

Croft House (Care) Limited

Croft Dene Care Home

Inspection report

Threap Gardens, Off Simonside Avenue
Howdon, Wallsend
Newcastle upon Tyne
NE28 7HT

Tel: 01912633791

Date of inspection visit:
31 May 2017

Date of publication:
25 July 2017

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

This unannounced focussed inspection took place on 31 May 2017. We previously inspected the service on 9 and 10 November 2016 where we identified that the provider was in breach of three of the Health and Social Care Regulations in relation to the safety of the premises and equipment, dignity and respect and governance. We also made recommendations about the design and décor of the home, the records related to best interest decision making and activities provision. At this inspection we found some improvements had been made but not enough to ensure compliance with the statutory requirements.

Croft Dene is a residential care home situated in Wallsend. It provides accommodation, personal and nursing care for up to 42 people with physical and mental health related conditions. At the time of our inspection 28 people lived at the service and five people were staying on a short-term basis.

A care manager was in post who managed the service on a daily basis but they were unavailable when we visited. The registered manager of the service was present. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We undertook an observation around the home to look at the safety issues which had been highlighted to the management team at our last inspection. We found that some action had been taken and checks were carried out around the premises; however we found these were still not robust enough to ensure compliance with the regulations. Several serious safety issues remained at the home which had either not been entirely addressed or not been monitored to ensure the staff complied with the instructions given to them by the management team.

The issues we previously found which related to the management of medicines had been addressed. We saw that the nursing staff and senior care workers took a consistent approach to managing medicines throughout the home. There was an updated medicines policy and procedure in place. We found no issues with the storage, receipt, administration, disposal and recording of medicines.

The provider had told us in an action plan that the care manager carried out daily, weekly and monthly checks on the quality and safety of the service and reported her findings onto the registered manager. We were only given evidence of monthly manager's reports. Although these checks had taken place they had not been robust enough to identify the on-going concerns we highlighted during our visit. The registered manager took immediate action to rectify the safety issues we highlighted. After our inspection the registered manager and provider gave us their assurance that the leadership and governance shortfalls within the service would be promptly addressed.

We received mixed feedback from staff, people and relatives about the leadership of the service. Some staff felt supported by the management team but equally there were staff who did not feel supported or valued

by the management. People and relatives told us further improvements were still required.

The management of complaints had not been sustained since our last inspection. We reviewed the last 10 recorded complaints and saw there was no acknowledgement or outcome letter sent to the complainants. Some investigation notes had been made in response to complaints but there was a lack of written evidence to suggest the procedure had been properly followed. A suggestion box was in place in the foyer to acquire feedback from people, relatives and staff, but their overall opinion was that they were not generally listened to.

There was an activities coordinator employed at the service. We saw information on display about planned activities but we noted this didn't reflect what had been arranged the week we visited. People, relatives and staff told us that activities still needed much improvement. We found there was a lack of meaningful and stimulating activities taking place on the day we visited and the planned activities had not always gone ahead. Records related to people's participation in activities were brief, unorganised, not up to date and had been unsuitably stored.

The upper floor of the home was designated for people living with dementia or related health conditions. The provider has recently employed a clinical lead nurse to oversee dementia care. They were not available on the day of inspection but we saw progress had been made towards improving the design and décor of the environment and the registered manager told us that the clinical lead nurse led most of the activities on the upper floor.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of most people to restrict their freedom in line with the Mental Capacity Act 2005. All staff demonstrated an understanding of the MCA and worked within its principals.

A roast dinner was prepared at lunchtime; we saw some people had asked for a lighter alternative which they were given. The food appeared appetising and well balanced. Special diets were catered for and the cook was familiar with people's dietary needs. People appeared to enjoy their food but spoke of previous dissatisfaction. The mealtimes we observed still lacked an opportunity for stimulation and socialisation and the dining rooms were not dressed consistently with a homely appearance. We have made a recommendation about this.

