Croft Carehomes Limited

The Croft Care Home

Inspection report

17 Snydale Road
Normanton
West Yorkshire
WF6 1NT

Tel: 01924223453
Website: www.croftcaregroup.co.uk

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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 of The Croft Care Home took place on 19 October 2016 and was unannounced. We also visited on 20 October 2016, this visit was announced as we wanted to ensure the manager would be available to meet with us. One inspector also visited the home on 2 November 2016, this visit was unannounced.

We previously inspected the service on 8 and 22 February 2016 and 17 March 2016. We rated the home as inadequate overall and placed it in special measures. We also took enforcement action by serving the provider with notice of our intention to de-register and close the home if significant improvements were not made. This inspection was to see whether the issues we identified had been resolved. At this inspection we found there had been improvements which were sufficient for the service to be rated as requires improvement overall with no inadequate domains. This meant the service could come out of special measures.

The Croft Care Home is located in a residential area of Wakefield. The home provides accommodation for up to 29 older people, some of whom are living with dementia. The home has communal living areas on the ground floor and bedrooms are located on the ground and first floor. On the first day of our inspection 21 people were living at the home. Following the previous inspection the registered provider voluntarily agreed to an embargo on admitting future people to the home; this was to enable them to concentrate on addressing issues identified at the inspection.

The service had a registered manager in place but they were not present during the inspection. An external management consultant and a manager, who had only commenced employment with the registered provider approximately three weeks before the inspection took place, were present on each day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager and staff were aware of their responsibilities in keeping people safe.

Improvements had been made to the management of medicines, for example the implementation of medicine profiles for people and a system of auditing. However, we noted a controlled medicine was not stored within the controlled drugs cabinet, we also saw staff had made an entry on a topical medicines record chart but a medicine administration record was not available.

Risk assessments were in place but they did not address all aspects of people's care. One person was at risk of harm due to unsafe bed rail bumpers.

There had been a number of improvements made to the environment, including redecoration, replacement

of some carpets and hot water was available in people's bedrooms. Cleaning schedules were in place but we found the conservatory lounge was not clean on the first day of our inspection. Since our last inspection a second shower facility had been provided at the home. Action was being taken to address the shortfalls identified at a recent environmental health inspection.

Staff had been recruited safely and there were enough staff on duty during our inspection to meet the needs of the people who were in the home at that time.

There were a number of people who used the service who had been assessed as not having capacity to make major decisions. Staff were aware of the need to ensure peoples care and support was only provided with the consent of the relevant person. However, the relevant documentation was not yet in place to support this aspect of peoples care.

People were encouraged to choose their meals and were supported to eat in a dignified manner. They were offered a choice of hot and cold drinks and there was the option of a hot meal at both lunch and evening time. The meal time experience was calm and relaxed.

Action was taken to monitor people who were identified as having lost weight. Food and drink records were kept for some people although the format of these documents meant it was not easy to identify if there were any gaps in staff's recording.

Staff training was on going and staff had received at least one supervision with the management consultant. There was a programme of induction in place for new staff.

Staff interactions with people were caring and kind. Staff respected people's privacy and supported people in a way which maintained their dignity. Records were stored confidentially.

Work had commenced to update people's care planning records. We saw the care plan for one person which had been re-written by the management consultant and found it to be reflective of the care and support provided to the person. The management consultant told us there was still a lot of work to be done to ensure everyone's care plans were accurate. There had been improvements to the recording of people's personal care although the format of the document meant it was not person centred and lacked detail.

Staff supported people to participate in a range of activities; records noted if people had enjoyed a particular activity or not.

Staff gave positive feedback about the recent changes at the home. We saw evidence a number of audits had been undertaken to assess and monitor the quality of the service provided to people. Meetings had also been held with staff and relatives to share information. During our inspection we found evidence of significant improvements which had been made to improve the quality of the service provided to people. However, as evidenced within the main body of the report there remain a number of areas where there is a need for further development.

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

Not all aspects of the service were safe.

Protective bumpers for one person's bed rail were inadequate as they did not provide enough protection to reduce the risk of serious harm.

We observed safe moving and handling of people.

Staff were recruited safely and there were enough staff to meet people's needs.

Action had been taken by the registered provider to improve the systems for managing people's medicines, although some aspects remained unsafe.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff understood the need to obtain consent, but peoples records did not consistently evidence consent was routinely obtained in line with the requirements of the MCA.

People were supported to eat and drink in calm, relaxed environment.

There was a programme in place to ensure staff received relevant induction, training and support.

