Shaw Healthcare Limited

Croft Meadow

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
• Croft Meadow is situated in Steyning, West Sussex. It is a residential 'care home' registered for up to 60 older people, some of whom are living with dementia or frailty and other associated health conditions. At the time of the inspection there were 54 people living in the home.

People's experience of using this service:
• There were serious concerns about the care people had sometimes received and the provider's lack of oversight to ensure that appropriate improvements were made.
• Risks were not always well-managed in relation to choking and there were concerns about people's safety.
• Medicines management was not always safe. Two people had not always had access to medicines to manage their health condition in accordance with prescribing guidance. There was a risk that their condition was not well-managed and their mobility could have been affected. Some medicine errors had occurred.
• Staffing levels were not always aligned to people's assessed needs and assessed level of support.
• There were concerns about the lack of oversight and failure to make significant, timely improvements since the last inspection. There was mixed feedback about the leadership and management of the home. Staff told us that they felt well-supported. One relative told us, "There is no leadership here. Staff have left because of the lack of management." Another relative told us, "Over the past year things have deteriorated."
• The provider's values were not always promoted in practice. Concerns about people's care had not been rectified and improved upon in a timely manner to ensure people received the care they had a right to expect.
• Quality assurance processes had not always identified the concerns that were found at the inspection. When issues had been identified there was insufficient, robust action taken to ensure improvements were made.

Rating at last inspection:
• At the last inspection the home was rated as Requires Improvement. (Supplementary report published 28 March 2019).

Why we inspected:
• Prior to the inspection we had received information of concern in relation to people's care.
• This was an unannounced focused inspection to look at the key questions of Safe, Responsive and Well-led. This was because at our last inspection, on 11 and 12 October 2018, the provider was in breach of Regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider and gave them a date by which the Regulations should be met. This inspection took place to check that improvements had been made and that the provider was now meeting the Regulations.

Enforcement:

• The provider had not met the Warning notice for Regulation 17 that had been issued following the last inspection on 11 and 12 October 2018. The provider was in continued breach of Regulations 12 and 17. There was a new breach of Regulation 9, person-centred care.
• The overall rating for this home is 'Inadequate' and the home is therefore in special measures.
• Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
• If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.
• For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
• Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
• We will continue to monitor the intelligence we receive about this home and plan to inspect in line with our re-inspection schedule for those services rated as Inadequate.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Croft Meadow

Detailed findings

Background to this inspection

The inspection:
• This focused inspection took place on 25 April 2019 to follow-up on information of concern that we had received in relation to people's care and to ensure improvements required at the last inspection had been made. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
• The inspection was undertaken by two inspectors and an 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.

Service and service type:
• Croft Meadow is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. People were accommodated in one adapted building, over three floors, which were divided into smaller units comprising ten single bedrooms with en-suite shower rooms, a communal dining room and lounge.
• The home had a manager who was registered with the Care Quality Commission. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The management team consisted of the registered manager and a deputy manager and team leaders. An operations manager also regularly visited the home.

Notice of inspection:
• The inspection was unannounced.

What we did:
• We did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make. This is because we were responding to potential risk and therefore had no

time to request a PIR. We took this into account when we inspected the service and made the judgements in this report.
• We looked at information we held about the home including notifications the provider has sent to us about important events.
• We spoke to four health and social care professionals before the inspection. We reviewed information sent to us from healthcare professionals, the local authority and members of the public.

During the inspection:
• We spoke with ten people, four visitors and relatives, a visiting healthcare professional, eight staff, the deputy manager, the quality manager and the operations manager. The registered manager was not present during the inspection. The management team were contacted following the inspection to provide additional information and evidence.
• We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for seven people, two agency staff, quality assurance audits, incident reports and records relating to the management of the home.
• We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
• We observed the care people received as well as the lunchtime experience and the administration of medicines.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

• At the last inspection on 11 and 12 October 2018, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of Safe. There was a breach of Regulation 12, safe care and treatment. This was because medicines management was not always safe. Risks to peoples safety were not well-managed.
• A Warning Notice was served and the provider was required to meet Regulation 13, safeguarding from abuse and improper treatment, by 31 December 2018. This was because one person had not been protected from the risk of abuse.
• At this inspection, some improvements had been made. The provider had met the Warning Notice and was no longer in breach of Regulation 13.
• The provider had not complied with their action plan or made the necessary improvements to ensure people received safe care and treatment. There was a continued breach of Regulation 12.

Assessing risk, safety monitoring and management; Using medicines safely:
• Risks to people's safety were not well-managed. People assessed as being at high-risk of choking had been advised by external Speech and Language Therapists (SALT) to have a pureed or soft diet. Guidance provided by the SALT had not always been followed. One person had been assessed as requiring their drinks to be thickened and food that was minced and moist. Records showed and staff confirmed that they had been provided with food items that were not in accordance with the SALT guidance. Records consistently showed that they had been given toast or sandwiches softened in soup or marmite. They had also been given jelly and ice-cream. Another person had been assessed by the SALT as needing thickened fluids and a pureed diet. Records showed and staff confirmed that they too had consistently been provided with sandwiches with soup poured over them. They had also been given jelly and ice-cream. Guidance provided by the SALT clearly stated bread should not be provided and that ice-cream and jelly should not be provided if people had their drinks thickened as the food could melt and become too thin which would increase the risk of choking. Despite these people being at an increased risk of choking, the provider had not considered the risks or taken measures to lessen them.
• There was insufficient monitoring and action taken for one person who was at risk of malnutrition. The person had been assessed three months before moving into the home. Staff had recorded the person's weight which showed they were within the healthy range and at low-risk of malnutrition. Upon admission into the home, staff had not re-weighed the person and instead had used the weight that had been recorded three months previously. The person had experienced ill-health in-between the initial assessment and moving into the home and had lost weight. Staff had not recognised this and the person had not been supported in a way that met their current needs. When the person was weighed ten days after moving into the home, it showed that they had lost two stone since the initial assessment, meaning they had lost almost a quarter of their body weight. Staff had then re-assessed them as being underweight and at high-risk of malnutrition. Despite this, staff had not followed guidance to ensure that the person was supported to have

sufficient food to lessen the risk of further weight-loss. The provider's guidance stated that people assessed as being at high-risk of malnutrition should be provided with two homemade high-calorie drinks per day and have access to a high-calorie and high-protein diet which was to include two snacks per day. They were also required to be weighed weekly to monitor for any further weight loss. Records to document the food the person had consumed as well as confirmation by staff, showed that they had not been supported in accordance with this guidance.

• The same person was at an increased risk of dehydration. Although the provider had sought medical assistance to determine the cause of the person's change in health condition, staff had not followed the guidance that had been recommended. Guidance provided by an external healthcare professional had advised that fluids should be encouraged due to the person's health condition. Despite this, there were concerns about the person's access to fluids. At lunchtime the person was being assisted to eat their meal, when staff were asked if the person had a drink they told us, "They had a drink a while ago, they could maybe do with another one." Staff had not been provided with guidance about the person's recommended daily fluid allowance and this had led to unsafe practice by staff. Two members of staff told us that the person was on a fluid restriction and they were trying to space out the person's drinks throughout the day. When the staff were overheard informing us of this, a registered nurse informed them that this was not the case and the person should not be having their fluids restricted. Records, to document the person's access to fluids, however, showed that they had a low fluid-intake and had not been supported to have sufficient fluids. The person's fluid intake had not been totalled or monitored and therefore it had not been recognised that they were not consuming sufficient fluids to lessen the risks caused by their health condition and the potential risk of dehydration.

• It was not evident that people at high-risk of sustaining pressure wounds had received appropriate care. One person had been assessed as being at high-risk of skin breakdown. Staff had been provided with guidance which advised them that the person was unable to turn themselves whilst in bed and needed to be repositioned every three-four hours. Records to document the frequency in which the person had been repositioned showed that they were not supported to reposition in accordance with the guidance provided. On one occasion the person had not been supported to change position for seven hours. This increased the risk of pressure area damage.

• People were at risk because staff did not always administer medicines safely and people did not always receive their medicines as prescribed. Despite this being raised as a concern at the last inspection, we continued to have concerns about people's access to their medicines.

• According to Parkinson's UK, people living with Parkinson's disease need to have their prescribed medicines at specific times of the day otherwise there is a risk that their condition might not be well-managed and their mobility could be affected. It advises that not getting medicines on time can mean the difference between a person being able to function independently or them becoming reliant on others. Three people had Parkinson's disease. Efforts had been made since the previously inspection to improve the timeliness of Parkinson's medicines. Alarms had been set up on the electronic systems, training had been provided to staff on how to use the electronic medicine records (EMAR) and staff were more aware of the need to provide medicines according to the prescriber's instructions. There had at times, however, been occasions when two people had been given their medicines outside of the prescribing guidance. For example, one person was assessed as being at very high-risk of falls. They had experienced 42 falls within six months. External healthcare professionals advised that the person's Parkinson's disease was a contributing factor. Despite this, the person had not always had their Parkinson's medicines according to the prescribing guidance. On one occasion they had gone without a dose of their Parkinson's medicines as staff had not taken timely action to ensure that there were sufficient stocks of medicines. There were other occasions when their Parkinson's medicines had not been administered in accordance with the prescribed times. This increased their risk of falls and there was a risk that their health condition was not well-managed. Another person had missed a dose of their Parkinson's medicines as they had attended a healthcare appointment and staff had not planned to ensure they had the medicines with them. On another occasion the same

person had been given their Parkinson's medicines two hours later than the prescribers instructions and one hour earlier on another. When doses had been given outside of the prescribed times, staff had not sought medical advice to establish if further doses of the medicine should be altered to ensure that there was sufficient time in-between doses.
• There had been some medicine errors and staff had not always supported people according to healthcare professional's guidance. One person had been prescribed steroid medication. On one occasion an error had occurred and they had been given three times the recommended daily dose and medical advice had needed to be sought.
• One person had experienced a decline in their health. Tests conducted by their GP had prompted the GP to contact the home to state that the person was not to be given their next dose of medicine as this could have a detrimental effect on their health. Despite this urgent guidance, staff had not acted in a timely manner and had administered the person's dose of medicine which had required them to seek further medical advice.
• Staff had not supported one person in a timey way when they had experienced difficulties opening their bowels. The person's bowel had become impacted as advice had not been sought until the person had not opened their bowels for a period of 12 days. Once this was recognised appropriate medical assistance was sought. However, despite this incident occurring five months previously, guidance about when to administer 'as and when required' laxative medicines had not been provided to staff to help inform their practice and ensure the person's health and comfort were maintained should a similar situation occur again. The lack of clear guidance for staff for 'as and when required' medicines had been identified at the last inspection and remained a concern.
• People were not always supported in a safe way when being assisted with moving and positioning. One person was supported to stand by a member of staff. The member of staff asked the person to position their hands on their walking aid and pull themselves up, rather than using the arms of the chair to propel themselves. As the person had difficulty doing this the member of staff had to hold the person under their arm to support them to stand. There was a risk that this could have caused an injury. Another person was assisted to transfer using a wheelchair. Staff did not ensure that there were footplates on the wheelchair at the time and the person's feet were not supported. There was a risk that this could have caused an injury to their feet or ankles.
• People were at risk as substances that had the potential to cause them harm had not always been securely stored. Thickeners had been prescribed to thicken some people's drinks to minimise the risk of them choking. A patient safety alert issued by NHS England in 2015 advised the safe storage of thickeners to minimise the risk of asphyxiation by accidental ingestion. Despite this, thickening powder was stored in an unsecured kitchen cupboard. Some people were living with dementia. There was an increased risk that people could have accessed the thickening powder. Industrial strength de-scaler, in a container that looked like a sports drinking bottle, was found opened within an unlocked sluice room. There was an increased risk, particularly for those living with dementia, that they could have accessed the substance and come to harm.

The provider had not ensured that people received safe care and treatment. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The environment and equipment was safe and well-maintained. People told us they felt the home was a safe and secure place to live.

Staffing and recruitment
• Planned staffing levels were sufficient to meet people's needs. There had been times, however, when this had not been delivered. Some people had been assessed as needing two members of staff to support them. Two relatives raised concerns about staffing at night. A relative told us, "We believe that, occasionally, there has been only one staff member covering both units at night." Staff rotas showed that on one occasion during the night there had been only one member of staff to each unit of up to ten people. This meant that if

a person required two members of staff to support them that one unit would be left without staff support.
• There was mixed feedback about staffing. People told us that there were enough staff to meet their needs and that when they called for assistance staff responded. People and relatives told us that there had been a high-turnover of staff and that this had impacted on the amount of agency staff that worked at the home. A relative told us, "Staff have been leaving in droves and all the time." A visitor told us, "Most days there are more agency than regular staff."
• Recruitment processes were followed before staff started work to help ensure they were suitable to work with people.

Learning lessons when things go wrong
• The registered manager had implemented some protocols to address some of the concerns that had been identified at the last inspection. These had not always been implemented or monitored effectively to ensure that sufficient improvements were made. For example, changes to the way that Parkinson's medicines were administered did not prevent them from being given outside of the prescriber's instructions. Guidance for staff about when to administer 'as and when required' medicines had not been implemented and there was a potential risk that people would not be supported in a timely manner if their health condition deteriorated.
• There have been reoccurring themes throughout the provider's other services which have not always been learned from or used as opportunities to improve practice. For example, Parkinson's medicines being given outside of prescribing guidance, a lack of oversight and compliance with the Deprivation of Liberty Safeguarding (DoLS) and the unsecure storage of thickening powders for drinks.

Systems and processes to safeguard people from the risk of abuse
• Following the concerns found at this inspection, CQC made safeguarding referrals to the local authority for them to consider under safeguarding guidance.
• The provider had met the breach of Regulation 13, safeguarding from abuse, that had been found at the last inspection. They had reported other incidents of alleged abuse to the local safeguarding team when it was identified.
• Staff were aware of how to protect people from the risk of abuse and knew how to raise concerns if abuse occurred.

Preventing and controlling infection
• Infection prevention and control was maintained and the home was clean.
• Staff understood the importance of infection control. They used personal protective equipment and disposed of waste appropriately. This minimised the spread of infection and cross-contamination.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this mean that the service met people's needs.

People's needs and Regulations were not always met.

Personalised care; accessible information; choices, preferences and relationships:
• People's needs had not always been assessed and appropriate guidance had not been provided to staff in a timely way. One person had moved into the home 12 days before the inspection. Guidance advised staff that some assessments such as falls risk assessments needed to be completed within four hours of admission. Despite this, these risks had not been assessed.
• Staff had not always been informed about people's needs. Two people had swallowing difficulties and were at high-risk of choking, yet potential risks in relation to this had not been assessed to ensure their safety.
• Staff did not have a good awareness of the person's needs and were observed not supporting the person in accordance with external healthcare guidance.
• Pre-admission assessments stated that one person had a right-sided weakness and required a cushion to support their posture. This information had not been provided to staff and the person was observed slumped to one side whilst sitting in their chair. After some time, staff noticed and asked the person if they would like a cushion. The member of staff then placed this behind the person's back, however, the person pointed to their arm and staff placed the cushion correctly in place.
• Reviews of people's care plans had not always recognised changes in their needs or guidance that had been provided by external healthcare professionals. For example, one person had Parkinson's disease. They had been assessed by a specialist nurse who had provided a letter detailing the specific times for the medicines to be administered to support the person to maintain their health and mobility. Despite this, staff were unaware of the guidance and had contacted the person's GP to ask for advice about the times of medicines and had failed to identify that this had already been provided one month previously. A monthly review of the person's medicine care plan stated, 'Compliant taking medication.' It did not recognise that the medication prescribing times had been provided by the specialist nurse and this conflicted with the times staff had recorded on the medicines care plan. Neither did it recognise that the person had not been having their prescribed medicines at the correct times and had sometimes been given them two hours later or one hour earlier than the prescribed times.
• External health care professionals and relatives told us that staff sometimes lacked understanding about people's needs and health conditions. A relative told us, "My relative was sent to the GP without any records or knowledge of why they had been sent."
• The provider understood people's information and communication needs. These were identified, recorded and highlighted in care plans and shared appropriately with other professionals involved in people's care. However, people's identified needs were not always being met. Information had not been adapted to support people who were living with dementia to make choices of be kept informed of changes within the home. Care plans were not provided in an accessible format should people wish to view information about themselves. Menus, providing information about the meals that were available, were written on a white board and were not supported with other types of communication that might aid people's understanding

and choice, such as photographs and pictures.

The provider had not always ensured that care and treatment was appropriate, met people's needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's access to stimulation and activities to occupy their time had declined since the last inspection. People were seen to spend large amounts of time unoccupied, with televisions playing without people actively watching them or engaged in any other types of pastime. A volunteer regularly visited the home and during these times some people were observed to be actively engaged in singing and dancing. An entertainer provided entertainment and sang songs from the 1940s. During these times it was apparent people were stimulated and enjoying themselves as they were observed smiling and clapping their hands to the music. It was not evident however, how people's preferences, interests and hobbies had been considered. When the lack of stimulation and interaction during times when there were no planned activities was fed back to the management team, they told us that this would start to improve as they had recently recruited another activities coordinator who had plans to implement a new programme of activities for people to enjoy.

Improving care quality in response to complaints and concerns:
• Concerns and complaints that had been raised had been dealt with appropriately and according to the provider's policy.
• People and their relatives had been made aware of how to raise concerns and complaints.

End of life care and support:
• People could discuss and make appropriate plans for care at the end of their lives.
• Staff had respected people's preferences when people had chosen not to discuss their end of life care.
• People received kind and compassionate care at the end of their lives to help ensure their comfort.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some Regulations were not met.

• At the last inspection on 11 and 12 October 2018, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of Well-led. The provider's own quality assurance processes had not identified the concerns that were found at the inspection. One person had not been protected from the risk of abuse. Risks were not well-managed and three people had not been provided with their Parkinson's medicines at the prescribed times. Records to document the care people had received were not well-maintained. Staff were not always provided with clear guidance about how to support people effectively. The provider had not shared learning and ensured improvements were made across their other services.
• The home was rated as Requires Improvement. At this inspection we continued to have concerns. The home has now been rated as Inadequate.

Planning and promoting person-centred, high-quality care and support; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care:
• The provider's values of wellness, happiness and kindness were not always implemented in practice. Staff were observed sharing friendly interactions with people, respecting their choices, equality and diversity as well as their right to make decisions. However, the systems and processes within the home and the provider's response to concerns that had been raised in relation to people's care, did not always promote this practice.
• We have concerns about the leadership and management. When concerns had been raised, the provider had, at times, not been receptive and had not recognised the level of risk that people had been exposed to. There were continued concerns about the provider's oversight and ability to make improvements. Concerns found at the previous inspection had not been sufficiently addressed or improved upon. For example, some people continued to be provided with their prescribed medicines in an untimely way. Risks were not well-managed. The provider had not ensured that they improved through shared learning of the concerns being found at some of their other services.
• There have been reoccurring themes throughout the provider's other services in relation to storage of thickening powders that could cause harm, medicines management for people who were living with Parkinson's disease and people assessed as being at risk of choking being provided with high-risk foods. Delays in giving time-specific medicines to people living with Parkinson's disease was identified at the last inspection and has now been identified in six out of 12 of the provider's other services in the Sussex area. The unsafe storage of thickening powder for drinks, that could cause people harm, has now been identified in four out of 12 of the provider's other services in the Sussex area. Providing high-risk foods to people that have been assessed as being at risk of choking has been identified at one other of the provider's services

within the Sussex area. Despite being found at the last inspection and within nine out of 12 of the provider's other services within the Sussex area, the lack of understanding and application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards continued to be a concern. For example, some people were living with dementia and were unable to leave the home without support from staff. Consideration had not been given in relation to people's capacity to consent to this and DoLS applications to the local authority had not been considered or made.

