The Croft (RCH) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 March 2017 and was unannounced. The Croft provides accommodation and personal care for up to 21 people, including older people with dementia and younger adults with mental health needs, who do not require nursing care. There were 16 people living at the home when we visited.

The Croft did not have a registered manager, however the manager had commenced the process to register with the commission. 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.

At the last inspection in September 2016, we asked the provider to take action to make improvements in relation to areas of the service including medicines management, record keeping, risk assessment and care planning, ensuring people's legal rights to make decisions were assured, recruitment procedures and infection control. We told the provider they must send us an action plan each month telling us what they were doing to ensure people received a safe and effective service which met their needs. Action plans have been received each month and show the manager has been working with a range of professionals to make the necessary improvements. Most areas have now been completed and the service is now embedding these in practice. The manager was aware of remaining action that is required such as ensuring the policies and procedures were up to date and a business continuity plan was in place.

The manager and provider were aware of key strengths and areas for development of the service. Quality assurance systems were in place using formal audits and through regular contact by the provider and manager with people, relatives and staff.

Care plans provided comprehensive information about how people wished to be cared for and staff were fully aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. Systems to manage medicines safely were in place although staff did not have individual information as to when 'as required' medicines should be administered.

People and external health and social care professionals were positive about the service people received. People were positive about meals and the support they received to ensure they had a nutritious diet. People were supported and encouraged to be as independent as possible and their dignity was promoted. Staff followed legislation designed to protect people's rights and freedoms.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work. Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care.

People were offered an extensive range of activities suited to their individual needs and interests providing both mental and physical stimulation.

People and relatives were able to complain or raise issues on a formal and informal basis with the manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Improvements had been made to the homes environment which was clean and safe for people. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

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.

Improvements had been made which were being embedded into practice. Systems to manage medicines safely were in place although staff did not have individual information as to when 'as required' medicines should be administered. People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse.

Risks to people were managed effectively. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. People received the personal care they required and were supported to access healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

An ongoing programme of redecoration was in progress providing a suitable and homely environment for people.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships.

People were positive about the way staff treated them. People were treated with respect. Dignity, choice and independence

were promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the care they required.

People were offered a range of in house and local community activities suited to their individual needs and interests.

The manager sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At this inspection we found improvements had been made although further time was required to complete the remaining work identified by the manager and to embed the changes into practice.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

The service had an open and transparent culture. External professionals were welcomed and the manager consulted with them when required.

A suitable quality assurance process was in place, including formal audits and informal monitoring of the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 2 March 2017 and was unannounced. The inspection was undertaken by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of, or experience of caring for a person with similar needs to people living at the home.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed action plans which we have been receiving regularly from the provider.

We spoke with ten people living at the home. We spoke with the manager, four senior and junior care staff and ancillary staff including the activities staff, the cook, administration and housekeeping staff. We also spoke with two visiting health and social care professionals. We looked at care plans and associated records for seven people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care, support and activities being delivered in communal areas. 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.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in September 2016 we found people were not receiving their medicines in a safe way, individual risk assessments were not in place and people were not always protected from risks relating to the environment. We also found that recruitment procedures had not been followed and people were not protected from the risk of infection. We told the provider they must make improvements and must keep us informed about the actions they were taking to keep people safe. At this inspection we found action had been taken to ensure people were safe. There was now a need to further embed and sustain the improvements into practice.

Overall people were supported to receive their medicines safely. One person told us "Staff do my medication for me". Three other people also told us that the staff gave them their medication. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Medicine administration records (MAR) documented that people had received their medicines as prescribed. We undertook a stock check of some medicines and found that whilst most were correct for one medicine there were less tablets remaining than records showed there should be. The manager immediately commenced an investigation and contacted off duty staff to try to understand how and when the error had occurred. Otherwise the stock check showed there were the correct numbers of tablets indicating that people had received these as prescribed and recorded on the MARs. Training records showed staff were suitably trained and had been assessed as competent to administer medicines. Some people needed 'as required' (PRN) medicines for pain or anxiety. Although staff had information about the PRN medicine there was no individual guidance specific to the person as to when this medicine should be administered. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration of the item when the cream would no longer be safe to use. The home were storing some medicines that required to be stored at cooler temperatures. A refrigerator was available and records showed medicine refrigerator temperatures were monitored. This meant that any fault with the refrigerator would be noticed in a timely manner and the safe storage of any items stored could be assured. The temperature of the medicines storage room was also monitored daily. This was recording at the higher end of safe and the manager said they may need to consider if the room could be cooled or if an alternative medicines room would be safer. At the start of each shift the senior care staff on duty carried out a medicines quality assurance process to ensure records were completed correctly and medicine had been managed safely.