Is the service caring?

Good

The service was caring.

Staff were caring and kind.

Staff took steps to maintain people's dignity and privacy. People were enabled to make choices in regard to their daily activities.

People's records were stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

One of the care plans we reviewed was detailed and person centred. Personal care records were tick box and did not accurately record the care offered or provided to people.

The provision of meaningful, person centred activities had improved since our last inspection.

Complaints were recorded and investigated by the management at the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems of governance were not yet embedded and due to the short time frame since the last inspection we were unable to evidence sustained improvement at the home.

Since the last inspection a number of improvements have been made to the service, although there remain some areas which still need attention.

Feedback from staff was positive about the changes at the home.

The Croft Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two adult social care inspectors. Before the inspection we reviewed all the information we held about the service. We contacted Healthwatch to see if they had received any information about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority safeguarding, commissioning and monitoring team, the district nursing team and reviewed all the information we held regarding the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with four people who were living in the home and three visiting relatives. We also spoke with a management consultant, the manager, a care co-ordinator, a senior carer, three care staff, a cook and an activity organiser. We reviewed four staff recruitment files, ten people's care plans and related documentation as well as a range of documents which related to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Our inspection in 8 and 22 February 2016 and 17 March 2016 found the registered person was not meeting the regulations as people's care as treatment was not provided in a safe way, the premises were inadequately maintained, medicines were not managed safely and there were insufficient staff on duty to meet people's needs. At this inspection we found a number of improvements had been made.

People told us they felt safe. One person said, "Yes I feel safe." None of the relatives we spoke with raised any concerns regarding the safety of their family member.

The manager told us they had not yet completed safeguarding training with the registered provider but they had attended training in their previous role. When we spoke with them they were clear about what may constitute a safeguarding concern and the action they should take to investigate and report the matter to the relevant authorities. Staff were also clear about what may constitute abuse, for example, physical, verbal and institutional abuse. We asked one staff member if they had any concerns about the service, they said, "No, no concerns. I think the management would act. If they didn't act I would talk to the director of care or inform CQC (Care Quality Commission) or the police." This showed staff were aware of their responsibilities in relation to safeguarding the people they cared for.

At our last inspection we observed staff using poor moving and handling techniques with people. During this inspection we saw staff use safe methods to transfer people who needed support, for example using a hoist or mobility equipment. On the first day of our inspection we noted staff struggled to support one person to get up from their chair although this difficulty appeared to be caused by the chair being too low for them to raise themselves up to a standing position. We discussed this with the care co-ordinator on the day of the inspection.

At our last inspection we found risk assessments were not always an accurate reflection of people's care and support needs. At this inspection we found improvements had been made. We reviewed the moving and handling documentation for two people who required the use of a hoist to transfer. The documents recorded they needed to be transferred with a hoist, the size of sling and which attachments were to be used. When we observed staff transferring one of these people we saw staff used the sling which was identified in their care plan. The details regarding the safe use of a wheelchair were absent in one of the care plans but we saw this had recently been put into place for the second person. Having risk assessments in place for all the equipment which is used by a person reduces the likelihood of harm.

We looked at the risk assessments for one person and saw they reflected the care and support they received during the day. However, Croft Care Home has two internal staircases which are accessible to people. This person was independently mobile and although they had a risk assessment in place we did not see this aspect of the environment had been risk assessed specifically around their individual needs. We brought this to the attention of the manager during our inspection who said they would review this aspect of the person's risk assessment documentation.

On the first day of our inspection we saw one person had safety rails in place to reduce the risk of them falling out of bed. The rail had a 'bumper' in place but this did not cover the full length of the bed rail. Having a bumper in place further reduces the risk of injury from the rails and reduces the risk of serious harm, for example, entrapment between the bed, mattress or the rails. The manager told us they were aware of this matter and they had informed the registered provider, the matter was addressed before we left on our second day.

This evidence demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incidents were recorded and we saw a copy of the document was retained in the individual's care file and also in the manager's office. The file where copies of accident and incident records were retained contained a document entitled 'good practice guidelines'. This provided guidance for staff as to the level of detail they needed to record, for example, the location of the incident and if it was witnessed. This level of information is important as the forms may be used as evidence in the event of a formal investigation being required. A log detailed all the accidents and incidents including action taken to reduce the risk of further incidents. The management consultant told us about a person at the home who had had a number of falls. They explained that following analysis of the accidents they had identified a possible cause and they had spoken with the person about moving bedrooms to a room with en-suite facilities. They said the person was in agreement with this and the move was planned as soon as the new room was ready for them. On the third day of our inspection, this person was in the process of moving bedrooms.