We saw care workers treated people with dignity and respect whilst assisting with personal care and at mealtimes. All staff had received formal supervision since our last inspection and had been made aware of our findings and the importance of ensuring people's dignity was always protected and promoted. Staff displayed kind and caring attitudes and people told us the staff were nice to them. People enjoyed a good relationship with the staff and it was apparent they all knew each other well.

Support plans had been improved and they were person-centred, thorough and up to date. We examined three individual care records in detail and reviewed four others. We did not find any issues with the care records. Care needs were assessed and reviewed as necessary. Individual risks which people faced in their daily lives had been assessed and preventative measures were in place to minimise the possibility of an incident occurring.

People told us they felt safe living at Croft Dene. Most relatives confirmed this. One relative raised concerns about the safety of the premises and of the care their relation sometimes experienced. The provider and registered manager were aware of this and a satisfactory resolution was on-going. Staff were trained in the

safeguarding of vulnerable adults and they were able to demonstrate their awareness with regards to protecting people from harm and abuse. Updated policies and procedures were in place to support staff with the delivery of the service.

Accidents and incidents continued to be recorded, investigated and monitored. Actions taken to reduce the likelihood of a repeat event were recorded. All incidents had been reported to external agencies as necessary. The information was analysed to track trends throughout the provider's organisation.

Most people and relatives told us that the staff responded quickly to them when called upon but felt there was not enough staff employed at the service. We heard a lot of comments about sporadic staff shortages. Care staff told us that in general they did not feel hurried in their duties and were able to meet people's needs in a timely manner. Staff continued to be safely recruited, trained in topics relevant to their job and had their competence regularly checked. Formal supervision and appraisals were carried out with staff to support them in their roles.

We have identified two on-going breaches and two further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 always safe.

Multiple safety issues still remained following our last inspection which posed an immediate risk to people's health and safety.

People told us they felt safe living at Croft Dene. Policies and procedures were in place to support staff to care for people appropriately.

Staff were safely recruited and deployed as necessary to meet the needs of the service.

Medicines were managed well and consistently throughout the home.

Is the service effective?

Requires Improvement 

The service was not always effective.

Mealtimes had not been suitably improved. They still lacked an effort by staff into making the experience positive and sociable.

Some improvements had been made to the design and décor of the home to create a dementia friendly environment. Further improvements were necessary to meet with best practice guidance.

Decision's made in people's best interests were recorded in line with Mental Capacity Act and staff worked within it's principals.

Staff were trained and received support in their role to maintain competency and people had access to external professionals to maintain their health and well-being.

Is the service caring?

Good 

The service was caring.

All staff acted professionally and were helpful and friendly, displaying a kind, caring and considerate attitude.

Staff knew people well and were able to tell us about people's life histories, preferences and routines.

Information, advice and guidance was available to help people find other services which may benefit them.

End of life wishes were respected in order to provide continuity of care when people's needs changed.

Is the service responsive?

The service was not always responsive.

Despite an established complaints process being in place, it had not been maintained. There was a lack of evidence to demonstrate that complaints had been responded to and acted upon.

The activities provision within the home still did not provide people with stimulating and meaningful activities which met their individual needs. The service had not actively addressed the previous issue in order to promote socialisation and inclusion amongst all people.

A person-centred, holistic approach to people's social care needs was not always provided.

Care records were improved. We found them to be thorough and up to date with the exception of records related to activities.

Requires Improvement 

Is the service well-led?

The service was not well-led.

A registered manager was in post and present however she was not usually based at Croft Dene. The care manager who took day to day charge of the service was not available.

Some audits and checks of the quality and safety of the service had taken place however they were still not robust enough to address the safety issues we highlighted. We found many concerns remained unaddressed or ineffective monitoring meant improvements were not sustained.

Recommendations from our previous inspection had not all been fully implemented.

There remained mixed opinions from people, relatives and staff about the management and leadership of the service.

