Quality Care Homes Limited

Little Croft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 29 June and 4 July 2016. Little Croft provides accommodation and personal care and support for up to 41 older people. This was an unannounced inspection, which meant the staff and provider did not know we would be visiting. At the time of the inspection there were 38 people living at Little Croft.

The previous inspection was completed in June 2016. At that inspection we found a breach of regulation in relation to ensuring people's mental capacity was assessed to ensure they were following the principles of the Mental Capacity Act. This is important where a person lacks the mental capacity, without this information there was a risk that people's rights were not protected. At this inspection we found these mental capacity assessments had been completed for people.

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

People's medicines were not always managed safety. Medicine audits had not identified these shortfalls. Care plans did not always include how to support people with their medical condition such as diabetes. We have asked the provider to make improvements to the audit systems to ensure these shortfalls were identified and addressed.

There were mixed messages from health and social care professionals in respect of the admission process. Assurances were given by the registered manager that they took into consideration the needs of the people already living in the home and the needs of the new person to ensure they could respond to their needs effectively and responsively. There was a staffing tool used to calculate the staffing based on people's needs and this was kept under review. Feedback from people and staff said the home was very busy. They felt people were safe.

People's nutritional needs were being met. Where there were risks to people there were clear plan of care in place. These plans identified the additional monitoring required and how good communication between the care and catering staff would be maintained. However, improvements were needed to ensure that fluid charts were clearer and that any concerns could be rectified where a person had not drunk sufficient fluids.

The home was clean and free from odour. There had been an occasion when a member of staff had not worn the appropriate protective clothing when supporting a person. This had been discussed through supervisions with staff and team meetings as a reminder of the importance of ensuring risks in relation to cross infection were minimised.

People were involved in structured activities in the home. These were organised taking into consideration

the interests of the people and were organised in small groups or an individual basis. People were treated with dignity and respect and were involved in decisions about their care. Whilst improvements had been made in relation to best interest decision recording this was not consistent. Where sensor mats and door alarms were in place more information was needed on who was involved in the decision and why the decision was made. This should be kept under review to ensure they were the least restrictive options.

People were treated with kindness and compassion by staff. The atmosphere was relaxed and we saw that staff knew people well. People appeared relaxed around staff. People's views were sought during care reviews, resident meetings and annual surveys. Complaints were responded to and, learnt from to improve the service provided.

People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse. Staff had been trained in how to follow the procedures. Systems were in place to ensure people were safe including risk management. Safe recruitment practices were in place to protect people.

Staff were caring and supportive. Staff received training and support that was relevant to their roles. On-going training was planned based on the needs of the people such as additional training in wound care management and end of life care. Systems were in place to ensure open communication including team meetings and daily handovers.

We found there were two 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 copy of this 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. People's medicines were not consistently managed safely in relation to recording and, ensuring they were stored at the correct temperature.

People were supported by sufficient staff.

People's safety was taken into consideration in relation to risk management. However, these did not always contain sufficient detail to mitigate the risks.

The home was clean and free from odour. Staff had received training in infection control. However, there had been an occasion when staff had not worn the appropriate protective clothing when supporting a person.

Is the service effective?

Requires Improvement

The service was not always effective this because it was not always clear when a person lacked capacity who had been involved in the decisions to use sensor mats or door alarms.

People were supported by staff who were knowledgeable about their care needs. Staff were trained and supported in their roles.

Other health and social care professionals were involved in supporting people to ensure their needs were met.

People's nutritional needs were met and this was kept under review. Records relating to fluids were not being checked to ensure the person was having enough to drink.

Is the service caring?

Good

The service was caring.

People were cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their approach.

People were actively asked for their opinion about their care

through regular meetings. People's views were listened to and acted upon.

Is the service responsive?

Requires Improvement

The service was mostly responsive to people care needs. Improvements had been made during the inspection to ensure there was clear guidance in respect of the support people may need with their medical condition.

People received care that was responsive to their needs.

People were supported to take part in regular activities in both the home and the community.

There was a complaints policy and procedure in place. People knew how to make a complaint if needed and complaints had been responded to.

Is the service well-led?

Requires Improvement

The service needed to make improvements to ensure their own systems identified shortfalls in care planning and medicine management.

The registered manager was open and transparent.

People, professionals and staff commented positively about the management of the home and were confident they were listened to. Their views were sought to improve the service.

Little 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 an updated rating for the service under the Care Act 2014.

This was an unannounced inspection, which was completed on 29 June and 4 July 2017. The previous inspection was completed in June 2016. There was one breach of regulation found at that time. This was because there was no information in people's care records on whether people had mental capacity or not. The registered manager sent us an action plan stating how this would be addressed. They had taken appropriate action to address the breach.

The membership of the inspection team included two adult social care inspectors and an expert by experience on day one of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was completed by one adult social care inspector,

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

We reviewed the information we held about the home. This included notifications, which is information about important events, which the service is required to send us by law. We received some concerns prior to this inspection from two health and social care professionals and a whistle blower.