During our previous inspection we had a number of concerns relating to the premises and environment which put people at risk of harm. On this visit we found significant improvements had been made. Internal doors closed properly and we did not see any evidence of doors being propped open. This is important as it ensures, in the event of a fire, the doors provide a level of protection for people. New window restrictors were in place and we noted the passenger lift 'levelled' on the ground floor, therefore reducing the risk of trips for people stepping in and out of the lift. On our previous inspection we found the supply of hot water in people's bedroom to be poor. On this visit we found there was hot water running from each of the hot water taps we checked.

We saw evidence external contractors were used to service and maintain equipment, for example the gas safety and the fire detection system. We also saw evidence of regular checks being completed by staff on the fire detection system and water temperatures. The manager showed us a comprehensive audit, recently completed by the management consultant on 10 October 2016 which highlighted a number of minor maintenance issues which needed addressing. Although at the time of our inspection they were still requiring attention.

A number of bedrooms and communal areas had been re-painted and some carpets had been replaced with cushion flooring. The manager told us the reception area, dining room and conservatory were yet to be completed. We looked in people's bedrooms, communal bathrooms and toilets before the domestic staff had had opportunity to complete their work but where we noted issues which needed their attention, when we checked later, they had been attended to. We went in one person's bedroom and found there to be an offensive odour. The manager acknowledged this was unacceptable but the cause of the odour could not be identified. The manager said they would look into this to try to resolve the matter.

We found seating in the conservatory was not all clean. For example, a pressure cushion was stuck to a chair and had liquid and crumbs underneath and there were crumbs under a second chair. We also saw food trodden into the carpet in the conservatory area. Cleaning schedules were in place for staff, including night

staff being responsible for cleaning the lounge areas. The cleaning had not been signed as completed for the night before our visit. The manager explained night staff had prioritised the care of the person who had been unwell, which we agreed was the correct course of action, however, the outstanding cleaning work should have been passed to the next shift to enable the seating to be cleaned for people to use.

The Croft Care Home had an environmental health inspection by a food safety officer, completed on 2 September 2016. The home received a score of one which meant a number of improvements were required. We spoke with the cook on the first day of our inspection and they told us how the environmental health officer had given them some advice when they visited, for example, the most appropriate shelf to use for different food stuffs. They also showed us all opened and 'in use' items in the fridge were labelled to ensure staff knew when they had been opened and when they had to be disposed of. The manager told us an external training provider had been booked to deliver training to relevant staff to ensure they had the knowledge and skills to perform their role and met their legal requirements in regard to food hygiene. This showed there were plans in place to address the issues highlighted by the food safety officer.

There were recruitment procedures in place to reduce the risk of employing staff who may not be suitable to work with vulnerable adults. We asked a member of staff how they had been recruited. They said they had attended an interview, references had been requested and a Disclosure and Barring Service (DBS) check had been completed. We reviewed the recruitment files of four staff and saw application forms had been completed and for staff recently employed, a record of the interview questions and answers had been retained. References had been obtained, including one from their most recent employer, and DBS checks had been completed.

During our previous inspection we found there were insufficient numbers of adequately deployed staff available to meet people's needs. When we asked one person if there were enough staff they said, "We have a call bell, they come." A member of staff said, "There is usually enough staff." Another staff member told us more staff were still being recruited and they said the manager and care co-ordinator would help staff if needed. During the two days we spent at the home we saw staff attended to people's needs in a timely manner.

The manager told us the home did not yet have a full complement of staff but they said recruitment was on-going and there were some staff who had were awaiting completion of pre-employment checks before they could start work. The manager told us shortfalls in staffing were being covered by agency staff, however, they said they tried, where possible, to get regular staff. They said the laundry was currently staffed over five days and they were in the process of recruiting to provide cover every day. They also explained staff dedicated to providing activities for people had also been employed. They said the staff worked from 9.30 to 5.30 which enabled them to provide a range of activities but they were also able to support care staff during busy periods, for example at meal times.

A dependency tool had been used to support the organisation in setting the staffing levels for the home. This incorporated a number of physical tasks and the level of support the person may need but it did not reflect the particular needs of people who were living with dementia who may be resistive to care interventions by staff. This meant there was a risk the dependency tool was not an accurate reflection of people's holistic care and support needs.

At our last inspection we found people's medicines were not managed safely. At this inspection we found although improvements had been made there was still further work to be done to ensure medicines were consistently managed safely and met current good practice guidelines.

