Care Quality Commission

Croft House (Care) Limited

Croft House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 20, 21, and 22 January 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

When we last inspected the home in January 2014 the provider was compliant.

Croft House is a 59 bedded home which provides residential and nursing care over three floors. At the time of our inspection there were 46 people living in the home. The top floor, known as 'Poppy' was primarily for residential care services, whilst the middle floor (Primrose) was a specifically designed dementia care unit. The ground floor (Bluebell) had accommodation to provide both nursing and residential care.

During our inspection there was a registered manager in post, however the registered manager had recently taken on a new role with the provider and a new acting manager had been appointed. The acting manager confirmed her intention to apply to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they liked living in Croft House and they found the staff very caring towards them. Relatives also commented on the kindness and support given to people by the staff. People also told us they enjoyed their meals.

We looked in people's bedrooms and the communal areas as well as the kitchen and found the home lacked cleanliness. Further work was needed to prevent the risk of infections spreading.

We saw staff had been safely recruited to work with vulnerable people. This included the provider taking up references and carrying out a Disclosure and Barring Services (DBS) check.

We looked at how the provider carried out their responsibilities under the Mental Capacity Act 2005 in assessing people's mental capacity. We found there were inconsistencies in the provider's practice.

We found a number of people had bed rails in the home and the provider did not have suitable arrangements in place to ensure these were checked for safety.

We looked at the care people were receiving and found some of the care needed to be improved. This included appropriate use of fluid balance charts to make sure people had the correct fluid intake and providing people with the correct support to eat.

We found the home had developed links with the local community centre and staff took some residents over to the coffee morning. People told us about the activities the home organised for them.

We saw the home had in place an activities fund into which people paid for trips out and activities. We found the management of the fund lacked clarity and had not been managed in line with the provider's guidance.

We found staff had not received supervision in line with the provider's policy. This meant staff had not had supervision meetings or appraisals with their line manager to discuss their progress, their training needs or be given an opportunity to raise any concerns.

We saw the management had put in place audits to test the quality of the service. However some of these had not been completed and they did not identify lapses in the quality of service delivery.

We found the system for record keeping incurred staff having to duplicate entries. In people's files we found documents had not been completed about people because they were not relevant to them and we found gaps in people's records.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service not always safe.

We found the home lacked cleanliness and the risk of infection was not minimised.

We saw people had fluid balance charts in place but there was no expected level of intake recorded. Care plans did not provide staff with clear guidance as to how risks should be managed.

We looked at five staff recruitment files and found staff had been safely recruited to the service.

Requires improvement

Is the service effective?
The service was not always effective.

We found there were inconsistencies in the provider's practice when assessing people's mental capacity and making best interests decisions.

People told us the food was good and they enjoyed their meals.

We found the provider did not follow their own policy in supporting staff and providing them with supervision meetings.

Requires improvement

Is the service caring?
The service was not always caring.

People told us the staff were caring and they were happy to live at Croft House. Relatives we spoke with during our inspection wanted to be more involved in the care of people in the home.

We found people who needed support to eat their meals were not treated with respect at mealtimes.

We observed a handover period during our inspection on each floor. We listened to staff speaking about people who lived in the home and found their attitude was caring.

Requires improvement

Is the service responsive?
The service was not always responsive.

We saw the provider had in place a complaints policy and since our last inspection we found people who lived in the home and their relatives had made complaints and had these been responded to.

We found the home had developed links with the local community centre and staff took some residents over to the coffee morning. People confirmed that activities were organised

Requires improvement

Summary of findings

We found care plans were reviewed by staff and people and their relatives were not involved.

We observed people were not always given a choice of drinks.

Is the service well-led?

The service was not well led.

We found the home had in place an activities fund into which people paid for trips out and activities. We found the management of the fund lacked clarity and had not been managed in line with the provider's guidance.

We found audits which had been carried out to test the quality of the service. However not all of these audits had been completed and did not identify lapses in the quality of service delivery.

We found the system for record keeping resulted in staff having to duplicate entries. In people's files we found documents had not been completed because they were either not relevant to them or staff had failed to record information.

Requires improvement

Croft House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20, 21, and 22 January 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

The inspection team consisted of three adult social care 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. The expert by experience for this inspection had a background in working with older people.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints.