We contacted six health and social care professionals to obtain their views on the service and how it was being managed. We received feedback from six. You can see what they said about the service in the main body of the report.

We looked at six people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included staff rotas, training records, recruitment

information for two staff and audits that had been completed.

We spoke with the registered manager, the deputy manager, six care staff, 12 people who used the service and a relative. We also spoke to a further two visiting health care professionals during the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Some people told us they felt there was not always enough staff and they had the impression staff were often busy. Staff told us the staffing in place was alright but it was often busy. They told us people were safe but if there were more staff then more time could be spent talking with people. A member of staff told us that some staff shied away from doing certain tasks, including answering call bells and it was the same staff that usually responded to these. Another member of staff told us they had raised a similar concern to the registered manager because a few staff were "not pulling their weight". They were aware the registered manager was addressing this. This had been discussed at a recent team meeting about the role of staff and the expectations of the registered manager and provider.

Medicines were not always managed safely. We looked at medicine administration records (MAR's) and saw several gaps where staff had failed to sign confirming people had received their medicines as prescribed. The MAR charts had been in use since 26 June 2017 and we noted seven gaps. There was nothing documented to indicate that staff had noted these gaps or taken action to correct them.

MAR charts had several transcribed entries, where staff had handwritten people's medicines. Some of these had been initialled by the staff member who wrote them, but not all, and none had been countersigned. This meant there was nothing to show that the entry had been checked for accuracy by anyone else. The provider's Medicines Management Policy and Procedure stated that transcribed entries for new admissions should be "witnessed and signed by a second person". We note that one of the transcribed entries had the incorrect dose and this was brought to the registered manager's attention and rectified immediately.

Eye and eardrops had not been labelled with the date of opening, despite dispensing labels with instructions such as "discard 28 days after opening". We saw two opened bottles of ear spray and one bottle of eye drops with no date on, which meant there was a risk that staff could administer out of date medicines.

Medicines were stored in a locked trolley and cupboards in a locked clinical room. The room temperature was monitored. However, the temperature had been recorded as 25 degrees centigrade for 11 days during June, which is the maximum recommended temperature for medicines storage. Additionally, on one day, the temperature had been recorded as 26 degrees but there was nothing documented to show what action staff had taken, if any, to ensure the medicines were safely stored. There was no fan in the room and the usual time for checking the temperature was at 7am and so it was not clear how staff could be assured that medicines were always stored at safe temperatures.

Medicines that required refrigeration were stored in a medicines fridge. The temperature was monitored daily Although minimum and maximum temperatures were not logged. The thermometer was inside the fridge and was reading at 9.5 degrees centigrade on the day of our inspection. The recommended temperature for medicines fridges is 2-8 degrees centigrade, which meant there was a risk that fridge items were not being stored safely.

Stocks of medicines were checked, including medicines that had been prescribed on a PRN (as required)

basis. However, PRN protocols were not in place. Although care plans detailed when people had been prescribed PRN medicines and detailed when and why people might require them, this detail was not held within specific protocols. PRN protocols provide information for staff on when and why people might require additional medicines and should also include information for staff on how to recognise when people might need them, for example if people are unable to communicate when they are in pain.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and Treatment.

Controlled medicines were stored safely. Medicines that were no longer needed were disposed of safely. We observed part of a medicines round. The staff member administering the medicines knew people well and took their time with people. They didn't rush them, asked them if they were happy to take their medicines and checked they had swallowed them prior to signing the chart.
Medicine audits were carried out monthly. We looked at these and saw that when issues were noted, the actions taken to address them had been documented. The deputy manager said that the gaps we saw in the MAR charts had been noted earlier that day, but that action had not yet been taken to correct them.

People's response to whether there was sufficient staff was mixed. Comments included, "I don't think there is enough of them on", "There is hardly anybody here", "You get what you pay for" and, "There is always someone around" and, "'Always someone if I need something ". People told us the staff were prompt when responding to call bells.

There was a minimum of four staff working in the morning and afternoon and three waking staff working at night. There were also housekeeping, laundry, two activity co-ordinators and catering staff. This enabled the care staff to focus on the care of the people living in the home. Each shift was led by a senior member of staff who organised the staff to ensure that people's needs were being met. The registered manager told us they were having difficulties covering the waking nights and had organised for a sleep in member of staff instead. Staff told us when this happened it was very busy. Staff also told us they had on occasions worked with only three staff during the day because a member of staff had phoned in sick at the last minute. Staff also told us usually the team would work additional hours to help and cover any shortfalls. The registered manager told us agency was never used and the regular staff were asked to cover any absences where possible. When we checked the rota for the last six weeks there was no evidence of these shortfalls. The registered manager had discussed the reporting of absences at short notice at a recent team meeting and felt this was improving.

After the inspection the registered manager sent us information about how the staffing was calculated using a dependency tool, which took into consideration the needs of people and occupancy. The registered manager told us in April and May 2017 there were six occasions when there were two waking nights and one sleep in member of staff. The occupancy of the home was between 37 and 34 during this period. The registered manager provided us with evidence that based on this tool the home was not understaffed.