Risks and harm to people were minimised through individual risk assessments that identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Staff showed they understood people's risks and we saw people's health and wellbeing were assessed, monitored and reviewed regularly. People were supported in accordance with their risk management plans. Risk assessments clearly described how to recognise signs of deterioration and actions staff should take. Risk

assessments in place included, safe management of people's mental health needs and people's physical health needs such as moving and handling, mobility, fluid and nutrition, skin integrity and falls. Risk assessments for mental health needs clearly identified the risk and level of risk. They included relapse indicators and information as to what situations may make the risk higher. Information was also provided for staff as to the most appropriate way to respond to people in various situations. Moving and handling assessments clearly set out the way staff should support each person to move and correlated to other information in the person's care plan and described by staff. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice guidance. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, and where necessary people were assisted to change position to reduce the risk of pressure injury. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk.

People were supported to continue some activities which carried a risk where this was their choice and would enhance their lives. For example, one person wished to continue to smoke cigarettes. A risk assessment had been completed which identified the person was at risk of smoking in the home placing other people at risk. Cigarettes and lighters for this person were therefore held by staff and we saw the person was provided with these whenever they requested them and staff supported the person to go outside whenever the person wanted a cigarette. This meant the person could continue the activity they enjoyed without placing themselves or others at risk. Other people who choose to smoke cigarettes had been assessed as being safe to hold their own cigarettes and lighters showing restrictions were only put in place where risk assessments identified the need.

Environmental risks were assessed and managed appropriately. The manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included, the use of electrical equipment, the laundry, clinical waste disposal and handling and the control of substances hazardous to health COSHH. No infection control concerns were identified and people were protected as they were living in a clean environment.

Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff told us they received fire training which was confirmed by records. People had individualised evacuation plans in case of an emergency which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and fighting equipment was regularly checked. There was an emergency 'grab bag' in the foyer which contained individual personal emergency evacuation plans which detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency. The manager had not fully developed a plan to deal with other foreseeable emergencies in the home. They told us this was a 'work in progress'. They did have access to emergency numbers and contact details for emergency services and there was a plan in respect of responding to a fire. Staff had been trained to administer first aid.

The provider had appropriate policies in place to protect people from abuse. One person told us "I feel this is a safe environment". Staff said they would have no hesitation in reporting abuse and were confident the manager would act on their concerns. One staff member told us, "If I had concerns I would speak to my manager or senior. If it was about my manager I would go to social services or CQC." Another staff member said, "If I had concerns I would contact my manager who would make sure everything is done correctly". All staff were confident the manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. The manager was aware of the action they should take if

they had any concerns or concerns were passed to them. They followed local safeguarding processes and had responded appropriately to allegations or concerns of abuse.

There were sufficient staff available to meet people's needs. Care staff were augmented by other ancillary staff, such as housekeeping, maintenance and catering. This meant they were able to focus on providing care and engaging with the people they supported. The manager told us staffing levels were determined by the needs of the people they supported. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and the manager and head of care were also available to provide extra support when appropriate.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

Good

Is the service effective?