For this inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not receive the request and following receipt of a reminder to complete the document contacted the CQC to state they had not received the original request. Due to the original request not reaching the provider, the provider was unable to send us their PIR. During the inspection we asked the provider to tell us what was good about the service and the improvements they intended to make.

During our inspection we spoke with eight people who used the service and 12 relatives or visitors. We also spoke with 17 staff including the registered manager, the acting manager, nurses, care staff, senior care staff, domestic and kitchen staff. We looked at 12 people's care records. 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

All the residents and relatives we spoke with said they felt safe in the home. One relative said, "Yes [the person] is safe and I come in every afternoon." Another person said, "Oh yes I feel safe it's the best place I have been in, they help me a lot", and another person said, "When I go to the toilet there is always someone with me." One relative said, "They help and watch him all the time."

We looked at the numbers of staff on duty during our inspection days and found there were enough staff on duty. We reviewed actual rotas and found there was always a nurse on duty. The rotas included staff who had been brought in specifically to escort people to appointments and staff training time.

We asked people if they got individual attention. One relative said, "Yes there are enough staff, they see to all his needs, since coming in here they have got him feeding himself and walking with a frame which he couldn't do before". Another person said, "There are definitely enough staff, one even came in on her day off and took him for a walk." One visitor told me "Some days there are not enough staff, I think more visits to [person's] room are needed."

We found people had access to two rooms which were potentially unsafe. We found the door to the activities room was open and inside we found activity equipment including a box containing scissors. This meant people who could not safely use scissors unsupervised were put at risk. We also found a storeroom open to people, the store room contained stained mattresses, a piano, chairs and an assortment of slippers. This room had little space for manoeuvring and people were at risk of trips and falls.

We looked at the cleanliness of the kitchen and found the high level grill was brown around the edges. We found the oven doors were stained brown and the bottom of the oven was also brown. We saw there was food debris and dirt on the walls behind the cooker and underneath. The area where the pans stood required brown staining to be removed. We asked to see the cleaning records for the kitchen. We were handed a file with papers falling out. The file was dirty with a stained plastic cover. We found there was a kitchen cleaning rota with tick box requirements. The rota listed tasks to be completed daily, once weekly, twice monthly and monthly. We saw according to the tick boxes the daily cleaning of the kitchen was not taking place every day for example there was no cleaning on Monday, Tuesday and Wednesday of the week commencing 8 December 2014. We also saw there was a sheet for each week and staff recorded, 'All cleaning done' and signed off for the week. On the second day of our inspection we found a staff member had updated the cleaning records. The acting manager explained to us these had been kept in another part of the kitchen. We compared the records with the staff on duty and found staff had allegedly cleaned the kitchen when they were not on duty.

We looked in people's bedrooms to see if they were clean and the spread of infection was reduced and found there was a lack of cleanliness. We found people's mattresses had brown stains. We looked at the commodes in people's rooms and we saw the chair seat pads were stained brown, commode pans were also dirty. We found bumper pads were dirty and torn; this meant they could not be kept clean. In one person's room we found food debris and medicine in the person's bed. The pillow had brown stains. In the ensuite bathroom we found there was no soap in the dispenser

In another person's room we saw there were dusty shoes behind the bed and dead flowers in a vase on the windowsill.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's bed rail risk assessments and found the risks were controlled by staff carrying out checks. In one person's bed rail assessment we saw staff were to carry out checks when they were putting a person to bed. We checked to see when staff carried out the checks and found staff did monthly reviews on the risk assessments. However we found nothing recorded to indicate staff had checked on the safety of the bed rails. Instead we found staff had written comments for example, 'Bed rails in situ'. This meant there was no clear record as to whether staff were checking on whether or not the bedrails were safe.

In one person's room we saw the person lying up against bed rails and were concerned for their safety. A sign outside of the room said, 'Please see a member of staff before entering the room.' We asked for a member of staff to check on the person and the meaning of the sign. The staff member told us the person had had 'MRSA' and they weren't sure if they had it now. We saw them entering the room without any protective clothing. We could not be

Requires improvement

Is the service safe?

assured by the staff member's actions if people were protected from the spread of infection. We looked at the person's care plan and found there was nothing recorded about MRSA.

