we looked at the way the service managed risks to people's safety and welfare we found that although risks were well managed in practice this was not always reflected in the records.

This was evident in the management of falls and the management of people who were at risk of poor nutrition.

In one person's records we saw the falls risk assessment for one person which had been reviewed monthly assessed them to be at moderate risk of falls and their mobility care plan stated their last fall had been in October 2015. However, the daily records showed this person had fallen twice in April 2016, yet the falls risk assessment had not been reviewed to consider if there was further action which could be taken to mitigate the risk of falls.

We looked at the records of another person who had fallen and sustained a serious injury in May 2016. We saw there were arrangements in place to manage the risk of further falls. However, the person's falls risk assessment and care plan had not been reviewed since 30 April 2016.

Another person's weight records showed they had lost 5kgs in four months. There was no malnutrition universal screening tool (MUST) assessment in the care file which meant the level of nutritional risk to this person as a result of this weight loss had not been determined. The care records showed the nurse

practitioner had been informed of the weight loss on 25 May 2016 and prescribed a nutritional supplement. However, when we looked at this person's MAR the supplement had only been signed as given from 5 June 2016 onwards. The deputy manager assured us the person had received the supplements from the date they had been prescribed but acknowledged this was not recorded.

We saw safety gates were used on some of the stairs. The registered manager told us they had explored other options and had concluded the child safety gates were the most appropriate solution. However, this was not supported by a documented risk assessment.

The home had a sprinkler system installed to reduce the risk of fire damage. However, they did not have Personal Emergency Evacuation Plans (PEEPs) in place for people living in the home. When people are likely to need assistance to get to a safe place or leave the building in the event of an emergency it is recommended that PEEPs are in place. This is to ensure everyone involved in the evacuation has access to clear and concise information about the level of support each person needs.

Although staff told us they felt well supported we found shortfalls in relation to staff training and development. The provider did not have an effective system in place to ensure staff were kept up to date with safe working practices. This created a potential risk to the safely and welfare of people using the service and staff.

Similarly we found that although people told us they were involved in planning how their care and support needs would be met this was not consistently reflected in the records.

We concluded the provider did not have effective systems in place to assess and monitor the quality and safety of the services provided or to ensure that accurate records were kept in respect of each person who used the service.

This was a breach of Regulation 17(2)(a) and 17(2)(c) the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not complying with the MCA 2005 Code of Practice. Regulation 11(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely and properly. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not always identified and reported to the relevant agencies. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate training to enable them to carry out their duties. Regulation 18(2)(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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to monitor and assess the quality and safety of the services provided. Regulation 17(2)(a) Accurate and complete records were not maintained in respect of each person who used the service. Regulation 17(2)(c)

The enforcement action we took:

Warning notice