The home was clean and free from odour. Staff had received infection control training. Policies and procedures were in place to guide staff on safe practice. Domestic staff were employed to assist with the cleaning of the home. People told us their bedrooms were cleaned daily. Senior care staff told us they completed daily bedroom inspections to ensure they had been cleaned to a good standard. Domestic staff were prompt in mopping up any spillages with carpets cleaned regularly.

Prior to this inspection, we received information of concern that a member of staff had not worn gloves when completing personal care and assisting a health care professional. This was discussed with the registered manager who confirmed they discussed this regularly with staff and there was always sufficient

gloves and aprons. They told us this concern had not been brought to their attention. We saw there were no gloves in people's bedrooms. The registered manager told us this was because some people had disposed of these down the toilets causing a blockage. We advised this should be risk assessed and addressed. We saw a member of staff was called to assist another member of staff, they stated they would have to go and locate some gloves. This meant there was a short delay in this person receiving support. Staff told us they always carried spare gloves in their uniform pockets. Of the five members of staff working on the day of the inspection, four had gloves in their pockets. We saw in supervision records that this same member of staff had been reminded to wear protective gloves on one occasion. It was evident the registered manager was taking steps to address this area with all staff through team meetings and through the observational assessments completed with all staff. This is where a senior member of staff observes the practice of staff every three months.

Care plans contained risk assessments for areas such as moving and handling, falls, skin integrity and nutrition. Where risks had been identified, some of the plans provided clear guidance for staff on how to reduce the risks to people, but in other plans this detail was lacking. For example, in one person's plan it had been documented that they had been assessed as at medium risk of falling. The guidance for staff was to "ensure shoes fit and are done up". The person was able to walk independently, but records showed they had fallen three times during the month, which indicated that the care plan guidance was not sufficiently detailed in order to keep the person safe. The registered manager told us where a person had fallen on three occasion they were monitored and referrals were made to the GP and the falls clinic. This included putting in sensor mats to alert staff if a person had fallen in their bedroom. These actions had been clearly recorded in the care plan of the person and the audit of falls.

Staff said they had received training on protecting people from harm or abuse. Through scenario-based questions, staff demonstrated their knowledge. All staff said they knew how to report any concerns. Staff were also familiar with the term "whistleblowing". Comments from staff included; "I would be happy to report any concerns about poor care" and, "I would go straight to the manager and report it". Incidents had been reported to the local authority safeguarding team in South Gloucestershire where necessary. Where appropriate we (CQC) had been informed of incidents of abuse where this had met the threshold.

There were safe recruitment and selection processes in place to protect people. All appropriate checks were completed prior to the member of staff working in the home. This included obtaining references and checking whether they had a criminal record. This ensured that the provider was aware of any criminal offences, which might pose a risk to people who used the service

People were protected from the risk of unsafe premises. The building was well maintained. Appropriate measures were in place to safeguard people from the risk of fire. We saw emergency evacuation plans had been written for each person, which outlined the support they would need to leave the premises. Routine fire testing was undertaken at the service. When last inspected by the fire officer in January 2016 the service was meeting fire regulations. Since the last inspection, the registered manager told us they had reviewed the fire procedure, risk assessments and other records relating to fire to ensure it was sufficiently robust to protect people in the event of a fire.

Where people required assistance with moving and handling, the equipment used was clearly described in care plans, along with how many staff should support the person to ensure their safely. Staff confirmed they received training in safe moving and handling procedures. Where people required assistance with moving and handling using a hoist, we were told there would always be a minimum of two staff to support the person, which ensured their safety. Staff told us there was sufficient moving and handling equipment. Staff were regularly observed in respect of moving and handling by the moving and handling assessor to ensure

they were competent and safe in this area.

Requires Improvement

Is the service effective?

Our findings

People told us staff always asked for their consent prior to any care being given. Some people did tell us about situations when they were not happy with the response from staff. One person told us that a member of staff had been very loud 'like a fog horn' and abrupt with them when they had fallen. They told us they were very frightened at the time because they thought they had hurt themselves. They said they had reported this to the manager and this member of staff no longer supported them. Other comments included, "Some staff are sharper than others", "It varies on who you get" whilst other people told us, "The staff are lovely, I am really happy here" and another said the staff were "Fantastic". A relative told us they were very happy with the home and the staff, and they felt their mother was well supported. One person told us they had only come to the home for respite and now had chosen to remain in the home. They told us, "The staff are all very kind". They told us their daughter had worked in the home in the past and it was the best decision they had made to move into Little Croft.

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 checked whether the service was working within the principles of the MCA.