We looked at a number of people's mattresses. In one person's room we saw a sign which said, 'Please do not tilt the head of the nursing beds when on an AIR flow mattress is in use as it alters the pressure to the mattress in [person's] bed'. We found the person was asleep in their bed, the air flow mattress was switched on and the bed head was tilted at an angle. We drew this to the attention of the acting manager who said adjustments had been made to accommodate this angle. We found the information given about the person's bed was confusing and had the potential to undermine the person's needs.

During our inspection we observed people using the SOFI. We observed one person being given their lunch whilst sitting in a comfortable chair. The staff member placed their lunch in front of them and walked away to the dining area to serve other people. We saw the person try to pick up a fork and they were unable to do that, we then saw the person pick up their mashed vegetables in their fingers and put it in their mouth. We saw they waited fifteen minutes before a member of staff came to support them to eat. Following the meal we checked the person's records and found staff were meant to remain in close proximity to the person and they needed support to eat to avoid choking. This meant without staff support the person was put at risk of choking.

We looked at people's fluid balance charts and found staff were recording people's intake of fluid, however there was no expected level of intake recorded in line with any care plan objectives. We found that differing fluid intake amounts did not trigger any action on the daily recording sheet or changes in the overall care plan. This meant that although records were being kept the impact of people's fluid intake was not being monitored. A member of staff pointed out there was a fluid guide on the wall of clinic room which showed how much a person was expected to drink per day according to their weight.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We observed a medicine round delivered by a senior carer. The carer confirmed they had received training in medicines and had been assessed as being competent to administer people's medicines. We observed the staff member administer medicines to six people. They explained to people what their medicines were for and checked with people if they needed any pain relief. We saw the staff member locked the cabinet so it could not be accessed by anyone else, the staff member then signed the Medication Administration Record (MAR). People told us after the medicine round they always got their medicines on time. We looked at the destruction of people's unused medicines and queried with the manager gaps in records including the home's name, a date and the waste collector's signature. We were directed to another document which confirmed the collection.

We looked at five staff recruitment files and found staff had been safely recruited to the service. We saw each person had completed an application form which detailed their past experience and qualifications. Staff were required to provide names of two referees. The provider had sought references for people before they started work. We also found staff had to produce evidence of identity and complete a medical questionnaire. Staff underwent a five day induction which covered the provider's policies and medication competency assessment. The provider had put in place arrangements for new staff to have mentors to guide them.

We saw the provider had in place a disciplinary policy. We found the provider had disciplined staff in accordance with the policy. We also found the provider had responded to whistleblowing by staff members and carried out investigations.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw the provider had submitted four applications to the local authority, one of these had been refused. We also saw staff had received training in DoLS and staff confirmed to us they had undertaken this training. In a staff meeting held in December 2014 the manager directed the senior staff and is recorded in the minutes as saying, 'All new admissions should have MCA and DoLS considered before the person is admitted'. This meant the home was addressing the issues of people's mental capacity and DoLS at the earliest opportunity.

We found the provider carried out mental capacity assessments and had answered the question about people having a mental impairment. We saw one person was unable to make informed decisions to maintain their health and safety. There was no date on the assessment and having made the assessment we found there was not a best interest's decision in place.

In one person's care records we found the manager had written to their GP to request their medicines be given covertly. However we found there was no capacity assessment in place to show the person was unable to understand the need to take their medicines. We saw some people had 'best interests' decisions in place which included their family members.

On walking around the home we found bed rails were in use in a number of people's bedrooms. We checked to see if the appropriate measures had been put in place to allow this to happen. We saw one person who was agitated whilst lying on their bed fully clothed at 11.30am and spoke with the acting manager. They told us the person was in a bed with bed rails because they 'like to get out of bed'. We pointed out given the time of day this was not unreasonable. We spoke with another member of staff who told us because of their behaviour's the person was kept behind bed rails. On the next day of our inspection we found the person had been supported by staff to get out of bed and was in the lounge. We looked to see if this person had a best interest's decision in place and found there was no decision in place and their bed rails assessment was not personalised to detail why bed rails were being used with this person. We spoke with relatives of other people about the use of bedrails and they confirmed the use of bed rails was all discussed with them when the person came to live at Croft House and decision had been made in people's best interests. This meant the provider was not consistent is following appropriate processes to use bed rails.