Requires Improvement 

Croft Dene Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 31 May 2017 and was unannounced. The inspection consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Croft Dene Care Home, including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

During the inspection we spoke with eight people who used the service and three relatives to gain their opinion of the service. We spoke with nine members of staff, including the registered manager, an administrator, two nurses, one senior care worker, three care workers and an activities coordinator. We spoke with the provider after the inspection. We reviewed a range of care records and the management records kept regarding the quality and safety of the service. This included looking at three people's care records in depth and reviewing four others.

Is the service safe?

Our findings

At our last inspection we identified a breach of Regulation 12 entitled, Safe care and treatment. We highlighted multiple safety issues with the premises and equipment to the registered manager and provider. We also had concerns about the management of medicines.

At the beginning of this inspection we undertook a tour of the home. We found several immediate risks to people's safety which were repeated from our last inspection. For example, emergency pull cords which should hang to the floor were propped out of reach. Rooms such as housekeeping cupboards, equipment storage rooms and the activities room were left unlocked or unattended for long periods of time. This meant people (who were unsupervised at times and many of whom lived with dementia) remained at risk from hazardous chemicals and dangerous equipment and they may not have been able to summon help in an emergency.

In the communal kitchenettes, we found three hot kettles (some of which still contained boiling water) had been left unattended on the bench. This meant people were at risk of scalding. We also saw bottles of 'extra-strength washing up liquid' were accessible on kitchen benches or stored in unlocked kitchen cupboards. Staff had continued to use these areas to store their own food. These items were not locked away and there were open foodstuff which was not labelled in the fridges and cupboards. Many items in the fridges were out of date. Further items such as 'Thick & Easy' thickening powder and 'Pro-Cal' which were individually prescribed for people who needed nutritional support were left unattended on the kitchen benches. This meant people continued to have further access to hazardous chemicals and could access food items or powdered supplements which could potentially cause them harm through the risk of choking, allergies or being out of date.

One of the new 'touch-free' pedestal bins was not working and this had not been reported to the management. Staff had continued to use the bin by lifting the lid with their hands which could potentially cause cross contamination and increase the spread of bacteria to food, crockery and cutlery.

Additional safety concerns were also raised at this inspection. An external fire door from a downstairs dining room had been propped open by staff with a plant pot. This meant the security of the premises was compromised and left the people who used the service and their belongings vulnerable, as strangers could enter the building without the staff knowing. People could have also wandered out of the premises into the car park and street. We observed items which had been left unattended on the floor posed a trip hazard. For example a large pile of flattened cardboard had been left in a main corridor and a large screen TV had been left in a communal bathroom.

We found an upstairs dining room was unkempt at 11:30AM and had not yet been cleaned after breakfast. Food debris was found on the floor and in a kitchen cupboard. Lids had been left off the plastic containers used to store dry cereals and a large tub of 'fish food' flakes had been left unattended. Again, this meant people were at risk of harm from slips, choking and food which was unsuitable for consumption.

In the absence of the care manager, nobody had taken responsibility for ensuring all checks on equipment were continued. We noted that checks on locked doors, bins, windows locks, nurse call, profiling beds, pressure mattresses, slings, bath lifts, kitchen equipment and wheelchairs had all fallen slightly behind.

This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safety of the premises and the equipment.

We previously raised concerns about the consistency of how medicines were managed throughout the home. We found these concerns had been addressed. We observed the treatment room on the upper floor and reviewed four medicine support records. We noted a consistent approach had been adopted throughout the home to the documentation and the nurses on duty demonstrated full awareness of their responsibilities. There were no issues with the ordering, receipt, storage, administration or disposal of medicines. We also found that medicine records were comprehensive and up to date.

At our last inspection, the provider needed to arrange the repair of two gas boilers in the home. At this inspection, the registered manager told us all of the gas boilers had been replaced for brand new models. Tests of the electrics, water and fire safety equipment were all up to date.

We asked people if they felt safe living at Croft Dene and with the staff who support them. Their responses included, "Certainly I do", "Yes I think they're [staff] quite good", "Oh definitely can't fault the staff", "I think they are good the staff, but they could do with more really", "As far as I can I suppose" and "Yes they're [staff] good." Most relatives agreed. One relative told us, they were still not satisfied about the responses they had received to their concerns about safety.