Improvements had been made to ensure people's mental capacity had been assessed. This meant that staff could support people to make day-to-day decisions within the framework of the legislation. We saw evidence of best interest decisions being recorded in people's care records where they lacked mental capacity. It was noted that the quality of the information was variable. For example, where someone required medical treatment it was clearly recorded who was involved and the decision was weighed up on whether the treatment should go ahead or not. However, in two people's plan there was a mental capacity assessment in place for the use of a door alarm, but there was nothing to show how this decision had been reached or whether it was the least restrictive option or in the best interest of the person. In another person's plan it had been documented that a floor alarm was in place. Again, there was nothing documented in relation to a best interest decision being reached, although staff said they did not think this alarm was actually being used. The registered manager confirmed they would review and improve the documentation in this area.

The registered manager told us at the time of the inspection there was no one who required bed rails but three people had a handrail fixed to their bed to aid them to get in and out. This enabled these people to continue to be independent in this area. The registered manager told us these had been installed on the advice of an occupational therapist and the three people had consented to their use. The registered manager told us they were aware that where people required bed rails then a risk assessment and best interest approach should be taken to ensure they were suitable for the person taking into consideration the least restrictive option.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us they had made DoLS applications for 16 people but these were waiting to be authorised by the local authority. The applications had been made because the person lacked the mental capacity to make the decision on whether they wanted to live in Little Croft. This was because the person was living with dementia and they would not be safe if they left the home unaccompanied.

We saw that an application had been made on two occasions for a person that had expressed they wanted to leave Little Croft and return to the family home. The registered manager told us they had done this on the advice of the GP and the district nurses. However, it was clear from reading the person's information they had the mental capacity and it could be portrayed as if they were being kept at Little Croft against their will. The registered manager told us they had made an urgent referral for a social worker to complete an assessment of their needs to ascertain whether this would be possible or alternate accommodation could be found. As part of this inspection process, we also discussed this with the local authority due to the person being adamant they wanted to live at home. Assurances were given by the local authority's safeguarding team this person would be reviewed.

A healthcare professional told us, "Little Croft impresses us with their protocols around the use of benzodiazepines, they are very strict and often reluctant to give PRN medications unless it is the least restrictive option and only until something else more effective has replaced it, this is something our team repeatedly have issues with in some other care settings, so it is refreshing that they are so proactive in this respect". They also told us the team made prompt referrals and listened and acted upon their advice. They said the staff do need some guidance at times on approach and strategies but were happy and willing to learn and follow their guidance.

Staff completed core training as part of their induction including safeguarding adults, health and safety, basic first aid, infection control, fire, food safety and moving and handling. Staff confirmed they had recently attended DoLS and MCA training. Other training included dementia care, medicines and end of life. The registered manager told us a district nurse was planning to come to the home to provide additional training on pressure wound care. This was confirmed in a conversation with a health care professional.

People were asked what they would like for lunch each morning and then later in the day what they would like for tea. There was a main choice and then people were offered alternatives, for example omelette, salad or a selection of sandwiches.

Feedback from people about the food was mixed. Comments included, "It is average", "It's ok", and, "Sometimes it is divine and others not so good". The registered manager told us they were reviewing the menu because people had raised concerns about the limited choices. There was a menu board but this provided only one option. The registered manager told us they were starting a new menu, which would include three options for people. It was evident from resident meetings that people had been consulted about what they would like to see on the menu. There were fruit bowls and jugs of juice for people to help themselves. Staff were observed offering people and their visitors refreshments throughout the day. Those people that had chosen to remain in their bedrooms also had jugs of squash or water. Staff told us these were changed frequently throughout the day.

People were supported to have enough to eat and drink. Nutritional risk assessments had been completed and regularly reviewed. People's weights were monitored. Some people were having their food and fluid

intake monitored. In these instances, food charts had been completed in full.

Fluid charts had been completed, but were hard to decipher because multiple days intake had been recorded on one chart. The target intake was not recorded on the charts, and the daily intake had not been totalled. This indicated that the charts were not being effectively monitored by senior staff. This was further evidenced because on several days people's recorded intake was low, but there was nothing documented to indicate this had been escalated or acted upon. We looked at the care plans for two people who were having their fluid intake monitored. In one plan the daily target was 1800 millilitres, but the recorded intake was only 700 millilitres on 26 June 2017, 600 millilitres on 27 June 2017 and 1050 millilitres on 28 June 2017. In the other person's plan, there was nothing documented in relation to the person needing to have their fluid intake monitored. Staff were unsure why the chart was in place and said the person ate and drank well.

Health and social care professionals were involved in supporting people. They included dieticians, physiotherapists, occupational and speech and language therapists and the mental health team. Their advice had been included in the plan of care and acted upon. Where people needed nursing interventions such as wound care or support with their diabetic medications. This was completed by the district nurse team. They reported they were being called out frequently during out of hours. They told us on occasions, staff did not know the person sufficiently in respect of their medical history.

People were in the main supported by two GP practices. This was because when the home increased their occupancy it was felt that another surgery would be used to enable workload to be shared. Both practices visit one day per week. One of the practices told us, they felt the staff were caring and knowledgeable. However, the organisation of requests for GP visits could be improved. They said they often had to see additional patients or they would be called out very late in the day when the call could have been put through before midday, as there had been signs this person had been unwell. They said better organisation from the home would enable them to plan their own caseload and enable them to prioritise.