We observed two staff administering medicines to people. We saw they locked the door to the medicines room and they locked the medicines trolley and placed all medicines back in the trolley when they went to administer a person's medicines. The medicine room, although a little untidy, was of an appropriate temperature and records of the room and fridge temperature were recorded, although this was sporadic.

The management consultant had begun to implement a medicine profile for each person who lived at the home. We reviewed two profiles which had been completed. They provided information about relevant health conditions, allergies and detailed the medicines the person was prescribed. We noted one person was prescribed a topical application (cream); their medicine profile recorded why they needed the cream. There was also a corresponding medication administration record (MAR) and a body map, which identified where the cream was to be applied. However, we saw another person who had a topical medicines record chart with a body map for a particular cream, which staff had signed as administered, 17 October 2016 but the MAR could not be located. This meant there was no evidence the cream was being administered in line with the prescriber's instructions.

A monitored dosage system (MDS) was used for the majority of medicines while others were supplied in boxes or bottles. We checked three individual boxed medicines and found the stock tallied with the number of recorded administrations. We also looked in the medicine stock cupboard and found it to be cluttered with items such as watches and purses. We noted a particular medicine which was classified as a controlled drug was not being stored in the controlled drugs cupboard. The care co-ordinator explained they had recently had a new lock fitted and had not issued the key to senior staff. They located the key during our inspection and placed the controlled drugs in the correct cupboard. They told us they would also ensure the medicine cupboard was cleaned out to ensure only medicines were stored in there.

Prior to the inspection we had received a statutory notification from the registered provider regarding a medicines error at the home. A senior carer told us that following this incident, relevant staff had received a letter to tell them about the incident, they had completed a questionnaire about safe medicine administration and a more senior staff member had observed them to ensure they were competent.

We saw two audits had been completed at the home by the management consultant, in May and September 2016. These addressed a number of aspects of medicine management including storage, administration and disposal. Both audits recorded their findings and their recommendations to improve practices at the home. Actions had been ticked off, to indicate they had been completed and there were hand written notes detailing further follow up actions either which had been addressed or still needed to be actioned. Medicines audits are an essential tool in reviewing systems of medicines management, enabling concerns to be identified early and required actions can be implemented promptly.

Requires Improvement

Is the service effective?

Our findings

Our inspection in 8 and 22 February 2016 and 17 March 2016 found the registered person was not meeting the regulations in regard to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. Where people lacked capacity, there was no evidence of capacity assessments and best interests' decision making. We also found applications to deprive people of their liberty had not been applied for in a timely manner.

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.

We saw from the care records we reviewed there were people who lived at the home who had been assessed as not having capacity to make decisions relating to where they lived and the care they received. We saw work had begun to complete relevant capacity assessments. We reviewed the care plan for one person who had a DoLS authorised by the local authority. Their care plans referred to their ability to make decisions in relation to different aspects of their care, for example, 'can make their own decisions on a day to day basis for example, what time to get up', and we saw evidence of a capacity assessment and best interests meeting in regard to a specific aspect of their care to which they lacked capacity to make.

Consent was not routinely obtained in line with the requirements of the MCA. We reviewed the care plan for a person who had safety rails in place to reduce the risk of them falling out of bed. The manager told us the person did not have capacity to consent to the use of bed rails but they had an authorised power of attorney in place. There was no evidence consent had been obtained regarding the use of bed rails through a best interest's decision. If a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney. Staff administered medicines to everyone in the home and we saw a number of people who lived at the home clearly lacked the capacity to manage their own medicines. We saw a document in the care plan of one person where a family member had signed their approval for staff to administer their relative's medicines but we were unable to evidence they had the legal authority sign to this document and there was no evidence of best interest's decision making. The management consultant and the manager said they knew there was a lack of information at the home in regard to these matters and they were taking action to address this. This meant where people did not have capacity to give their consent we were unable to evidence care had been agreed in their best interests to keep them safe and well.

The manager expressed a good foundation of knowledge; they said "Never assume a person has not got capacity, just because they have confusion or a communication problem, if they aren't able to make an informed decision, then it's a best interests meeting." We saw evidence staff had received training in MCA and DoLS and staff we spoke with were able to tell us about the decisions people were able to make. One staff member said, "We support people who don't have capacity to stay independent. We ask people, give

them a choice." Another member of staff told us about a person who could be resistive to personal care, they said, "Its (person's) choice, we can't make them." This showed people's rights were protected by staff who had understood the basic principles of the Mental Capacity Act 2005 (MCA).