Staff were aware of safeguarding procedures and were familiar with the company whistle blowing policy. At our last inspection we followed up on a number of concerns raised anonymously with CQC and saw these had been addressed. We had not received any further anonymous calls. The safeguarding policy remained in place and the staff demonstrated an understanding of their own responsibilities towards protecting people from potential harm.

Accidents and incidents continued to be recorded, investigated and monitored to minimise the likelihood of a repeat occurrence. Appropriate action had been taken and the management had notified the relevant external agencies as necessary.

The care manager, nurses and senior care staff continued to assess the risks individuals faced in their daily lives. Care records were up to date with information about people's mobility, nutrition and behaviour for example. This meant the service had recognised individual risk and ensured steps were taken to meet people's needs in a safe manner. Personal Emergency Evacuation Plans (PEEPs) were up to date, but a fire drill had not taken place since March 2017.

The care manager had demonstrated that staff were safely recruited. Staff who had been employed since our last inspection had been subject to the relevant pre-employment vetting checks and references.

The management had kept the service dependency tool up to date. We did not see any issues with staffing levels during our visit (except at mealtimes) and the number of staff on duty matched the dependency tool results. However, there remained mixed opinions about the home being short staffed. One member of staff felt that some of the safety issues had arose that day because she was too busy to do everything she was expected to do. She explained that she was working on shift with a senior care worker from an agency and felt pressurised into assuming more than an equal responsibility for the tasks. Comments from people

included, "Just lately when I go to bed they just haven't taken notice of me, I say can you put me to bed please? They say can you wait a few minutes then I have to buzz again, this is just happening lately (in the last month). I used to love the place, it's just gone downhill, if they haven't got enough staff they shouldn't bring other people in" and "I wait about at least 15 to 20 minutes, could be dead half the time, it happens all the time. I know they have other residents but they should cater for all this." Other people told us, "Yes they come pretty quickly, they can't just down tools, you've got to use your loaf don't you" and "Yes, never have to wait long."

Is the service effective?

Our findings

At our last inspection we made a recommendation about the design and décor of the premises and in particular to creating a dementia friendly environment on the upper floor. At this inspection we found the provider had made some progress towards this. They had employed a clinical lead nurse who was responsible for overseeing dementia care. Although they were not available on the day we visited, we could see some improvements which they had made to the environment. The registered manager told us the clinical nurse lead led most of the activities on the upper floor and followed best practice guidelines. However, we noted that menu boards and 'date' blocks on display around the home presented the wrong information which was meant to familiarise people with daily life. Further work was needed to ensure that the service followed best practice guidance.

We observed mealtimes during the inspection and we found that insufficient improvements had been made to make the experience more positive and stimulating for people. Tables were not consistently dressed throughout the home to make all of the dining rooms attractive and homely. Some tables lacked condiments and cutlery. In one dining room there were no beakers or glasses available for the staff to serve the juice and we saw they poured the juice into teacups. Staff were preoccupied with the tasks they had to complete and lacked the time to socialise and interact with people properly.

We recommend the provider refer to NICE guidance regarding positive mealtime experiences for people living in residential care.

There were mixed comments about the food. One person said, "It's nice I enjoy it, there's just enough" another told us, "It's rubbish and cheap." We saw there was only one option of a roast dinner on offer which consisted of meat, mashed potatoes and vegetables but we saw the cook had prepared lighter alternatives for people who did not want the main meal. People were given the choice of a small or large portion and there was plenty of food available which smelled nice and looked appetising. We asked people about the food and the choices available, they told us, "Not really [much choice], it's usually edible there's nothing wrong with that, but it's not always what I would like", "For what food they have yes [it's nice], but they have very little choice", "They do ask the day before", "Generally they ask me if I want some more" and "Very little choice, don't like salad I'm a meat person."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we made a recommendation that the provider should undertake a review of the records related to best interest decision-making and ensure all staff worked within the principles of the MCA.