The service had participated in a pilot in reducing falls and admissions to hospital. A physiotherapist and occupational therapist worked alongside the staff on a weekly basis to review why certain people were falling. The registered manager said at the last inspection this had been a positive experience and had seen a reduction in falls for some people. Monthly audits were completed on all falls exploring why and what actions could be taken to reduce these. A healthcare professional told us they had seen a reduction in falls from the previous quarter. Whilst another group of healthcare professionals thought there had been an increase compared to other homes, with them being called out to respond to a significant number of skin tear type injuries.

Staff completed core training as part of their induction including safeguarding adults, health and safety, basic first aid, infection control, fire, food safety and moving and handling. This included completing the care certificate, which was a nationally recognised induction programme for care staff. Other training included dementia care, medicines and end of life. The registered manager told us training was planned with the district nurse team on supporting people with diabetes and pressure wound care.

Staff confirmed they received supervision from either the registered manager or the deputy manager. Supervisions are a process where staff meet on a on to one basis with a line manager to discuss their performance and training needs. The registered manager told us that supervision with staff should take place a minimum of six times per year. This was a combination of face-to-face meetings and observations of staff practice. A supervision planner was in place detailing when the supervision should take place and when it had been completed. The registered manager completed annual appraisals of staff performance enabling them to monitor staff competence and plan the training for individuals and as a team.

Little Croft was two residential properties that had been renovated into one care home. In the last two years, there had been a further extension to the rear of the property to provide a further five bedrooms all with ensuite facilities. Signage was now in place to assist with orientation for people. There was also signs on people's bedroom and bathroom doors.

There were menu boards in the dining areas and an activity board to remind people what was available and happening in the home. This helps people living with dementia to orientate themselves around the home. There was a digital clock, which included the date in one of the lounges. Two people told us this was new. However, they were struggling to see the date.

Bedrooms were personalised with people's possessions including furniture, pictures and ornaments. All bedrooms had an ensuite facility and were decorated to a good standard.. All the bedrooms on the ground floor and the new extension had access to a small garden accessed by patio doors. There was a well maintained garden. People told us they enjoyed spending time in the garden when the weather was warmer. Some people continued to enjoy gardening and raised beds had recently been put in place.

Since the last inspection, the new kitchen had been completed. A member of staff told us it was a pleasure to work in this area and was much bigger and better organised that it was before. The old kitchen had been made into a laundry facility.

Good

Is the service caring?

Our findings

Generally, people told us the staff were caring and supported them well. People told us, "'I feel very cared for", "I think ninety percent of them do care", and, "They are a good lot". One person told us how a member of staff had recently shouted at them. The registered manager had met with the person, addressed their concerns, and spoken with the member of staff who apologised to the person for being loud. The registered manager had also held a recent staff meeting to remind staff about their approach to people and to avoid shouting at each other across communal areas or upstairs. When asking people if the staff talked to them on a personal level about their care they replied with such statements as, "Yes we are always having a chit chat", "They do talk to me all the time", "They always ask if you are ok", and, "Overall, I think most of them do".

One person told us they had recently moved to the home. They told us they had settled in well and the staff had been kind in helping them during this time. Another person told us, "My daughter made the decision for me to move to this home and I cannot fault it, I did not think I would like living in a care home but it has exceeded my expectations". They went on to say, "I am having the best time of my life".

Feedback from health and social care professionals included, "The staff are caring and considerate to their residents. They make an effort to know them. There is a nice personal approach", and, "At times Little Croft can appear quite bustling and sometimes noisy, but it is generally with carers chatting and laughing with each other and the residents". Another health professional told us, "Staff at Little Croft are extremely caring and work hard to look after their residents. During my visits to Little Croft I have been impressed by the kindness and respect shown to residents by staff and I have had positive comments from residents and their families about the caring attitude of the staff".

People were treated with kindness and compassion by staff. The atmosphere was relaxed and we saw that staff knew people well and spoke to them by name. People using the service appeared relaxed around staff.

We observed staff interactions with people as being open and inclusive. When staff walked through both the communal lounges they spent time talking to people and making sure they were comfortable. This included asking people whether the music or the TV was at an appropriate level. When personal care was completed, staff took the time to sit and speak with people.

People had not only evidently built good relationships with the staff but each other. People were heard asking after each other why they had not appeared in the lounge areas. They were also engaged in conversations with each other. There was a friendly and open atmosphere in the home. One person told us, "I like to spend time in my bedroom in the morning and then join my friends in the afternoon for the activities".

People and their relatives had been consulted about their life histories, significant relationships and what was important to them. This enabled staff to respond to people living with dementia who may not recall all their life histories and aid conversation with the person. Each person had a one page profile detailing this

information. Staff were knowledgeable about people and what was important to them.