• Quality assurance processes were not always effective. Despite the untimely administration of Parkinson's medicines being identified at the last inspection in October 2018, the provider had not introduced a way of appropriately monitoring this until February 2019. Although these had identified concerns about people's access to their medicines, changes to the way this was managed had not been introduced until March 2019. This included setting an alarm on the laptops that contained people's EMARs. This was not always effective as the laptops were stored in locked medicine rooms and could not be heard by staff when they were not in the area. Other changes such as setting up a message that appeared on the front screen of the EMAR had been introduced. One person who had Parkinson's disease, however, was not included in this message and therefore staff would not have been alerted to their prescribed medicine times.

• The manager's audits on the timeliness of Parkinson's medicines were conducted the day after they had been given. This meant that no timely action could be taken to ensure that people had access to their medicines according to the prescriber's instructions to lessen the potential effects on their health condition. Neither did it allow for later doses to be altered to ensure there was sufficient time in-between doses if an earlier dose of medicine had been given outside of the prescribing guidance.

• The provider has a dedicated quality assurance team who had conducted audits of the home on two occasions since the last inspection. They had not always identified the concerns we found about medicines management. They were asked why changes had not been made to their audits to ensure that the timeliness of Parkinson's medicines was monitored during their visits. They told us that this could not be implemented until April 2019 when the audit was due for review as they could not change the way they audited services throughout the year as this would not be a fair way of judging their performance.

• There was a lack of clear, robust action when audits had identified issues that needed improvement. For example, there was insufficient action taken to ensure changes and improvements were made and people received their medicines on time. Audits had identified on two consecutive occasions that weekly controlled drugs (CD) checks had not been sufficiently completed for a period of six months. Care plans had not been completed in a timely way when people had moved into the home and assessments and care plans were not being reviewed when there were changes in people's needs. There were no clear plans on how this was to be improved.

• There was a lack of oversight to ensure people were receiving care that met their assessed needs. It had not been recognised that people who had been assessed as being at high-risk of choking were being given high-risk foods. Neither had it always been identified that people were not being supported in accordance with external health care guidance and that assessments and plans to provide guidance for staff were not completed in a timely manner.

• Records to document the care people had received were not well-maintained or completed in their entirety. When people required their health condition, repositioning, food and fluid intake and weight to be monitored, records did not always document the care they had received. It was not evident if people had received appropriate care or if staff had failed to complete the required records.

• A system had been introduced where daily records to document people's food and fluid intake and repositioning if they were at high risk of pressure area damage, were filed and archived each day. This did not allow for sufficient oversight and staff were unable to easily monitor and analyse people's condition over time. This created a potential risk of staff not recognising patterns and trends in people's condition and therefore appropriate action or intervention might not have been provided.

• There was mixed feedback about the leadership and management of the home. One person told us, "The management here is very good." Staff were also complimentary about the management and told us they felt

well-supported. Other feedback was less-positive. One relative told us, "There is no leadership here. Staff have left because of the lack of management." Another relative told us, "Over the past year things have deteriorated." A visitor told us, "Staff morale has plummeted due to the lack of leadership."

The lack of robust quality assurance meant people were still at risk of receiving poor quality care. The provider had not always lessened risks relating to the health safety and welfare of people. Records were not always completed. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Regular staff, residents' and relatives' meetings ensured that people and staff could air their views and discuss any ideas or suggestions.
• Since the last inspection the management team had sought advice and support from external healthcare professionals and local authorities and were working with them to make continued improvements.

How the provider understands and acts on duty of candour responsibility:
• The provider had complied with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.
• People and their relatives told us and records confirmed, that the provider had informed them when there had been changes in people's care.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

We have issued a Notice of Decision to impose conditions on the Provider's registration at Croft Meadow.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Maintain securely an accurate, complete and

contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and any decisions taken in relation to the care and treatment provided.

Evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) and (e).

The enforcement action we took:

We have issued a Notice of Decision to impose conditions on the Provider's registration at Croft Meadow.