At this visit, we checked the records related to best interest decisions and we found that the service had improved this aspect of the service. All staff worked within the principals of the MCA.

Staff training was up to date and the new staff had been enrolled on a robust induction programme. The management continued to support staff in their roles with regular supervision and annual appraisal. Competency checks were carried out to ensure staff remained suitably skilled for their role. Staff told us, "We get supervision every three to six months", "We've had a few lately" and "I've had more than I should, I've had four since I've been here. I ask for them if I get frustrated, I do it this was so it is recorded."

Staff meetings had still not taken place as often as expected, however all staff had been briefed following our last inspection and our findings had been discussed with them. Care staff handover meetings took place on a twice daily basis to ensure staff were notified of information about people's daily needs as well as appointments and issues. Daily notes remained detailed and up to date. This meant effective communication between all of the staff who cared for people had been sustained.

People continued to have access to external health and social care professionals to support their general well-being. Care records showed that people regularly saw their GP, dentist, optician and social worker. Relatives told us that in general they had no concerns about healthcare referrals but two relatives gave an example when this had not happened as quickly as they would have expected.

Is the service caring?

Our findings

At our last inspection we identified a breach of Regulation 10 entitled, dignity and respect. We reported on specific examples of interactions we witnessed between non-care related staff and people who were diagnosed with dementia. The provider and registered manager had taken immediate action to address these issues and the matter was rectified.

During our visit, we observed all staff spoke nicely to people and they treated people with respect. Staff showed that they protected and promoted people's dignity and that people were given privacy as necessary. People told us the staff were lovely. Comments included, "They've got some lovely staff here", "They are very polite", "They treat me well", "They are down to earth and you can have a good laugh with them" and, "It's the staff that keep me here." However, people also told us and we observed on occasions that staff were focussed on tasks and did not have the time to sit and talk with people for any meaningful lengths of time. This meant that people were not always at the centre of the care they received, such as at mealtimes or during activities.

Staff treated people as individuals and respected their individual preferences which were recorded in care records. We observed staff considered people's differing needs and abilities when going about their duty. One person told us, "There is no favouritism in here" and another said, "They are all respectful, that's one thing I can say." Staff demonstrated that they knew people well and we saw that people's needs were met in a way which reflected their personal wishes and choices.

We spoke with five members of care and nursing staff about individual people's care needs and they told us about people's life histories, their preferences and their likes and dislikes. The staff clearly knew the people they supported well. There were 'Thank you' cards and compliments on display around the home.

Information, advice and guidance was on display around the home which would benefit people who need or use adult health and social care services. The care manager had designated some 'champion' roles to staff members and information about this was on display. For example, there was an infection control 'champion' whose responsibility it was to promote best practice and share new initiatives with staff to increase their knowledge and awareness in this topic. An up to date service user guide and statement of purpose was available to people and relatives which provided information on the service and what can be provided.

People's personal data and sensitive information continued to be stored securely in an office. Staff maintained people's confidentiality and spoke discreetly to us and their colleagues when necessary. We noted that records relating to activity provision had not been securely maintained and this could have potentially led to a breach of confidentiality.

There was no-one who used the service accessing an independent advocate. Most people had family or friends who acted on their behalf. Any legal arrangements were recorded in care records to ensure staff knew who had the legal right to make decisions on people's behalf. An advocate is a person who represents

and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

There was no-one currently receiving end of life care although people were living with terminal illnesses. We saw in care records that staff had asked people and their relatives (where appropriate) to consider sharing their end of life wishes to ensure that the service could continue to care for people as they would prefer when they may no longer be able to communicate those wishes themselves or in an emergency situation. Advanced care planning, emergency care and resuscitation preferences were documented. Some people had decided not to share this information and that was recorded and respected.

Is the service responsive?