People were encouraged to be as independent as they were able. Care plans included what the person could do and where they may require assistance in relation to daily tasks such as personal care. One person had previously enjoyed gardening prior to moving to Little Croft. Staff confirmed this person was supported to continue with what they had enjoyed. There were raised flowerbeds to enable this person to be involved in this area safely. People evidently enjoyed accessing the garden. There was a raised fishpond and the registered manager and a person were talking about how this could be improved. It was evident the person was very much involved.

Another person told us they did not particular like the activities that were taking place. They told us the registered manager was helping them to find a computer that they could have in their bedroom. They said this would enable them to keep in contact with the outside world. Another person told us they had been a musician. When we discussed this with the registered manager, they were fully aware who we were talking about. They told us a member of staff had a similar musical instrument in their loft and they were planning to bring this in for the person. It was evident the registered manager was knowledgeable about the people living in Little Croft and wanted to make a difference to each person's life based on their interests. People told us the staff organised for daily newspapers to be delivered to the home. One member of staff told us they brought in a free newspaper so people could read this as well. People were seen sharing their newspapers when they had finished.

We saw one person walking around with one member of staff offering them orange segments. They enjoyed being part of this and they were laughing and chatting as they did it. On another occasion as people were walking into the dining room for lunch, we heard staff encouraging people to "remember to use your stick" and "where would you like to sit today?" It was evident people were encouraged to make day to day decisions about their care and their independence was encouraged.

Staff spoke positively about their roles. Comments included; "I'm here for the residents. I love my job, I spend a lot of time with people, we're like one big happy family", "I'm caring and respectful and I spend time with people if they're upset" and, "I know I make people happy. I've been told I'm good at my job and I've got a close relationship with the residents".

One person was becoming upset, as their relative had not arrived. The staff picked up this person's anxiety promptly and explained their relative would be here within the next half an hour. They then suggested that they could help with the teas and coffees and handing out biscuits to people. This person's mood completely changed and they became engaged in their role with no further evidence of their previous anxiety. Another person was confused about a pending GP appointment. Staff took the time to explain what was happening and the treatment required. This happened again later in the afternoon and the staff patiently explained again, what was happening to provide further reassurance to the person. This person also requested a donut and the staff immediately responded to the request.

All the bedrooms were single occupancy and people could spend time in their rooms whenever they chose. Bedroom doors were lockable and people were offered keys to their rooms. We observed the staff respecting people's private space by knocking on doors and waiting for a reply before entering. People were asked for their opinion of the colour scheme of their bedroom when they first moved to the home and as part of the redecoration programme of communal areas of the home. People were also encouraged to personalise their bedroom with small pieces of furniture, pictures and ornaments.

People's visitors were free to see them as they wished. Visitors told us they could see their family members

or friends when they wanted to and were made to feel welcome by staff. Visitors were offered refreshments when they visited.

We observed staff asking people if they would like assistance and their wishes were respected. Where people had declined assistance with personal care we observed staff returning later in the morning to offer assistance. This meant people were supported to make day-to-day choices on when they would like to receive care and these were respected.

Staff took an interest in people. Staff were complimentary about people and commented to them on how lovely or smart they looked. It was evident the people liked the compliments. Care records included what was important to people. For example, 'It is important I have my handbag with me at all times', 'I like to look smart and wear, a vest, shirt and tie'

Meetings had been organised for people using the service and their relatives. They had been consulted about activities, the menu and the refurbishment of the home. A monthly newsletter was sent to people and their relatives detailing forthcoming birthday celebrations, social events and other news relating to the home.

People's religious and cultural needs were taken into account on admission and during care delivery. The local church visited on a monthly basis. One person told us they regularly went to church as this was important to them.

Care files showed people were asked about their end of life wishes. Relatives provided further information including their contact details and when and if they would like to be contacted. Some staff had completed training in end of life care. Staff told us they would liaise with the district nursing team and GP to ensure all equipment and medicines were in place to ensure people were pain free when receiving this care. A relative had thanked the staff in supporting their relative at the end stages of life. The registered manager had introduced a new booklet so people could record their end of life wishes in one easy read document. These were being completed by the person and their relatives with support from the staff.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home by the registered manager and the deputy manager. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. The registered manager told us people were also re-assessed if they had an admission to hospital. This was confirmed in the records we viewed, with information recorded such as now can weight bear and can return home. However, we saw that when one person returned from hospital, staff had just written returned from hospital. There was no information about any change to their care in respect of medication or treatment required. In another person's record it just stated the person had returned it was not clear where from. This lack of recording could put people at risk.

A health care professional told us that at times they were concerned about the mix of people living at Little Croft, which could often change the dynamics of the home. They said that sometimes they felt that due to a number of people deteriorating and requiring more support, this had an effect on the level of care that people received. This was echoed by another health care professional. The registered manager told us they were aware of this, and that they felt they considered this when completing the initial assessment and thereafter when planning the staffing.