We spoke with a group of family members who were unanimous in their praise of their service and told us staff could not have done anything more for them. They told us the staff had supported them and tried to meet their needs at a difficult time.

We asked relatives if anyone had eaten with their loved ones. No relative we spoke with had a meal with their relative but some told us they had sat with them while they ate. One person said "I am here while they give [the person] soft food". Other relatives said, "The food they have is very good, we would buy in if necessary", and "His food is good he enjoys it". Other people told us, "The food is very nice in here" and "They feed us well in here." We saw the provider had in place a menu and the kitchen staff told us if people did not like something they could choose what they wanted. One person said, "If I don't like what is on offer they will get me something else." Staff showed us the arrangements they had in place for people on soft or pureed diets. They showed us how they prepare the food in advance and freeze the vegetables ready for use.

We looked at the food testing arrangements in the kitchen and found the meat temperature was last recorded on 23 August 2014 and the last probe check was recorded as 13 September 2014. This means the provider did not have in place regular testing of food temperatures in the kitchen to ensure the meat was safe to serve. Following the inspection the provider showed us food temperatures were checked at the point of serving. However there were gaps in the recordings provided which meant there was no evidence which showed peoples food was checked every day. This meant the provider did not always check people's food was served at the right temperature.

We spoke with people about being supported individually. One person told us, "I like knitting, they help me to cast on and off, I knit blankets." Another person told us, "The staff take me out and my relatives take me to church but the home organises everything for us, the taxi is waiting when

Requires improvement

Is the service effective?

we get down to the door." One person's relatives told us "They encourage [name] to feed and drink himself. We are amazed how [name] has come on in the time [name] has been here we cannot believe it."

We looked at nine staff records and talked to staff about them receiving support from the manager to carry out their work. Staff told us they received supervision. A supervision meeting occurred between a staff member and their manager to discuss their progress, look at their training needs and discuss any concerns. We saw the provider's policy stated staff were to have four supervision meetings each year. We found the provider was not following their policy. For we found one staff member had been working in the home for over a year had met with their manager once. Another person who had worked in the home for eight months had also met with their manager once for supervision.

We also found some staff did not have an annual appraisal.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Staff told us they did 'lots' of training. They told us this included e-learning. We looked at the training plan and found staff had carried out training in safeguarding, food hygiene, and dementia and infection control. This meant staff were offered training appropriate to their role. The relatives and people we spoke with told us they thought staff knew what they were doing. One person told us they thought staff were well trained.

In the 'Resident Information Guide' it says, 'On admission to the home you will be allocated a named keyworker who will help you settle in and support you during your time in the home. For residents with nursing needs your keyworker will be a qualified nurse. Should you wish to change your keyworker at any time please ask the care manager and she will deal with your request. None of the people or their relatives we spoke with were aware of a named keyworker. This meant the home, having stated keyworkers are allocated to increase the effectiveness of the service had not yet met their own stated aims.

Requires improvement

Is the service caring?

Our findings

One person said to us, “The staff always ask before they see to me”. Other comments included:-

“I couldn't get any better they do anything for me”.

“I am as happy as anything, they look after me very well”

“I am more than happy, they are all very nice”

“I do feel well looked after, I couldn't be better looked after”

“The staff are lovely nothing is a trouble to them”

People told us the home was a happy place, “It is like being at home, everyone is very happy” and “It is very nice, I cannot complain at all.” One relative said, “The care is very good but we don't know what it is like when we are not here.”

We asked people if they were involved in their care and they told us they had not been involved. In the ‘Residents Information Guide’ we read people’s keyworkers would help people update their care plans so it always meets your current needs. We found people and their representatives were not engaged by keyworkers in this process. Two relatives spoke to us about having received an inappropriate response about their relative’s medicines. They told us they did not know if they could take down the bed rails to give their relative a cuddle. Another relative told us they did not feel involved in their relative’s care.

We observed people being treated with dignity and respect. One person told us they had privacy and said, “Yes they shut the door and the curtains if necessary”.

During a lunchtime period we observed staff supporting people to eat and drink using our SOFI. We observed people were not being given personal attention and saw one person was left for 40 minutes without any staff contact over a lunchtime period before being given their meal. We saw staff feed people without talking to them, and one member of staff talked to another member of staff about the person they were feeding. We saw one person was woken up, had a bib put on by a member of staff without being asked their permission and their lunch was then put in front of the person. We found people were not treated with respect at mealtimes.