Our findings

People told us they knew how to complain. They said, "Oh yes, I'm very verbal", "Yes, I would tell them" and "Yes you can tell them but it won't do any good, they don't take any notice." We were given examples of when and why people had complained. One person told us, "It was dealt with as best they could, it wasn't very good, I wasn't happy how things were said and done but I just gave up they always win with you." Another person told us, "Some changes were made as a result [of my complaint] for a short while, and then it reverts back to normal." We spoke with two relatives who had made complaints and they told us they had not been satisfied and were awaiting further outcomes. They told us responses from the management had not been timely.

The complaints policy and procedure had not been fully adhered to. We noted that the process we saw at our last inspection had not been maintained. We reviewed the last 10 complaints made to the service and found that no acknowledgement or outcomes letters had been communicated in writing to the complainants. We saw some notes had been made to show that an investigation had taken place but these were mainly handwritten and brief. There was some evidence that the care manager had spoken to staff and sometimes relatives but the formal complaints procedure had not been followed in line with the company's policy. We were unable to ascertain whether actions had been taken and outcomes achieved. Where no action was taken, the reasons for this were not recorded. This meant the provider was unable to demonstrate compliance with the regulations and verify that people had been responded to and their complaints had been acted upon in order to improve their service.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to, Receiving and acting upon complaints.

At the last inspection, we recommended that a thorough review of the activities provision was undertaken in order to provide meaningful activities which encouraged people to socialise or pursue hobbies and interests. We found that this had not been achieved when we revisited.

People told us that the activities provision still required improvement. Comments included, "I don't think there's much on at all," "I haven't noticed any activities like bingo or dominoes or I would join in," "I'm never asked if I want to go out" and "I stay in my room, now and again they ask me and on a Tuesday two ladies used to come and do baking and they don't come now." One relative said, "Don't know [about activities], she played bingo the other day but I don't know about anything else, she doesn't mix very well, that's the trouble." Another said, "I have seen occasionally CD's playing in the lounge and sing-a-longs, 95% [of the time] its TV in her room, there's nothing dedicated to my relative." A third relative told us, "There are lots of activities but she doesn't pursue them, the activities coordinator does do one-to-one."

People told us they did not get taken out much unless they went out with their family and nobody could recall taking part in a one-to-one activity which met with their own hobbies and interests. People said, "There have a little something on but to tell you the truth, I don't go, it's not my sort of thing", "There is nothing that I know of but I never go into the lounge" and "I don't do anything." When we asked people what

they normally do through the day, comments included, "I do nothing", "I stay in my room", "I snooze in my room" and "I [used to] sit in the lounge, see people in different places but now it's just sitting all the time."

The care staff we spoke with told us, "Sometimes there's a radio on in the corridor and we dance and sing, they love playing with balloons and bats. The activities coordinator does little bits and bobs", "There isn't a lot of activities carried out throughout the home and no individual activities", "They do nothing really. Sometimes there is a little something on upstairs but they just get forgotten about, like they don't exist" and, "There's a resident trying to get out all of the time and he needs one to one because he is bored. Management are aware of it but nothing has happened so far."

We saw a plan of the activities for the week on display on the wall, but people and staff told us this had not taken place as scheduled. We noted that some of the activities planned for the week had not gone ahead. We saw the activities coordinator was on duty and we observed them providing one-to-one feeding assistance at lunchtime in people's rooms but we did not see them conducting any stimulating and meaningful activities. We briefly saw them reading an article from a book or magazine to a small group of people and there was an external church group visiting the home. We saw they spoke with a small number of people in the downstairs lounge.

We reviewed the activity information and the records kept to demonstrate people had participated in social events or one to one sessions. We found that it was not person-centred and it did not meet with each person's individual needs. The activities coordinator had not been involved in evaluating social care plans but had maintained some notes about participation. We found these notes to be unorganised, brief and not up to date. We were also told that these records had been taken home by the activities coordinator and therefore had not been stored securely in line with the provider's policies related to people's personal data.