Another healthcare professional said, "They are cautious and thorough when it comes to assessing potential new residents and always seek to ask for our advice if unsure". They went on to say, "There have been occasions where following an assessment and obtaining as much information as possible from any professionals involved that they have ended up with residents who are very complex not by omission of information but because the resident settles in and their presentation changes, in these cases the management team will quickly refer to our team for input". From our discussions with the registered manager, they were aware of the concerns and tried to find the balance of ensuring the right people and the right support was in place taking into consideration the existing group of people.

People had a care plan covering all areas of daily living based on the person's assessed needs. This included personal care, eating and drinking, sleep, hobbies and interests and any risks associated with their care. The care documentation included how the individual wanted to be supported for example, when they wanted to get up, their likes and dislikes and important people in their life. These were reviewed on a monthly basis or as people's needs changed.

We saw that some people were diabetic. There was no guidance in the plans of care for these people on how they should be supported. Some people were insulin dependent, others took medication, whilst others were diet controlled. There was no information of the signs and symptoms of hypo or hyperglycaemia. This meant there was a risk that staff would not recognise the symptoms and would not know how to respond. The lack of guidance could put these people at risk as staff may provide inappropriate treatment. When we returned on day, two these were in place for people, which gave information for staff on what to do if these people became unwell due to their diabetes and what to look out for. This was a rectified breach.

The registered manager told us they would review all care plans and ensure where someone had a medical diagnosis there was guidance in place for staff to support people consistently. We saw that where people had epilepsy clear plans of care were in place for two people. One person's was minimal and little information about the type or how to respond. The registered manager told us this was because when they had requested further information, little was known about this person's epilepsy, as they had not had a seizure for many years.

People told us about a variety of activities that took place at the home. Some people told us they preferred to sit in the quieter lounge chatting, reading or doing their colouring. Whilst others preferred to spend time in the lounge where in the main the activities took place. One person told us, "You can do whatever you want here". However, another person told us they were bored. When we explored this with the activity co-coordinator they told us they tried to engage with the person but often they refused. This person told us they liked to spend time in their room or the quiet lounge but they did enjoy arts and crafts. It was evident they were still looking at options for this person in respect of their interests and spent time with them on a one to one basis chatting.

Activities included games afternoons, coffee mornings, bingo, pamper sessions, discussion groups to aid memory, quizzes, baking, gardening and arts and crafts. In addition, there was time allocated for one to ones with people who did not like to participate in group activities. There were two activity co-ordinators employed to support people with activities of their choosing either in group sessions or on a one to one basis. The activity co-ordinator told us there were formal activities arranged each afternoon five days a week. Weekends were less formal with more one to one activities organised by the care staff. The activity co-ordinators worked in the kitchen in the mornings.

External entertainers visit the home to provide music events at least a four times a month. A hairdresser visited the home once a week and the local church provided a communal service on a monthly basis. The registered manager told us it was also important for people to continue to be part of the local community. Some people were supported to go to the local garden centre and trips out. People told us about a recent trip to Weston Super Mare where the majority of the people had spent the afternoon, which included a fish and chip supper. One person did say they would like to do this more often and go on day trips and they wished they could come and go as they wanted.

Daily handovers were taking place between staff. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. Staff described how they worked as a team to enable them to respond to people's needs and stated that communication was important to ensure continuity of care. For example, if a person declined personal care or was not eating normally this was shared with other colleagues so this could be offered at a more convenient time to the person.

Staff recorded in care documentation when people declined care and this information was shared between staff so that care could be offered again either later that day or the following day. However, the records of personal care had gaps for example one person had refused care but there was no recording for a further seven days. Another person had refused care but in the daily records, the person had been independent in this area. Another person had not received any personal care throughout the month of May 2017. The registered manager told us they felt this was a recording issue and would address this with the staff.

There was a complaints policy and procedure. The policy outlined how people could make a complaint and the timescale for when people could expect their complaint to be addressed. We looked at the complaints log. We found people had been listened to. The records included the nature of the complaint, the

investigation and the outcome. We found complaints had been responded to within the agreed timescales. There had been five complaints since our last inspection. There were no themes to these. One was about creased clothes, another about someone not returning back to the home as they required nursing care, one about how a member of staff not answering the phone appropriately and two concerns about the conduct of staff. All were investigated and a letter with the response and outcome sent to the complainant.

When we asked people if they knew how to complain and if they felt comfortable doing so, they responded with such statements as, "I would talk to the boss lady", "I don't think I have anything to complain about, but if I did I don't see why I couldn't", "The boss would listen", "Oh yes I am not a shy person", and, "I think I would just tell a staff member or the woman in charge".

One person told us at the last inspection they were not happy with the building works because this was obstructing their view of the garden. The registered manager responded immediately and spoke with the person. It was agreed that if the person wanted to change rooms this would be supported or the registered manager would organise for hanging baskets to go on the wall opposite their window. We followed this up during this inspection. They told us they were very happy with the completed building works and there were hanging plants and some ceramic butterflies. They said it was, "Fantastic and was very happy with their small garden area". This showed the service responded and acted upon people's concerns.

Another person recently stayed in the home for a short break and was unhappy being on the first floor. In response as soon as a ground floor room became available this person moved. From talking with the staff and the registered manager, it was evident if people raised a concern or identified an area for improvement, this would be listened too and acted upon.

In addition, to the complaints the service had received six compliments from relatives about the service. One relative stated, 'Thank you, such a supportive team. Lovely and hugs when needed', and another had said, 'Thank you all so much, she really enjoyed her time with you and always spoke highly of you all. You deserve a medal'.

Requires Improvement

Is the service well-led?

Our findings

Some improvements were required to ensure the service was well led. This was because the checks that were being done on the quality of the service and delivery were not always effective. We found there were shortfalls in some areas such as medicine management and the recording of care delivery such as personal care and care planning.

These had not identified the gaps in recording of medicines and ensured that safe temperatures were maintained of the storage of medicines and, medicines such as eye and eardrops had a clear date of when opened. Whilst care documentation was audited, the registered manager and provider had not identified missing care plans such as those relating to a person's medical condition or that fluid charts had not been totalled at the end of each day. There were also gaps in the recording of personal care. These shortfalls could potentially put people at risk.

Two members of staff were responsible for writing the care plans for people and whilst they contained some personal information to enable staff to treat people in an individual way, often the information was similar in content. This was specifically around falls and activities. For example, the falls care plan for the records we viewed stated 'ensure suitable or appropriate footwear' or 'make sure room was clutter free'. There was no link that in the care plan that some people may fall when they had an infection, the weather was warmer or to check whether the person was dehydrated. This information could be useful to staff to signpost them on what to monitor to reduce the amount of falls or additional safeguards that should be put in place. These areas required improvement.

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

There was a registered manager in post at the time of the inspection. They had been the registered manager since January 2012. Staff told us they felt the registered manager was approachable and had an open door policy. One member of staff said, "She's good. She'll always try her best to sort out any problems". Another said, "The manager and the deputy are both very supportive and approachable". People using the service told us, "She is lovely always coming round to check on us", and, "I can talk to the boss here, that's always an important factor".

The registered manager told us although their office was on the first floor they often worked in the deputy manager's office so they could feel more part of the home. This was situated on the ground floor near to the main entrance. From conversations with the registered manager it was evident she was knowledgeable about the people that lived in Little Croft. The registered manager was seen throughout the inspection engaging with people and staff when walking through the building. It was evident they were passionate about providing individualised care. A visiting healthcare professional told us, "Although CQC are in the building the atmosphere is no different to when I normally visit". They told us they were always made to feel welcome and staff were always engaged with people in conversation or with activities.

The registered manager was supported by a deputy manager and a senior team leader who were partly supernumerary. This meant they were in addition to the care staff and not counted in the four staff that were working each day. The registered manager told us the provider visited the home at least twice a week and spent time monitoring the quality of the service. This included completing some of the audits in relation to the environment and medicine management.

There was a staff structure, which gave clear lines of accountability and responsibility. There was always a senior care worker on duty to guide the care staff. Most of the staff wore a name badge and uniform, which was colour coded to the role. Where staff had no name badge, these were being ordered. Staff had job descriptions that defined their roles and responsibilities. Concerns were raised with us prior to inspection that some staff had false painted nails. We discussed this with the registered manager who told us the expectations of staff in respect of uniform, jewellery and nail care. From our observations, we saw that staff were wearing the correct uniform and nails were short. Minutes of team meetings showed that dress and staff conduct was discussed at regular intervals. There was also a policy to guide staff in this area.

Staff confirmed regular meetings were taking place where they were able to discuss the care and welfare of people, policies and procedures and their roles. Minutes were kept of the meetings and any actions.

People were involved and asked for their opinions during care reviews, resident meetings and annual surveys. People had made suggestions for improvements and these had been acted upon, such as activities and the improvements that were planned to the menu. They were introducing a new four week menu with three options available each day to enable people to have more choice. This had been identified via a residents 'meeting and a meal experience audit. It was identified in May 2017 that new menus were needed with more variety. The registered manager told us they had bought new table menus and were planning to introduce the new menu the week after the inspection. It was evident the catering staff had been involved.

Healthwatch South Gloucestershire completed a review in January 2017 and they concluded the home appeared well-staffed, well run and offered a safe and caring environment to people. The registered manager had listened to a previous visit where they had noted activities and signage in the home as an area for improvement.

The registered manager completed checks on accidents and incident reports to ensure appropriate action had been taken to reduce any further risks to people. This included looking at any themes. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incident reports were produced by staff and reviewed by the registered manager. From looking at the accident and incident reports, we found the registered manager was reporting to us appropriately.

The registered manager was aware of when notifications had to be sent in to CQC. A notification is information about important events, which had happened in the home, the service is required to send us by law. The CQC used information sent to us via the notification process to monitor the service and to check how any events had been handled.

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 How the regulation was not being met: People who use services and others were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The registered manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a).