Our findings

Following the previous inspection in September 2016 we found improvements were needed to ensure people's legal rights to make decisions were assured, the Mental Capacity Act 2005 had not been fully implemented and records of care people had received were inadequate and incomplete. We also found staff were not receiving a formal induction which incorporated the care certificate. We told the provider they must make improvements and must keep us informed about the actions they were taking to provide an effective service. At this inspection we found improvements had been made and systems were in place to ensure people received an effective service.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to 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. Where people had been assessed as lacking capacity, best interest decisions about their care had been made and documented, following consultation with family members and other professionals, where relevant. The home had identified all possible restrictive practises that may be in place for individual people such as the use of bed safety rails, movement alert equipment and the locking of external doors. Where these were in place specific assessments to demonstrate they were in the person's best interests had been completed. For example, a best interest decision had been made for a person who required the use of bedrails for their safety when in bed. A decision specific assessment of the person's ability to understand and consent to the bed rails had been undertaken. As this showed they could not make the decision themselves a best interest decision had been made with relevant people and staff.

Care staff told us how they offered choices and sought consent before providing care and were clear about the need to seek verbal consent before providing care or support. We heard care and other staff seeking verbal consent from people throughout our inspection. One care staff member said, "We ask them. If they said no, we don't do it but try later. We would also try a different staff member, that often works."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met. We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. The manager was aware of how to contact the local authority lead for MCA and DoLS and told us how they had previously contacted them for guidance and support. Some people had restrictions in place due to other legislation. The manager was aware of how these restrictions should be managed and what action they should take to ensure these were complied with.

People received the personal care they required. Care staff described how they supported people which reflected the information in people's care plans and risk assessments. Staff recorded the personal care they

provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. The manager stated they reviewed records of care to monitor that people were receiving the care they required.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. One person said "Staff accompany me to my hospital appointments". We heard care staff advocating on behalf of a person to a social worker as to why a particular medical investigation would provide reassurance to a person about a health concern they had. People were seen regularly by doctors, opticians and chiropodists as required. The manager was aware of how to arrange opticians and dentists to visit the home should people be unable to attend local surgeries or opticians. During the inspection we saw a visiting dentist and dental nurse undertaking assessments of people's dental needs. They said that if treatment, other than very basic, was required this would be arranged within an accessible NHS clinic. The Croft had equipment suited to the needs of people living there. We spoke with two visiting professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person said "The food is very good here and if I don't like something I can have something else". Another person told us "I am diabetic so I have to be careful what I eat, staff help me to make healthy choices". People received the appropriate amount of support and encouragement to eat and drink. Where people required support this was done in a kind, unhurried way. The staff members providing the support were talking with the people, encouraging them and asking them if they were ready for more. Staff were attentive to people and noted when people required support. Staff noted when people had not eaten well. We heard the cook asking a member of staff whose plate of food was returned only partially eaten and if they required something else. The cook reminded the care staff member to "Make sure it is recorded in her care notes".

People were supported to have a meal of their choice. The cook was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they adapted their food so they had similar to everyone else. For example, using sweetener in their puddings rather than sugar. People were also able to choose the size of meal they preferred. The cook decided on the main meal each day as she was aware of people's preferences. They told us they adjusted the meals to suit each person's likes. For example, although on the day of our inspection the choice for the main meal was beef and onion pie or chicken the cook was preparing cheese on toast for one person and another alternative for someone else. We saw a person being offered an alternative dessert to what was on the menu and heard care staff asking people if there was anything else they wanted. Drinks, snacks and fresh fruit were also offered to people throughout the day, these included hot snacks in the evening such as pizzas or hot dogs. Staff told us they could provide people with food at any time this was requested or required. One person had chosen to eat prior to the main meal time and staff offered to keep another person's desert "for later".

Staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. One person was heard asking for ketchup which was provided. Meals were appropriately spaced and flexible to meet people's needs. People were able to choose where they ate their meals. Some were happy to eat in the dining area, others in their bedroom and some in front of the television. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The manager had created a personal profile for each member of staff which identified their skills and abilities, experience, communication skill, leadership and best fit for the home. This profile in conjunction with a system to record the training allowed the manager to identify training needs and skills gaps within the home. They had arranged two training session a month for staff and the content was based on the managers training needs analysis. Training included, medicines training, safeguarding adults, fire safety and first aid. Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service, such as, dementia awareness, mental health awareness, mental capacity act and physical interventions. Care staff were positive about the training they received and new staff confirmed they had received an appropriate induction and were doing the Care Certificate. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, we saw staff supporting a person who was anxious in a calm and relaxed manner. We saw staff using infection control equipment such as disposable gloves appropriate including disposing of them when they had completed each specific task.