Care plans and assessments had been regularly reviewed and were kept up to date if changes occurred. This meant staff could respond to people's health and personal care needs in a manner which was unique to each individual. However a holistic approach to people's overall needs was not always achieved, for example, social, emotional, cultural, religious and spiritual needs were sometimes overlooked. Staff told us, "We try our best to give them the needs they want and deserve." Another said, "In some cases, we can be flexible [to meet people's needs]" and a third said, "They're not [flexible], I don't think we can meet some people's needs."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to person-centred care.

We had previously found that although care records were in the process of being reviewed and updated when we last visited, attention to detail had not been comprehensively applied which meant the records we reviewed at that time contained inaccuracies and still lacked sufficient detail about each person.

At this inspection we examined three care records in detail and reviewed four medicine records. We did not raise any issues with care related record keeping. People's individual healthcare needs had been assessed and a care plan was in place. Any risks associated with those needs had been assessed and recorded with preventative measures and instructions for care staff in the event of an incident. These records were person-centred and contained personalised information about people's wishes and choices. We found no inaccuracies within these records. Staff were able to tell us about people's healthcare needs, the care which they delivered and what they told us matched the information in records.

Is the service well-led?

Our findings

The care manager who managed the service on a daily basis was not available during our inspection; they had not yet completed the application to become the registered manager of the service despite starting the process over 12 months ago. The existing registered manager of the service was present although she was not usually based at Croft Dene. The management team had not changed since our last visit. The registered manager had accepted legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

We asked staff about the leadership of the service. We asked them if they felt supported. Their comments included, "Management don't really support you, but the nurses do", "No definitely not, just doesn't matter what you go to see them about, I just do my job and go home" and "Not all the time." We asked staff if there were clear and consistent messages from the management team. They told us, "No, sometimes it's do this, do that, then the next day it's, what did you do that for", "No, I suppose there is sometimes but not all the time" and "Yes it is clear that it is there way or no way." We also asked staff if they felt they could approach the care manager with any concerns. They said, "Yes, but whether they'd be addressed is another matter, we've been on about the food and [care manager] doesn't listen" and "I feel that [care manager] is approachable but don't feel they'd all be addressed."

We also asked the staff if they felt the service had any areas for improvement. Unanimously, all the staff we spoke with named, food, activities and staffing levels as the most important areas for improvement.

Overall, people and relatives spoke of dissatisfaction with the service. People told us they were bored and that any comments they had made to the management had been dismissed or had only improved for a short while. We asked people if the care manager came to see them often, four people said no and one person said, "If she has a reason, yes I suppose." We asked people if they had met the senior management team. Three people said no and one person said, "They do come in but never talk to the residents."

Four people told us that 'resident' meetings were held often. One person told us they had been to a few meetings and three people told us the meetings happened but they didn't like to go. We asked people what they would change about the service to make it better, one person said, "The whole lot, I wouldn't know where to start, they need to change quite a lot, get right staff on and pull it back to normal", another said, "They need to change the manager and the cook."

There was a suggestion box in the foyer for people, relatives and staff to post anything they wished to raise in confidence with the management. We saw these suggestions were reviewed by the management team, however through our discussions with people, relatives and staff we found that they did not feel listened to or valued. People couldn't recall receiving a satisfaction survey about the service. One person said, "I don't think I've ever had a questionnaire", another person said, "No, don't get asked a thing." A member of staff told us, "I've raised issue about the food, not really listened to in particular, listened to at the time but it's still the same now." Another said, "I hope so, I've raised something today and if it doesn't get sorted I will take it higher."

Staff meetings had not been carried out periodically, this meant staff had not had an opportunity to raise and discuss issues which might affect them all and they did not have the opportunity to share their experiences and resolve issues together as a team. Daily handovers took place between care staff to ensure people's needs were met.

The provider told us in an action plan that the issues and concerns we raised at our last inspection had been addressed. They told us that the care manager completed daily, weekly and monthly checks on the quality and safety of the service. At the inspection we were only provided with evidence of a monthly manager's report which included checks of the service and premises. We found that these reports had not been effective enough to comprehensively monitor the improvements which needed to be made. We considered that the provider's action plan which had been created in conjunction with the care manager and registered manager had not been robustly monitored to ensure adequate oversight of the service and that actions identified were not being fully carried out to address the issues raised.