We observed a handover period during our inspection on each floor. We listened to staff speaking about people who lived in the home and found their attitude was caring. Staff compared notes and discussed what was happening with each resident. We found the information passed from one shift to another was detailed and provided prompts for the next shift to care for people.

We found relatives acted as natural advocates for people who lived in the home. One person told us if there were any problems their family would sort it out with the staff.

We saw the home had tried to involve family members by holding a relatives meeting. We saw the minutes of the meeting involved a sharing of information between the manager and the relatives. One relative told us there were only four people at the last relatives meeting. Another relative told us they were not aware of such meetings. Following the inspection the manager told us these meetings were displayed on posters around the home.

Requires improvement

Is the service responsive?

Our findings

People told us staff sat and talked to them, one person said, “Oh yes they do we have a good laugh, they sit and chat, they couldn't be any nicer, nothing is too much trouble”. Another person told us about staff talking to people, they said, “They (staff) do if they are not too busy” and “Yes they do but I talk too much anyway.”

We talked to people about the activities they were involved in. Three people said they did not get involved with activities. One person said “I do the exercises”. We saw those who were able to go out were taken out on trips and meals. One person said, “We go out occasionally on outings”. We found the home had developed links with the local community centre and staff took some residents over to the coffee morning. Another person expressed a wish to be able to develop a previous hobby. We found the provider arranged activities to prevent people from being socially isolated.

We spoke with people about what happens if they became ill. They told us they did not go to the doctors the staff would get the doctor in if necessary.

We found people living in the care home had care plans and risk assessments in place. Before a person came to live in the home visits had been carried out to each person to do an assessment of the person’s needs. We talked to people about their care plans and if relatives were involved in the care plans and the care plan reviews. We found care plans were reviewed by staff. One relative told us they get updated, “Only what I read from the district nurse report.” Another relative said, “We get updated straight away if there is a change.” Other family members told us they did not know what was happening with their relative and were concerned staff had not learned when their relative was in pain. Another family told us about a specific medical condition and we spoke to staff about the persons’ medical condition. They told us they had not received any information on the condition and were not sure where the information came from. During our inspection we found relatives who were able to give information about people who lived in the home, but the service had not routinely involved them in care reviews.

We looked at people’s care plans and risk assessments on each floor. We found on the Poppy floor information was detailed for example topics of conversation which led to increased agitation in people were recorded. The detailed records provided staff with sufficient information to care for the person. We found on the other floors care plans and risk assessments were not as detailed. We spoke with the acting manager about our findings; they attributed our findings to having a consistent staff group in place on the Poppy floor.

We noted in one person’s records it was recorded that they had capacity to make simple decisions for themselves. We observed a member of staff bring the person into the dining room in a wheelchair and manoeuvre the wheelchair towards a table. A conversation took place about the person with one member of staff saying they would make the person a cup of tea. We found the person had not been asked by that member of staff and was not given the choice.

We saw the provider had in place a complaints policy and since our last inspection we found people who lived in the home and their relatives had made complaints. In the ‘Resident Information Guide’ we read, ‘An accurate record must be maintained of all complaints and compliments received whatever the source. The record should also show the outcome of all complaints and a description of the investigation which took place’. We saw the provider had recorded the complaints and gave information about the outcome of each complaint.

One person told us they had not made a complaint but said “If it was necessary I would go to the manager and would feel I could.” Another person told us they had made a complaint and it had taken a while to get things sorted out.

Requires improvement

Is the service well-led?

Our findings

During our inspection there was a registered manager in post, however the registered manager had recently taken on a new role with the provider and a new acting manager had been appointed. The acting manager confirmed her intention to apply to become the registered manager. At the time of inspection we had not received any notification of the management changes. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke to people and staff about the managers, the responses we received varied, some gave negative and some positive and some did not respond.

During our inspection we found in a 'Resident information Guide' a section on charges which said, 'All residents are required to make a contribution to the activities fund which is managed and controlled by the activities committee'. The registered manager confirmed the contributions to the amenities fund were voluntary and following the inspection the registered manager showed us an updated guide which reflected this statement. We looked at the number of people paying into the fund and found that not everyone subscribed. Two relatives told us they did not know this was an optional fund.