Staff had regular supervisions with the manager. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff also received an annual appraisal, with the manager, to assess their performance and identify development objectives. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away.

At the time of our previous inspection in September 2016 the provider had just started a programme of refurbishment of communal areas and bedrooms. At this inspection we found this work had been undertaken. Many of the bedrooms had been redecorated and there was some new furniture, particularly in the bedrooms. People's bedrooms were personalised and met the needs of the person using them. Communal rooms had been rearranged to more clearly define separate areas for eating and relaxing. Redecoration had considered the needs of people living at the home. For example, hand rails in corridors were now a more contrasting colour to the walls making them more noticeable to people with limited vision or those living with dementia. This would make people more likely to use the hand rails reducing their risk of falling. The manager identified they had further plans to continue the improvements on an ongoing basis. People were able to access external spaces and fresh air if they wanted to do so. People had free access to a paved courtyard area which provided various seating options. We saw people accessing the courtyard throughout the inspection.

Good

Is the service caring?

Our findings

People were all positive about the way staff treated them saying that all the staff were kind and caring. One person said "I get on well with all the staff". Another person told us "The staff are caring". Similar comments were made by all other people who also told us they liked the staff. People said they liked living at The Croft and they felt supported by the staff.

We observed staff over the course of our inspection and found all staff were caring and kind. Staff spoke to people in a respectful but friendly manner and people responded in a similar way. Staff had a good awareness of people's needs and there was a great deal of warmth evident between staff and people. Staff responded to people in a caring way that also protected their dignity. For example, we observed staff supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with them about the food. Staff were kind and compassionate; for example, we observed staff make sure people had a drink with them most of the day, and when their drinks needed to be topped up, staff offered an alternative. Staff interacted in a friendly way and people seemed happy and were laughing with staff. We observed two members of staff assisting a person to move to a wheelchair using moving and handling equipment. The staff explained to the person what they were about to do and gained consent before commencing the procedure.

Staff had built up positive relationships with people. Staff spoke about their work and about people warmly. Staff demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. A new member of staff said "I am learning about people by reading their files". They added "I am finding out about their earlier lives and what makes them happy". A staff member had brought in a box of a person's favourite chocolates. They said they had been in the supermarket and saw them and knew the person would like some. This showed the staff member knew the person well and, even when not at work, considered what may make the person happy and enhance their life. Staff showed respect for people by addressing them using their preferred name and maintaining eye contact. Care was individual and centred on each person. Care plans included specific information which would help support people's dignity and sense of wellbeing. For example, in one care plan there was information as to the support a person required to have their hair colour refreshed on a regular basis. People received care and support from staff who knew and understood their history, likes, preferences and needs. When people moved to the home, they and their families (where appropriate) were involved in assessing, planning and agreeing the care and support they received.

People were relaxed and comfortable in the company of staff. All the interactions we observed between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff were not only talking with people but actively listening to them, giving them plenty of time to respond, testing people's understanding and act upon this as required. Staff did not rush people when supporting them. We heard good-natured banter between people and staff showing they knew people well. Staff responded promptly when people required assistance. For example, a person was having difficulty eating which a member of staff noticed. The staff member discreetly removed the person's teeth as these were loose fitting

and meant the person was unable to eat.

People's dignity was protected during the provision of care at all other times. One person fell asleep on the sofa after lunch. A member of staff noticed the person's back and underwear was exposed and very gently placed a blanket over the person maintaining their dignity. On another occasion a person stood and their trousers fell down. Immediately a staff member approached them, discreetly explained what they were going to do and pulled up and secured the trousers. From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff told us that privacy and dignity was adhered to and we observed care was offered discretely in order to maintain personal dignity. One staff member told us, "I shut the curtains and make sure the doors are shut. I tell the person what I am doing and make sure they are okay with it." People's privacy was protected by ensuring all aspects of personal care was provided in their own rooms. Staff knocked on doors and waited for a response before entering people's rooms. One care staff member said "We make sure people are covered as much as possible when we are providing personal care". Staff were able to tell us if people preferred a specific gender of care staff to provide personal care and staff said they were able to meet these preferences. Confidential care records were kept securely and only accessed by staff authorised to view them.