Provider monthly audits had taken place. Although they didn't find any safety issues on the day of their audit, the lack of monitoring between audits on a daily basis meant that staff did not always follow the safety instructions on a routine basis. This was evident on the day of our unannounced inspection because several safety issues were immediately noted such as the fire exit propped open, the housekeeping and activities cupboards unlocked and the hazards in the kitchenettes.

The governance of the service had not been improved or sustained in other aspects of the service. The provision of activities had not been addressed in line with the recommendation we made at our last inspection. We found there remained a lack of stimulating and meaningful activities. We observed that people were not fully engaged with the activities coordinator and activities were not always carried out as advertised. The record keeping related to people's participation in activities was brief, unorganised and not up to date. The records had also not been stored securely and had to be collected from the activities coordinator's home in order for us to review them.

Complaints had not been managed well recently. The records related to the management of complaints were not robust and there was no clear evidence that complaints had been responded to and acted upon.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance.

During the inspection we discussed our findings with the registered manager and brought several issues to her immediate attention which she promptly addressed. We later spoke with the provider to discuss the inspection. They assured us that immediate action had been taken to address the safety issues and an intermediate action plan had been drafted to respond to the shortfalls, governance and leadership of the service.

Since our last inspection the management team had addressed some performance issues amongst the staff and had shared our findings with them in formal supervision. This meant the staff were aware of the actions which were necessary to improve the service. We saw there had been improvements to some aspects of the service, premises and equipment.

The provider had enlisted the assistance of an external company to conduct a thorough audit of the service following our last inspection. The registered manager told us the external audit had provided a comprehensive report and action plan for the care manager and management team and they shared this with us. We saw the external company had identified some similar issues and they had provided advice and

guidance on how to address these.

Staff told us that they did enjoy their job. One said, "I love working with the residents, I wouldn't be here if I didn't. It's just not the kind of job you can leave behind when you go home." They told us they thought people got a good service because the care workers were "good", "caring", "polite" and "loving." One said, "I think people like me because I have a good sense of humour" another said, "I make sure to the best of my ability that I give 110%, but you have to prioritise and while doing that someone else is going without."

We asked people what the service did well. One person said, "Basically everything", another said, "They count my money for me" and a third said, "Looking after you and keeping you clean."

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider had not always ensured that a person centred assessment was undertaken to meet all of the needs people may have. At times, social, emotional, cultural, religious and spiritual needs were overlooked.</p> <p>Activities were not always provided to all people based on their individual preferences to enable them to pursue their interests and hobbies. Evaluations and reviews of these needs were not always carried out to ensure goals were met and still relevant. Records were not maintained well.</p> <p>Regulation 9 (1)(2)(3)(a)(b)(c)(d)(e)(f)(g)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The company complaints policy and procedure had not been fully adhered to as there was not always an acknowledgement or outcome letter sent to the complainants. Due to the lack of written evidence we were unable to ascertain whether actions had been taken and outcomes achieved. Where no action was taken, the reasons for this were not recorded. Although there was a system in place it had not been effectively operated to ensure compliance with the regulation.</p> <p>Regulation 16 (1)(2)</p>

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way. The provider had not ensured that all risks to people's health, safety and well-being were mitigated against. Environmental and premises risks remained, some of which were a serious concern for people who used the service. Regulation 12 (1) (2)(a)(b)(d)(e)(h)

The enforcement action we took:

WN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Although systems were in place and established, they were not operated effectively enough to ensure overall compliance with the regulations. The provider failed to adhere to their own action plan with regards to previously highlighted issues. They had not fully addressed the concerns in order to improve the safety and quality of the service. Governance systems remained ineffective and recommendations about the service at the last inspection had not been fully implemented. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(e)(f)

The enforcement action we took:

WN