We read a document entitled 'Croft Care Group Residents Amenity Fund' and found the provider was not adhering to their own guidance on the management of the activity fund. For example the guidance said some items may require discussion with residents for them to approve expenditure for example Christmas presents, birthday presents and floral tributes. Following the inspection the registered manager provided us with a different version of the same document it stated, 'All residents must be consulted regarding how the amenity fund is spent'. We looked at the financial transactions for the activities fund and found expenditure on 23 December for Christmas presents in excess of £450, this amount included presents for people who did not pay into the fund. We found neither people nor their relatives had been involved in expenditure decisions. We also found the registered manager had considered but not set up an appropriate bank account. However the manager told us the fund was kept separately from other funding streams coming into the home.

We found in one person's care plan who paid into the fund they were unable to join in any activities. We spoke to the registered manager about this person who told us they would review the person's contributions. We found the service had failed to review the appropriateness of people's contributions.

We found other services had been engaged by the home to support people. This included GP's, Community Psychiatric Nurses, psychiatrists and the district nursing team. This meant the provider was seeking support for people who had additional needs.

We saw the acting manager had carried out a number of audits and we asked them to explain what happened to the care plan audits. They told us the actions resulting from the audits were passed to the nurse on duty, who may pass them to the next nurse if they cannot complete the actions. We pointed out there had been no response to the audits since November 2014. We found this was not an effective quality assurance method.

We asked to see the existing mattress audit tool and found staff had checked mattresses. However on some of these checks the dates were missing. We spoke with one relative who pointed out to us a large brown stain on the underside of a mattress and told us it had been there 'for months'. We found the auditing of people's mattresses required improvement. We spoke with the acting manager who showed us a new auditing tool they had devised to audit people's mattresses.

We looked at the kitchen cleaning records and found there was a requirement for the manager to sign. We saw the records had not been checked and signed by a manager.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at people's medicines audits carried out by the registered manager and found they were not fit for purpose. We saw the completed audits did not consider the safe management and handling of people's medicines.

We recommend the provider review the auditing systems in place in the light of current NICE guidance.

Requires improvement

Is the service well-led?

We looked at people's records and found there were different recording tools for staff to complete for example staff were expected to complete a personal care chart, records of contact with professionals and records of contact with family members as well as complete daily notes. We saw staff completed a personal care chart, the chart included making sure a person's room was clean and tidy. We also saw another chart staff were expected to complete to say they had cleaned a person's teeth. We found there were two fluid balance sheets in place, one sheet required staff to record fluids only and encouraged staff to total inputs and outputs. We found these were not completed. Another sheet included food intake as well as fluid. The latter sheet did not require staff to total the intake of fluids.

We looked at the personal care charts and found there were gaps in the charts. We compared these with the daily records and we found some of the records did not indicate if a person had received personal care. Following the inspection we sought clarification from the acting manager who checked people's daily records. They reported back to us that although there were gaps in people's personal care charts there was some information in people's daily records to say people were given personal care, but these did not contain detail. The acting manager told us they had instructed staff to add dates and times to all entries.

We found sheets for recording visitors and contacts with other professionals were out of date. We compared the daily records with the contacts records and found they did not match, for example we found in the daily records people had been visited by family members but these were not recorded on the visitor's sheets. This meant the record systems in place duplicated information.

In people's files we found documents had not been completed about people because they were not relevant to them. This made the files bulky and reduced the personalisation of people's files. We found records were incomplete for example one person did not have their service user profile completed. In another person's care file there was a plastic pocket labelled DoLs but there was no record of a DoLs application having been made. We found people's daily care records were incomplete. Information about visitors was written in the daily care records but not recorded on the visitors sheets.

We observed one staff member ask another for their surname so they could sign the records when a person required two people to care for them. We queried this practice and the staff member said, "Yes you can do that". We found due to this method of record keeping staff were not personally signing to say they had carried out the delivery of a person's care.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered provider had not taken steps to ensure each person was protected against the risks of receiving care that was inappropriate or unsafe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered provider did not have in place effective systems to regularly assess and monitor the quality of service provision.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered provider had not maintained appropriate standards of cleanliness and hygiene activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered provider did not have in place accurate records.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider did not have in place suitable arrangements for staff to receive appropriate supervision and appraisal