From the evidence gathered during the inspection we were satisfied the management consultant, the manager and staff were aware of the need to ensure peoples care and support was only provided with the consent of the relevant person. However, at the time of the inspection the relevant documentation was not yet in place to support this aspect of peoples care in line with the requirements of the MCA. This evidence demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) as described in MCA. The manager told us three people who lived at the home were subject to a DoLS authorisation. During our inspection we observed one person who made frequent attempts to leave the building via the front door and another person who often said they wanted to go home. We saw one person had a DoLS authorisation in place and the other person had an application with the local authority which was awaiting approval. This demonstrated where people had been deprived of their liberty the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person's rights were protected.

Our inspection in 8 and 22 February 2016 and 17 March 2016 found people's care and treatment was not provided in a safe way. This was due to a failure to ensure all that was reasonably practicable to mitigate any risks had been identified and acted upon in regard to people's nutrition. People were not always offered choice at meal times and people did not consistently receive an appropriate level of support to enable them eat and drink sufficiently. On this inspection we found significant improvements had been made.

We asked one person about the food at the home and they said, "It's fine." The management consultant told us they had disposed of the plastic plates and new plates had been provided. They also said a hand blender had been purchased and people were given the option of smoothies, which we saw being offered to people during the afternoon. This showed people were being offered a variety of nutritious drinks.

The dining tables were set with cutlery, condiments and flowers. There was a picture menu board but that was not reflective of the day's menu. However, the menu was written on a white board and was updated after lunch for the tea time menu. We observed the lunch time meal and saw staff ask people what they would like for their lunch, about the portion size they wanted and if they wanted vegetables and gravy. Where people required an aid to enable them to be independent, for example a plate guard, this was provided for people. We also heard staff asking if people wanted their food cutting up and we saw a staff member cutting up the meal into smaller portions for one person to enable them to eat in a dignified manner. One staff member noticed a person had drunk all their juice, so they provided them with a refill. Part way through the lunch a staff member offered people tea or coffee. The atmosphere was calm and relaxed, people were given time to eat and their plates were removed and pudding served in a timely manner. When puddings were served we heard one person ask for jelly, the staff member asked if they wanted to add ice cream also. We saw staff ask a person what pudding they would like, the person was clearly not able to make a choice, the staff member plated up two different choices and showed them to the person. We saw the person reach out and make their own choice which the staff member then placed in front of them.

We also observed the tea time meal and found the atmosphere was equally calm and relaxed. People had a

hot option, for example, on the first day of our inspection this was fish cake, chips and peas. We saw staff serve this to one person who was not sat at a dining table; the staff asked them if they wanted salt or ketchup with their meal. An individual stand of sandwiches and cakes was placed on each dining table for people to choose from. People were prompted and supported in a timely and dignified manner.

In the kitchen the cook showed us a list they had of people who required staff to monitor their food and fluid intake. They also had a list which identified people who needed a specific diet, for example, low sugar or sugar free. The management consultant had implemented a project to ensure the meals and drinks served to people were in line with their individual preferences. We saw this was not yet completed but we reviewed two of the completed records and saw they were detailed and person centred. For example one recorded 'Breakfast – 7- 8.30, or when I am hungry. I don't have a set sleep pattern and may want breakfast quite early'; it also recorded some of the specific foods they liked and disliked. This level of detail is important as a number of people who lived at the home had memory impairments and were not always able to communicate their preferences.

The management consultant told us they had noted that when people were being weighed there were sometimes large differences in their weight which could not be accounted for and as a result the weighing scales had been re-calibrated in August. During the inspection we reviewed the weight records for eight people. We noted one person had steadily lost weight throughout the beginning of the year but this had stabilised during the summer months and the dietician had discharged them from their care. We saw their weight was recorded as 53.2kg, 20 August 2016 and 46.6kg, 10 October 2016. A member of staff had requested the person be re-weighed in a week's time. On the final day of our inspection we checked and found they had been weighed again and their weight had remained stable. We also noted hand written entries had been made on their nutrition care plan to evidence these changes. This shows the care plan for this person had been updated to record recent changes to their needs.

We looked at the food and fluid monitoring charts for three people, which included the two people with recent weight loss. We saw staff were recording what they ate and drank on a daily basis however, due to the layout of the form it was difficult to identify if meals or drinks had not been recorded and staff did not consistently record how much of the meal the person had eaten. We spoke with the manager on the third day of our inspection regarding how the layout of the document could be improved to enable more accurate recording and enable staff to clearly identify gaps in records.

Staff told us they had received training and supervision. One staff member said, "I had a lot of training when I started." Another staff member, who was still in their induction period, said they were currently working on shadow shifts (where they are extra to the staffing numbers and work with a more experienced colleague) and they were scheduled to attend training at the registered provider's head office the following day. Another staff member told us they received an induction when they started and they had also completed online training in a variety of subjects but they had also received practical training in moving and handling. They added that they had preferred the face to face training.

Each of the staff files contained evidence of staff induction. The form indicated the induction was spread over five days and detailed the areas of learning to be addressed on each day and included a section to be signed to confirm the staff member was 'deemed competent to work'. We saw on one record sections were not signed as completed including the 'section deemed competent to work'. On another record, the induction record had been fully completed but there were only two dates recorded on the form. This was shared with the manager on the day of the inspection. Ensuring staff receive a thorough induction at a pace which is appropriate for them is important to ensure they learn the skills and develop the confidence to perform their role to the expected standard.

We saw evidence staff had completed or were in the process of completing, training in a variety of topics. This included moving and handling, infection prevention and control, safeguarding and dementia care. We reviewed the training matrix which recorded the names of staff and their role and highlighted if they were not in an active role at present, for example due to ill health or extended leave. We randomly checked the dates on the matrix against the dates of certificates in one staff member's file and found they matched.

Three of the staff files we reviewed were of staff who had commenced employment since the last inspection; we also reviewed the file of one staff member who had worked at the home for over two years. We saw they had each received supervision with the management consultant. The record was detailed and noted the topics discussed, feedback about the staff's performance and comments from the staff member receiving the supervision.

We spoke with the manager regarding staff induction and training. They told us how they intended to support new staff through induction, training and where appropriate the Care Certificate. This is a set minimum standard that should be covered as part of induction training for staff who are new to care work. The management consultant showed us a matrix which recorded the names of staff and the dates their supervision was planned for or had been completed on. They told us that mentoring and supervision of staff was an area which still needed to be developed. Regular supervision and on on-going training helps to ensure staff have the skills and competencies to meet people's needs and that their work meets the standards expected of them.

We saw evidence in people's care plans of the involvement of other healthcare professionals, including the GP, district nurse and dietician. We also saw evidence in care plans and from notifications submitted by the registered provider that people attended hospital in the event that an accident or incident resulted in an injury which required further examination or treatment. This showed people received additional support when required for meeting their care and treatment needs.

Croft Care Home is set over two floors with bedrooms, bathrooms and toilets to the ground and first floor. There is a conservatory & dining area, lounge and separate smoking room on the ground floor. Toilet and bathroom doors were painted yellow, a number of them having picture signage on them; this can help people who are living with dementia to locate toilets and bathrooms more easily. Bedroom doors were painted different colours and many had the room number and the name of the occupant. There was a lack of directional signage; for example, when a person came out of their bedroom or the lift, to direct them to the lounge, dining area or bathroom. We asked the manager about this and they assured us signage had been obtained and was due to be put in place following completion of the redecoration programme.

In the reception area there was a whiteboard which detailed the day and date, the staff on duty for the day and the planned activities for that day. There was access to a decked patio area which provided a table and seating. The area looked clean and tidy. At our last inspection we found the home had limited accessible bathing and showering facilities for people who lived at the home. On this visit we found a bathroom on the first floor had been converted to a wet room shower and there was also an accessible shower on the ground floor. Ensuring facilities are suitable for the purpose for which they are intended is a key factor in providing safe and effective care.

Good

Is the service caring?

Our findings

Our inspection in 8 and 22 February 2016 and 17 March 2016 found the registered person was not meeting the regulations regarding dignity and respect and maintaining secure records.

We asked people if staff were kind and caring. One person said, "They are very good, I have no grumbles." Another person said, "I felt poorly this morning and they (staff) told me to stay in bed, but I came downstairs as I was bored." A relative said, "The care is good, they do look after (name of person). We asked one person if they were able to bath or shower regularly, they said, "Oh yes, at least once a week."

Throughout the inspection we observed staff to be caring, kind and patient. Their interactions with people and each other were friendly and appropriate. Staff bent down to the level of the person they were talking to and used appropriate touch, for example, holding someone's hand and touching their arm or shoulder. When we spoke with staff, they spoke about people as individuals and were able to tell us about the care and support people received. This showed people were supported and cared for by staff who knew them well.

Staff respected people's privacy and dignity. We saw one person who was walking towards the dining area during the lunchtime meal. A member of the domestic staff walked to the dining area with them and prompted the person to choose where they would like to sit. We also heard this member of staff knock before entering a person's bedroom, they told the person who they were and asked if it was alright to enter their room. There was information on display in the reception area about dignity and staff were able to tell us how they maintained people's privacy and dignity. One staff member said "We close doors, and if people are safe, we leave them to use the commode." We saw people were appropriately dressed, although one person had bare legs. When we asked them about this, they said they would prefer staff to put tights on.

During our inspection we noted some people's bedroom doors were locked. The manager told us some people requested their bedroom door was locked when they were not in their room. They explained staff locked the room for them and opened it for them as and when requested. One person we spoke with said they would like a key to their bedroom. The manager and management consultant told us they were aware some people would like to have their own key to enable them to lock their bedroom doors. They said they were currently reviewing how this could be facilitated to ensure this choice was available for everyone as well ensuring staff were able to access people's bedrooms quickly, for example, in the event of a fire. On the third day of our inspection the manager told us this person had been supplied with a key to their room.

Staff offered people choices throughout the day. People were prompted to choose where to sit, what they would like to eat and drink and the activities they wanted to participate in. During the afternoon, the care co-ordinator asked people what film people would like to watch, engaging in conversation with people regarding the options available. On the afternoon of the second day of our inspection two staff were sat at the dining table writing in people's records. A person spoke to the staff and the staff member responded promptly, asking if the person wanted to participate in an activity or if they wanted to move and sit in an easy chair. The person decided they wanted to move to sit in an easy chair; the staff member went to get a

wheelchair and supported the person to move. The staff member chatted with the person during the task in a caring, friendly manner.

Information in the communal areas was current, for example the clock was at the correct time and the whiteboards gave the correct day and date. This is important, particularly for people who are living with dementia, to enable them to rationalise daily routines, for example, meal times.

During our last inspection we found records relating to people's care and support were left in the dining area. On this visit we found people's records were no longer in public areas. This ensures personal information cannot be accessed by unauthorised people. We asked a member of staff about confidentiality and they told us confidential phone calls were taken in the office or treatment room. Staff were aware not to discuss confidential information outside of the home. These actions reduce the risk of confidential information being disclosed inappropriately.

Requires Improvement

Is the service responsive?

Our findings

Our inspection in 8 and 22 February 2016 and 17 March 2016 found the registered provider had failed to ensure people were provided with and supported to participate in meaningful activities which met their needs and reflected their personal preferences. People's care plans were not person centred and did not accurately reflect people's needs.

The management consultant told us they had spent a lot of time improving people's care records and related documentation, including information related to medicines management, food preferences and activities. They said the care plan for one person had been completely overhauled and sections of other peoples had been reviewed and updated but added, "There is still a significant amount of work to be done. I want them to be accurate, if it's not right, then it's pointless."

We looked at the care plan for one person whose records had been re-written by the management consultant. The file was neat, well organised and provided consistent information about the person's needs and preferences throughout the document. The care plan was also detailed and person centred, for example, 'I like to wear my jeans with a belt' and 'staff to put two sets of clothes out for me so when I get up and am ready to get dressed, I can choose from these.'

There had also been changes to how staff recorded their review of people's care plans. The review sheet in two of the care plans we looked at recorded which care plan had been reviewed, along with the outcome. This meant there was a clear record of the care plans which had been reviewed.

During our last inspection we found records relating to people's bathing and showering were erratic and not person centred. During this inspection we reviewed the personal care records for eight people and found the recording standard had improved since our last inspection as records were dated and people's names written on them. There were also significantly fewer gaps where staff had not signed to indicate if the care had been provided. However, the records were tick box and did not indicate if people had received a bath or a shower, or if they had refused personal care. We noted one person who had a slightly unpleasant odour. The manager explained and we acknowledged, this person was frequently resistive to personal care intervention, however, there is a need for staff to ensure the dignity of this person is maintained. There was no record from 1 to 19 October 2016 to indicate this person had been offered, received or declined support with washing, bathing or showering. The manager also told us they had become aware that people's daily care records were not always being completed by the staff member who had provided the care. They told us they had spoken with staff and taken action to address this immediately. It is important people's records are an accurate reflection of the care and support people have been offered, provided and where appropriate, declined.

Prior to the inspection we received information regarding two people who were not being supported to access the toilet during the day and were left sat in easy chairs for extensive periods of time. We reviewed the documents completed by staff to record the position changes for these two people but they did not record when staff had supported them to the toilet during the day. This meant we were not able to clearly

evidence this aspect of their care, however, we did observe staff assisting one of the people to access the toilet in the afternoon. We discussed our findings with the management consultant and the manager during our visit to the home.