People were supported without restricting their independence. We saw people were provided with suitable eating and drinking utensils to enable them to be as independent as possible. For example, two people had their drinks in mugs with a cover and mouth piece and another person was given a straw to enable them to drink independently. Another person told us how staff helped them to keep their room clean. They said "I am supported to clean my room". Where people were more independent we saw they were able to come and go from the home as they wished. Care plans included information about what aspects of their care people could do themselves, tasks they may verbal reminders for and when physical assistance would be required. This would help ensure staff only provided help when needed and avoid people becoming more dependent on staff than was necessary.

Staff knew about people and what was important to them and were supported to maintain friendships and important relationships. Care records identified people who were important to the person. There were no restrictions on visiting and visitors and relatives were made welcome. Everyone told us they could have visitors at any time. Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. One person said "I am Catholic and a member of staff takes me to Mass". A local Christian minister provided a monthly service in the home for those people and staff who wished to attend. The manager was aware of how to contact other faith religious leaders if required.

Good

Is the service responsive?

Our findings

Following the previous inspection in September 2016 we found improvements were needed to ensure care files and records were accurate and up to date. We told the provider they must make improvements and must keep us informed about the actions they were taking to provide an effective service. At this inspection we found improvements had been made and systems were in place to ensure people received a responsive service.
People experienced care that was personalised and care plans contained detailed information specific to each person. Assessments were undertaken to identify people's individual support needs and their care plans had been developed, outlining how these needs were to be met. Care plans provided information about how people wished to receive care and support and were comprehensive and detailed, including physical and mental health needs. For example, care plans included individual information that may indicate that a person's mental health may be deteriorating. These are called relapse indicators and where known help staff ensure people received prompt support before they get too unwell and reduces the need for medicines or hospital treatment. Care plans also detailed how staff could support people with their mental health needs. For example, one care plan advised staff to encourage the person to take part in activities as a distraction if they were anxious.

We saw staff responding appropriately when people required support. A person became distressed and started shouting. A care staff member used deflection techniques, calming the person and reassuring them. The staff member later explained they were aware of the person's 'trigger points' and how to deal with them from the care plan.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required when mobilising. This corresponded to information within the person's care plan. A senior member of care staff had been allocated specific time to enable them to complete care plans and undertake monthly reviews of care files. This process was being overseen by the manager. Records of care confirmed that people received appropriate care and staff responded effectively when their needs changed. Some people or their relatives had signed care plans demonstrating they had been involved in identifying how their needs would be met. Two people told us they were involved in their care plans and setting personal goals. One of them said "My goal is to be mentally well".

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift. Staff responded appropriately when people's health needs changed. We saw that the GP had been contacted as staff thought a person may have an infection. Antibiotics had been prescribed indicating that staff had appropriately contacted the doctor. The manager confirmed that systems were in place which would ensure ad hoc medicines could be promptly received at the home meaning there would not be a delay in people commencing treatment.

The manager reviewed all accidents and incident and where people had fallen, the person's risk assessment was reviewed and staff considered additional measures that could be taken to protect the person. The manager analysed the incidences of falls across the home to identify any patterns. One person had had a series of falls; the manager carried out analysis of the falls using a falls prevention tool and identified the need for adaptive footwear and closer supervision by staff while mobilising. Since this has been adopted the person had not had a further fall.

People were offered a range of activities suited to their individual needs and interests. Activities were provided in a planned formal and ad hoc manner by care and activities staff. This included a range of valuing activities as well as crafts and exercises both within the home and local community. One person said "I see to all the flowers on the patio and I go to the bank every Monday with a member of staff". Another person told us "I went to the pancake race yesterday [held in the town] with a member of staff". A third person said "A member of staff took me to Sainsbury's the other day to help me buy some new clothes". The person added "I enjoy going out with staff and having a cup of tea". A person told us about future plans for activities and said "I'm going to start swimming again and staff are coming with me as I am worried how I am going to get in and out of the pool". We observed other instances of staff making arrangements with people to do activities in the future. Staff also supported people to access a range of local community facilities including the library and a community signing group. Staff told us how people had responded positively to the range of activities and about one person who would now go out of the home with staff whereas previously they had refused to leave the building.