During the time we spent at the home we saw people engaged in a variety of activities which included painting, knitting, playing games, listening to music and watching films. We saw these activities were offered to individuals, for example we saw one person knitting and another person painting. We reviewed the records relating to activities and saw this evidenced regular activities were provided including family visits and outings; for example, one person went with staff to the local town to purchase some footwear. We saw an entry where staff had recorded another person would like to go to church, there was a further entry which showed staff had facilitated this, '(person) really enjoyed church on Wednesday'. We saw staff also recorded where people had not enjoyed an activity, for example '(person) not really interested in arts and crafts sessions' as well as the activities they had appeared to enjoy. This information is important, particularly where people are living with dementia and may not always be able to verbalise their likes and dislikes.

When we reviewed one care plan we saw their relative had raised a concern about their family member was not receiving a satisfactory standard of support with their personal hygiene needs. The care plan recorded a discussion with the relative and the management consultant to discuss this issue, the management consultant also told us about the meeting with the relative and said they were currently monitoring this person to ensure the issue was resolved.

We reviewed the complaints file. We saw a log of complaints had been implemented by the management consultant which recorded the complaints received from May 2016 onwards. There were a total of five complaints logged; three were in regard to concerns about the laundry service. The manager said that as a result the registered provider had agreed to increase the laundry cover from five days to seven days. This showed that where a theme had been identified action had been taken to address the concerns.

Requires Improvement

Is the service well-led?

Our findings

Following our inspection in 8 and 22 February 2016 and 17 March 2016 we took enforcement action and placed the service in special measures. The purpose of this inspection was to see if significant improvements had been made and to review the quality of the service currently being provided for people.

The Croft Care Home had a registered manager in post but they were not present during the inspection. An external management consultant and a manager, who had recently commenced employment with the registered provider, were present on each day of the inspection. The management consultant told us the registered provider had commissioned the support of an external management consultancy company to facilitate the necessary improvements at the home. They said the home had received a significant amount of input from them and another management consultant over the previous weeks and this was still on-going. The registered provider had also brought in an experienced care co-coordinator from another service to provide additional support for the home.

At this inspection we received positive feedback about the impact the new management were having. One staff member said, "(Manager) seems good, they is here a lot and they listen to you." Another member of staff told us, "Things are much better. They (management) are dealing with things. It's a joy to come to work now. Some staff don't like being managed. We are having a few who are leaving or off sick, but we are getting new staff in."

The management consultant, manager and care co-coordinator demonstrated an understanding of the regulatory requirements to which care homes should operate and they also verbalised a desire to ensure people received a high standard of care from skilled staff. The manager said, "It's important staff feel valued; there is nothing worse than staff feeling undervalued."

The management consultant said the policies for the home had recently been reviewed and updated. They said polices were available in the office, and over the coming weeks staff would be encouraged to refresh their knowledge and understanding of relevant policies.

We reviewed the audits which had been competed at the home. This included a number of observational audits regarding peoples dining experience and 'respect and dignity' audits which had been carried out during August and September 2016. These evidenced observations of good practice and where there was still areas requiring improvement. However, from the comments on the audits, for example 'residents waiting a long time to be served' and ' no variation of portion size', and our observations during the inspection, we were able to evidence the progress that was continuing to be made in regard to this aspect of the service.

We asked how matters relating to the home had been communicated with staff and people who lived at the home. We saw staff meetings had been held in May, June, July, August and September 2016; these had involved the registered provider and the management consultant. There had also been a relatives' meeting held on 25 August 2016 and a further one was planned for 22 November 2016. Meetings enable information

to be shared with staff and people who use the service and also provide an opportunity to gather feedback about the quality of the service provided to people.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for the registered provider to display ratings of their most recent inspection. When we looked at their website we saw no information provided for people to enable them to see the most recent rating by CQC of the service performance. This was brought to the attention of the registered provider.

During this inspection we found significant improvements had been made to a number of areas, including medicines management, people's meal time experience, the provision of activities and the attitude and approach of staff to the people they supported. However, as evidenced within this report there are still areas where improvements were still needed, for example, assessing risk and care planning documentation. Due to the relatively short time frame since the last inspection, we were unable to evidence the improvements were truly embedded and standards of care delivery were consistently maintained. Future inspection will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance are reflective, transparent and robust.

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 12 HSCA RA Regulations 2014 Safe care and treatment Peoples care and treatment was not always provided in a safe way.