Activities were also provided in the home for those less able to access the local community. One person was doing some colouring and a care staff member stopped and told them how well they were doing and how neat the colouring was. Another person told us they enjoyed the in house exercise sessions. A new staff member explained that they were "Going to be doing reminiscence work with the residents".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. The manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. The manager also sought formal feedback through the use of quality assurance questionnaires sent to people which included visual prompts and were written in a way that met people's needs.

People's views about the service they received were actively sought by the manager. We looked at the minutes of the latest meeting that had taken place in February 2017, which covered areas such as outside activities, trips and personal fitness. Questionnaires were sent to people on a regular 3 monthly basis and covered various aspects of the service provided such as food and activities. We looked at the results of the latest sets of questionnaires and found people had responded positively and were happy with the service they were receiving.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The manager told us they had not received any formal complaints and explained the action they would take if they did receive one.

Requires Improvement

Is the service well-led?

Our findings

Following the previous inspection in September 2016 we found improvements were needed to ensure records were accurate and up to date and that the service was well managed. We told the provider they must make improvements and must keep us informed about the actions they were taking to ensure the service was well-led. At this inspection we found improvements had been made although further time was required to complete the work identified by the manager and to embed the changes into practice.

Overall records were now well organised and reflected the service being provided. This included management records and records relating to individual care people were receiving. The manager identified there were some outstanding records related to the management of the service which they were working on. These included a business continuity plan and a need to review all policies and procedures.
There was a clear management structure, which consisted of the manager, deputy manager, head of care and senior team leaders. Staff were confident in their role and understood the part each other played in delivering the provider's vision of high quality care. The manager encouraged staff and people to raise issues of concern with them, which they acted upon. A new care staff member said "I feel very supported by all the staff". Another care staff member described how the home was a "nice place to work" and described how the manager had made a big positive difference to the home. They commented that the manager "knows so much and can explain it to us". Other staff told us they enjoyed working at The Croft, and felt supported by management and other senior members of staff.

Although a limited company The Croft is essentially family owned and two members of the providers family are actively involved in the day to day running of the home. One, who is mental health nurse, has taken responsibility for the management of the home. The senior provider, who is the mother of the manager, was fully engaged in running the service and their vision and values were built around creating a home which has a comfortable and homely atmosphere where people were safe and treated with dignity and respect. Staff were aware of the provider's vision and values and how they related to their work. One member of care staff said "I refer to the home as the Croft Community as it is their home and staff are encouraged to prompt and help the residents".

Regular staff meetings provided the opportunity for the manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. The manager had an open door policy for people, families and staff to enabled and encouraged open communication. People were given the opportunity to provide feedback about the culture and development of the service. People all told us they were happy with the service provided. One person said "Since the change of management things are much better now".

There was an open and transparent culture within the home. Visitors were welcomed and there were good working relationships with external professionals. In order to drive forward improvements within the home,

the manager had arranged for 'The Social Care Institute for Excellence' (SCIE) to visit the home and carry out an independent review of the homes policies and risk assessments to ensure they are compliant with best practice. The manager had also engaged in a programme of other audits by external organisations, covering all aspects of the home, to identify areas of development and set a benchmark for the future. Where issues or concerns were identified the manager developed an action plan to ensure areas for development were monitored and resolved.

This programme of audits had just concluded and the manager had established an internal system to monitor the quality and safety of the home. These included infection control, the cleanliness of the home, people's bedrooms, staff records, falls, accidents and incidents, medicine management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. The manager carried out an informal inspection of the home during a daily walk round. In addition to these checks the manager also undertook out of hours visits when required or in response to any concerns raised by people. On one out of hours visit they identified that staff were failing to carry out their duties robustly and this was dealt with by way of their staff discipline procedure.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The manager had started the process to become registered with the CQC and understood their responsibilities and the need to notify CQC of significant events in line with the requirements of the provider's registration. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred.