Broadoak Group of Care Homes

St Marys

Inspection report

The Old Vicarage
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Tel: 01623795231

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 12 January 2017.

St Marys is a care home with 23 places for older people and people living with dementia. On the day of our inspection there were 11 people living permanently at the service and four people receiving short term care.

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

At our last inspection of the service on 25 January 2016 we identified the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider had not ensured staff had received appropriate training, development and support.
After the inspection the provider sent us an action plan to tell us of the action they would take to make the required improvements. At this inspection we found the breach in this regulation had been met. Staff received an appropriate induction when they commenced their employment. The frequency of staff supervision and appraisal meetings for staff to discuss their work and development had increased. Staff received appropriate opportunities to complete training and update their knowledge and skills.

Some concerns were identified with the environment, this included safety concerns relating to dining chairs, radiators and maintenance to windows.

Staff had received training in adult safeguarding therefore were aware of how to protect people from harm. Risks associated to people's needs had been assessed and planned for. However, those people in receipt of short term care had no risk plans in place to instruct staff of what their needs were. Accidents and incidents were recorded, monitored and analysed for themes and patterns and action was taken to reduce further reoccurrence.

There were sufficient staff on duty on the day of our inspection to meet the needs of people at the service. However, there were no clear systems used to review people's dependency needs to ensure sufficient staff were available at all times. Staff were recruited through safe recruitment processes.

Following an infection control audit by the local clinic commissioning group, improvements were being made to the cleanliness of the service and the measures required in the prevention of infections. Some issues were identified with the management of medicines. This involved not having clear information about medicines used as and when required, and how people liked to take their medicines. The audits in place had failed to identify some minor discrepancies with the stock of medicines.

People's rights were protected under the Mental Capacity Act 2005. Staff were aware of the principles of this legislation and correct action had been taken when people lacked mental capacity to consent to their care.

People received a choice of what to eat and drink and these met people's needs and preferences. People were supported appropriately with their healthcare needs and the service worked well with external healthcare professionals.

On the whole staff were caring, kind and compassionate and had a good approach when supporting people. People were involved in opportunities to discuss and review the care and support they received. Information about independent advocacy services was available should people have required this support.

People told us that they found the activities limited. Care plans to support staff to know how to meet people's needs in the main were informative and were reviewed regularly. However, there were no care plans in place for people in receipt of short term care. Information about the provider's complaint policy and procedure had been made available for people.

People who used the service and staff received limited opportunities to be involved in the development of the service. There were no plans in place to continually drive forward improvements.

The registered manager had met their regulatory requirements because they had notified us of events they are required to do. There were systems in place to monitor the safety of the service provided. However, these were not effective and had failed to either identify risks or take appropriate action to mitigate risks to people.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some safety issues were identified with the environment.

Staff were aware of how to reduce potential harm but risk plans associated to people's needs were missing in places.

Sufficient numbers of staff were on duty to meet people's needs during our inspection. However, systems were not robust to ensure that sufficient staff were on duty at all times. Staff were recruited through safe recruitment processes.

Improvements were being made to the prevention and control of infections. Some issues were identified with medicines management.

Is the service effective?

Good

The service was effective.

Improvements had been made to staff induction, training and support.

People's rights were protected under the Mental Capacity Act 2005.

People received sufficient amounts to eat and drink and external professionals were involved in people's care as appropriate.

Is the service caring?

Good

The service was caring.

On the whole staff were kind, caring and compassionate and people's privacy and dignity were respected.

People and their relatives were involved in decisions about their care.

Advocacy information was available for people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people had care plans in place to inform staff of how to meet their needs. Activities required some improvement.

A complaints process was in place and available to people and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor the safety of the service provided, however, they were not effective.

People and their relatives received limited opportunities to be involved in the development of the service.

The provider had met their regulatory requirements.

St Marys

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 12 January 2017 and was unannounced. The inspection team consisted of one inspector 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 service.

Before our inspection, we reviewed the information we held about the home. We also contacted the commissioners of the service, healthcare professionals and Healthwatch to obtain their views about the care provided at the service.

During the inspection we observed care and spoke with six people who used the service and two visiting relatives for their feedback about the service. We also spoke to a visiting healthcare professional, the registered manager, home manager and three care staff. We looked at the relevant parts of the care records of six people, staff recruitment files and other records relating to the management of the service. This included medicines management and the systems in place to monitor quality and safety.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. 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

People were protected from avoidable harm. People told us that they felt safe living at St Marys. One person told us, "Safe? Oh good gracious yes with all these red buttons and staff around all the time. And at night you are confident someone's there." A visiting relative said, "Safe yes, very safe."

Staff told us how they ensured people's safety. One staff member told us, "If we had any concerns about abuse in any form we would not hesitate to report it to the manager, who would act on it." Staff were clear about their responsibilities in protecting people from harm and risks associated to their needs including the environment. Staff told us they had received adult safeguarding training and records confirmed this.

Information about adult safeguarding was displayed on the noticeboard in a communal area. This advised staff, people who used the service and visitors, of the action to take if there were concerns of a safeguarding nature.

People told us how risks associated to their needs were managed. One person told us how staff supported them to remain safe. This person said, "They [staff] do help me with bathing, they don't leave me." A visiting relative told us, "[Name of family member] has a mat by their bed because they got out of bed and fell once, they [staff] can check now. It was set off by accident by me and they came straight away."

Staff were knowledgeable about how risks were assessed, managed and monitored. One staff member said, "We are assessing risks on a daily basis. For example, [Name of person] has a hospital appointment today and is going with their relative. However, due to concerns with the person's mobility today we will send a staff member too." Staff gave examples of people's risk plans and the equipment identified as required to support people and maintain their safety. This included pressure relieving mattresses and cushions for people at risk of skin damage. People at high risk of falls had sensor mats in place to alert staff to when the person had got out of bed. We saw this equipment was in place and being used.

We found examples of people's risk plans that advised staff of the action required to manage known risks. These were reviewed regularly and when changes occurred were updated. An example of this was a person experienced a change to needs associated with their skin and their care plan was amended to advise staff. However, we identified that people who were at St Marys receiving short term care did not have risk plans in place. Short term care means people who do not live permanently at the service. This meant there was no written guidance for staff to safely meet these needs. We discussed this with the registered manager and home manager who agreed to address this immediately.

We observed staff provided safe and effective care to support people's safety. We noted that during both the morning and afternoon there was always staff presence in the two lounges. Asked about this one member of staff told us, "Some people are unstable on their feet. Even if they can walk they may have problems getting up. It's better to be safe than sorry."

We saw two members of staff transferring a person from a wheelchair to an easy chair. We saw that the staff

did this in a safe manner, using best practice guidance. Staff were gentle, kindly and patient, all the time reassuring the person and allowing them to do as much for themselves as they could. However, we saw another person supported by a member of staff who struggled to transfer the person from a wheelchair to a dining chair. Other staff came to assist and it was identified that the wheelchair brake was not on which contributed to the difficulty. This was not safe practice.

Personal emergency evacuation plans were in place that informed staff of people's support needs in the event of an emergency evacuation of the building. The provider also had a business continuity plan in place and available for staff that advised them of action to take in the event of an incident affecting the service. This meant people could be assured that they would continue to be supported to remain safe in an unexpected event.

Whilst we saw there were checks completed on the environment and equipment for safety, we identified some risks that these audits and checks had not identified. This included safety issues with regard to some radiators, dining chairs and internal cracks in window sills. We were aware that the local clinical commissioning group had completed an infection control audit in November 2016. Recommendations were made to improve hygiene and cleanliness and prevention and control of infections. The registered manager had produced an action plan and improvements had been made with further timescales in place to complete the required actions.

There was sufficient staff deployed appropriately to meet people's individual needs and keep them safe. People told us they felt there were enough staff at the home to meet their needs. A visiting relative told us they had no concerns about staffing levels provided. Comments included, "I think so [referring to sufficient staff available], I've never seen anyone waiting."

Staff told us that when people were well they felt staffing levels were adequate. However, staff said that if people's needs increased this put a strain on staff, and it impacted on how they met people's needs. Examples were given about when people required additional care at the end stage of their life, and people who were unwell due to an infection that affected their health and wellbeing. We asked the registered manager how they assessed people's dependency needs to ensure sufficient staff were provided. They told us there was no system in place used to determine what staffing levels were but said they would increase staffing if required.

We found staff were organised and provided safe care and support. Response times to calls for assistance were within appropriate timescales. We found there were appropriate numbers of staff on duty on the day of our inspection and deployed appropriately to meet people's needs. Staff on duty had a good mix of experience, knowledge and skills.

The provider operated an effective recruitment process to ensure that staff employed were suitable to work at the service. Staff we spoke with confirmed they had undertaken appropriate checks before starting work. We looked at four staff files and we saw all the required checks had been carried out. This included checks on employment history, identity and criminal records. This process was to make sure, as far as possible, that new staff were safe to work with people using the service. This showed that the registered manager followed robust recruitment practices to keep people safe.

People told us that the service handled their medicines well and that they got them on time. One person said, "I'm on I don't know how many tablets, they [staff] get them for me. Some are painkillers but I don't have to ask for them, I get them regularly." Another person told us, "I do nothing, they [staff] do it all. There's one particular tablet I have to take three times a day because of my condition and I get them fine."

We observed a staff member administering people their medicines. They were unhurried and gave an explanation to people about the medicine they were administering. They were seen to ask people who were on pain relief medicines as and when required, if they required any medicine and respected people's decisions. However, we saw that good practice guidance was not always followed. For example, we saw the member of staff administering a person their tablets. The staff member poured the tablets from a cup into their hand before handing the tablets to the person. The staff member was not wearing gloves. This meant there was a risk of cross contamination.

Medicine Administration records (MAR) were used to confirm each person received their medicines at the correct time and as written on their prescription. We saw these had been fully completed and confirmed people had received their medicines correctly. Each MAR was identified with a picture of the person. This meant staff could safely administer medicines to the correct person. However, not all records showed what the person's preference was to how they took their medicines.

Whilst protocols for medicines prescribed as and when required, had some level of detail for staff of when to administer, this lacked specific detail. For example, it did not state what the maximum dosage should be within a 24 hour period. This meant staff did not have clear instruction and people's safety may have been compromised. Audits and checks were in place to monitor that medicines were managed safely. However, we did a sample stock check of medicines and found two discrepancies where a small amount of tablets were missing. There was no account for this. We discussed our findings with the registered manager and home manager who said they would review their procedures.

Covert medicines are medicines administered in a disguised way for example, in food or in a drink, without the knowledge or consent of the person receiving them. Where a person was receiving covert medicines, there was documentation to show there had been consultation with and approval from the GP and the pharmacist had been consulted to ensure the medicines given covertly were not affected by the use of this method.

Medicines were stored safely and room temperatures were taken daily and these were seen to be within safe limits.

Good

Is the service effective?

Our findings

At our last inspection of the service we identified a breach with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not receive sufficient training and support. At the time of this inspection we found this regulation had
been met.

New staff received an induction that included the Skills for Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to. This told us that staff received a detailed induction programme that promoted good practice and was supportive. The registered manager said that on completion of the care certificate staff were automatically registered onto a health and social care diploma course. Staff told us and records confirmed, staff had gained or were working towards different levels of the diploma qualification. This was good practice and supported staff to develop their knowledge and skills further.

Staff told us about the training opportunities they had received in the last 12 months; staff said this was a mix of both on-line training and face to face training. Staff told us that they also received support and opportunities to develop their awareness of healthcare needs from visiting district nurses. A staff member told us, "I've completed training in first aid, health and safety, infection control and diabetes. The training is of good quality and the manager would source additional training if requested." They added, "We've also had awareness training from district nurses which was really useful."

We looked at the staff training plan and training certificates that confirmed staff had received appropriate training within the last 12 months as described to us.

Staff told us that they received one to one meetings with the registered manager or home manager and that this was helpful and supportive. One staff member said, "Supervision meetings are more frequent and we have a yearly appraisal of our work. It's easy to become complacent so it's good to review your work. Issues are discussed and we receive praise and recognition too."

We looked at the staff supervision and appraisal plan and three staff files that confirmed staff received regular opportunities to discuss and review their work, training and development needs.

People's consent to care and support had been appropriately gained where they had the mental capacity to consent. We saw examples of people signing care plans to show they had been involved and agreed with the decisions made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found examples that when people were not able to make specific decisions for themselves, mental capacity assessments had been completed and best interest decisions were documented. Staff were aware of the principles of the MCA and what their responsibility was in ensuring people's capacity was considered. Where best interest decisions were made on behalf of people least restrictive options were considered to ensure people were appropriately protected.

We saw examples of do not attempt cardio-pulmonary resuscitation orders (DNACPR) in place. From the sample we saw these had been completed appropriately. Some people had 'Lasting power of attorney' (LPA). This means another person has the legal authority to make decisions on behalf of a person who lacks mental capacity to make decisions for themselves. Where LPA was in place this was known, recorded and a copy of the authorisation was in the person's care record. This told us that people's rights were understood and protected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). One person had an authorisation in place with a condition and this was being met. This meant that people could be assured they were effectively and lawfully supported.

Some people were living with dementia and experienced periods of increased anxiety and agitation. People told us that staff supported people well during these times. A visiting relative told us how their family member's mental health needs had recently deteriorated, resulting in regular episodes of behaviour that was challenging for staff to manage. They said they were confident appropriate action had been taken.

We found staff had information and guidance of how to support people at times of heightened anxiety. We also saw how referrals were made to external health professionals to carry out further assessments and provide guidance and support.

People were supported to eat and drink and maintain a balanced diet based on their needs and preferences. People told us that they were satisfied with the meal choices and were positive about the quality and quantity of both meals and drinks. One person said, "The menu's quite good. In a morning they'll [staff] ask you what you want, tell you what's on. I get enough yes." Another person told us, "You always get a sweet which is good, you get quite enough, they sometimes ask if you want more. Tea is usually sandwiches but you can have things on toast too." A third person added, "If you don't like what there is they'd do you something else, an omelette or something." A visiting relative told us the "home cooked food is nice, homemade cakes every day."

We observed the breakfast and lunchtime meal servings. People had a good choice of hot and cold breakfast choices. We saw staff asked people what they wanted for their main course, there was a choice of two meals and staff gave people their preferred options. One person followed a vegetarian diet and they had a meal that we saw was listed in their care records as a meal preference. We saw that the meals were well presented and looked appetising. People told us that the meals were hot.

We saw there were good stocks of food and this was freshly prepared on the premises. We saw there was a menu with a five week menu. Information about people's needs and preferences were available for kitchen staff, this included recommendations from healthcare professionals such as people that required a soft diet due to needs around swallowing.

People's nutritional needs had been assessed and planned for including consideration to religious or cultural dietary needs. This included monitoring people's food and fluid intake and weight to enable action

to be taken if concerns were identified. We saw these records were up to date and action had been taken in a timely manner to respond to any changes.

We spoke with a visiting healthcare professional. They told us they had been visiting the service for the last three years and had no concerns about how people's healthcare needs were supported. They described the service as, "It's one of the best care homes I go to, wound care, palliative care is very good."

Staff were knowledgeable about people's health needs and the action required to support people. For example, staff told us clearly and confidently how they supported people effectively with diabetes and catheter care. This told us people could be assured their health needs were known and understood by staff.

People's care records showed that staff worked with healthcare professionals to meet people's needs. Recommendations made were seen to be followed and referrals to external professionals were completed in a timely manner.

Good

Is the service caring?

Our findings

People had developed positive and caring relationships with the staff that supported them. One person described staff as, "They are very nice and respectful." Another person said of the staff, "Nice lasses." A third person added, "Anything you want they are there for you." Additional descriptions used to describe the approach of staff included, "Very caring, considerate, thoughtful and sociable."

A visiting relative told us, "Staff are warm, approachable, all very pleasant." This person added, "The home being so small means the staff know all the people so well. I've always asked [family member] if they are happy here and they would tell me if they weren't and they always say staff are so lovely, nice. When I go away I'm happy [family member] is being looked after." Another relative described the care provided as, "Amazing, brilliant, really good. Because it's a small home they [staff] get to know [family member] I've every confidence in them."

A visiting healthcare professional gave positive feedback about the care and approach of staff. They said that staff understood and knew people well and were caring, friendly and organised.

Staff that we spoke with spoke positively about their work and that they enjoyed time spent with people in their care. One staff member told us, "I like working here; it's a friendly good service where the staff are excellent. Each person is different and are supported well."

We observed people's dining experience that demonstrated care could have been better. For example, tables were set with cutlery, paper napkins but no condiments for people to use as they wished. However, we saw one person did ask for pepper and a staff member fetched this for them. One tablecloth had food marks from a previous meal. One table did not have a cloth. The bare surface of this table was sticky due to the varnish coming off but also had food deposits on it. This meant there had been a lack of attention to detail to ensure people received their meal in a respectful manner.

We saw that staff were present in the dining room throughout lunchtime and were attentive offering to assist people if they wanted this. They continually checked that people were, "Alright" and interacted with people in a friendly, kindly manner. However, we observed the interaction of one member of staff that could have been better. For example, one person living with dementia sitting at a dining table became confused and kept standing up and saying they had to find their "rent book." We saw a member of staff tell the person that they would help them look for it later and then saw them encouraged the person to sit down and eat their meal. Initially the staff member did this in a kindly, gentle manner but as the person persisted, we saw that the staff member became impatient and looked at other people at the table and rolled their eyes. We then saw that another staff member came to the person and took time to listen to the person, reassured them and offered them a dessert. When the person said they did not understand the choice of desserts the staff member said that they would "bring both" to show them which they did. This told us that on the whole staff were kind, caring and compassionate but some staff were inconsistent in their approach.

We found staff responded well to people's comfort needs. For example, one person whilst eating their meal

at lunchtime began to cough; a member of staff responded quickly and provided support to clear their mouth of food. They were calming and reassuring towards the person. We then noted another staff member kept a close observation of the person until they had finished their meal.

We observed a person who had a particular health condition that affected their breathing. This person was seen to become anxious at times with their breathing. Staff were quick to pick up on this and asked if the person was alright and gave reassurance. Another person was described by staff as not being well, we found them to be very attentive to the person. We observed a person living with dementia liked to sing, however, this annoyed others and a person shouted for them to stop. We noted a staff member responded immediately to the person shouting and discreetly spoke with them. This person acknowledged what was said and stopped shouting at the other person.

We saw that the care extended to visiting family members. One relative returned with their family member from attending an outpatient hospital appointment. We saw that both the person and their relative were offered a cup of tea.

Information about independent advocacy support was available. This meant should people have required additional support or advice, this information had been made available. People and visiting relatives told us that they felt involved in how care and support was provided. People told us they were aware of their care plans and some told us they were involved in the development of these. One person said, "I think I've got one, my niece will deal with that." A visiting relative said, "I've seen and signed them [care plans] going back a while, don't ask me what it is."

We found care plans were reviewed monthly and we saw example of meetings and discussions with people and their relatives about the care and support provided.

People told us that staff treated them with dignity and respect. A person who received support from staff with their bathing told us, "They are respectful, there's no embarrassment." Another person told us, "What is very good, they [staff] take me for a bath and even though that could be very embarrassing they handle it very well, treat you with respect, help you maintain your dignity."

A visiting relative said, "Staff always treat [family member] with dignity and respect. If [family member] is being uncooperative they don't use force or anything, they just step back and talk kindly, just respect them." This relative added, "If we need to talk about [family member] they take us into the office but they'll still bring [family member] in with us."

We observed staff knock on people's door and wait for a response before entering the room. We found some concerns with privacy locks on toilet doors missing. This was a concern as we saw a person's privacy and dignity was compromised when they were using the toilet. We discussed this with the home manager who agreed to report this to the provider for attention.

Staff we spoke with told us how they valued people's privacy, dignity and respect. "One staff member said, "Whilst we support people we respect their privacy and ensure their dignity is maintained. I treat people as I would want to be treated."

The importance of confidentiality was understood and respected by staff and confidential information was stored safely.

Requires Improvement

Is the service responsive?

Our findings

A reoccurring concern was made about the lack of activities available for people. One person told us that during the day they would, "Sit here, go to my room after dinner, and watch television in there." Another person said that they, "eat, sleep and drink tea." This person added, "There's nothing to do. When I've been at [another similar service] we played bingo, cards, dominoes and quizzes but they don't do that here."

One person who we spoke with in their room, told us they spent most of their day there watching DVDs and reading the newspaper. This person said, "I'd rather be up here [bedroom], there's nothing to do downstairs, there could be more to do. At Christmas time there was singing and carols but that's just Christmas time. I remember one or two years ago there was a trip out but that's the only time." Though some people told us they preferred to stay in their rooms rather than go into the lounges, it was not clear if this was by choice or was because of the lack of any stimulating alternative.

A visiting relative told us that during the day their family member would, "sit in their chair and watch television." This person added, "I don't think there's anything to do all day. I've never been aware of any activities during the day. At Christmas they had a few things on, Carol service, pantomime. A party. All very nice. Someone came in and sang."

Staff said that they tried to provide activities in the afternoons. One staff member told us, "I would like to see more activities for people but participation is limited, people often refuse anything offered." Another staff member said, "Two people attend an external day service which they like. We try and do things in the afternoon. [Name of person] likes to walk around the church garden next door and I sometimes take them." Staff told us there was a visiting hairdresser but some people chose to go to a hairdressing salon in the community, and a local church group visited on a monthly basis.

We observed an external entertainer visited in the afternoon of our inspection and provided chair based exercises. The home manager said they visited monthly. We observed one person enjoying completing word puzzle books. Another person watching television.

We did see activity records which listed activities such as, "armchair exercises, skittles, floor bowls, nail and hand massages, watching TV, chatting with staff". However, a significant number of entries stated people, declined, were sleeping, agitated or received a visitor. This told us that activities provided limited stimulation, interest and occupation.

The home manager told us that they completed an assessment before people moved to the service. We saw care records for people that were receiving short term care. Whilst we saw pre-assessments had been completed, there were no care records in place that advised staff of what their needs were and the support they required. Staff told us that they were advised in hand over meetings what people's needs were, but there were no care plans in place to refer to. This was a concern as this could have impacted on people's health and well-being. We discussed this with the registered manager who said they would complete care plans for people on short term care as a matter of priority.

People told us that their routines and preferences were responded to by staff. This included a choice of bedtime and morning routines. Some people had specific needs and we saw information was available to support staff to provide a responsive service. For example, one person had diabetes and information was clear for staff to know how to support this person to remain in good health. This included the signs and symptoms to look for and action required, should the person's diabetes become unstable.

The provider enabled people to share their experiences, concerns and complaints. The complaints procedure was available for people. People told us they felt they could and would if necessary, make a complaint. One person said, "I've had no problems so far. If I had I'd talk to them [staff]." Another person told us, "I've never had to make a complaint. Any issues are dealt with straight away." A third person added, "I've never needed to make any complaints but would if I needed to. To me they do listen to what you say. Don't just sweep it under the carpet." A visiting relative told us, "I have had no need to make any complaints. If I had any issues I'd just talk to them [staff]."

We saw compliment cards received from relatives for the care and compassion shown by staff to their family member. We looked at the complaints log and saw no complaints had been received.

Requires Improvement

Is the service well-led?

Our findings

We identified some risks with the environment that had not been picked up on by the provider's quality and safety checks that were in place. For example, a number of dining chairs were found to be unsafe due to arm rests not being secured. This posed a safety risk to people's mobility needs.

We saw that there were large cracks and gaps in the window ledges in the dining room and a window frame was rotting. This meant people's safety was compromised.

We saw that a radiator in one of the lounges had the control valve knob missing and that the thermostatic valve head was missing. This radiator and others downstairs were found to be very hot to touch and were not covered to provide protection, or risk assessments completed. This meant people were at risk of injury.

Monthly audits completed on fire safety in October and November 2016 identified there was an issue with a person's fire door. The audit recorded that this had been reported to 'head office'. Audits completed for the internal and external environment showed that a floor tile in the dining room was cracked. This too had been reported to the provider along with a kitchen door that required replacing, the car park wall and fencing was in need of repair and security to the garden needed action. These issues were all found to be still outstanding and there was no action in place to show when these issues were to be addressed. This meant people could not be assured of their safety.

The registered manager acknowledged that they had not identified all the issues that we had during this inspection. However, they said they had discussed the need for the service to be refurbished with the provider who was due to visit the service. We were concerned that the systems and processes in place to assess monitor and improve the quality and safety of the service provided were ineffective. Risks had not been fully identified or mitigated.

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

People who used the service and their relatives gave a mixed response about opportunities they received to give feedback about the service. One person said about meetings for people to attend, "I don't think so; I've never been to any. I've never known about any." A visiting relative who told us that they had not been to any meetings said, "but I feel able to talk to them [staff] at any time if I need to or they'll talk to me when I come in. I do get a lot of feedback from them." Two relatives could recall completing a feedback questionnaire. A person who used the service said, "I haven't seen any, filled one in."

We saw records that stated in May 2016 a questionnaire had been sent to people inviting them to give feedback about the service. We noted from the returns that one relative had enquired about a visiting dentist and another relative asked about the opportunity of occasional outings. The registered manager said that they had not analysed or responded to the feedback given. We asked if meetings were arranged for people and their relatives. The registered manager said that they were poorly attended. From viewing

records we found the last meeting was in September 2015. This told us that people received limited opportunities to share their views and experiences about the service provided, and were not actively involved in the development of the service.

A registered manager was in post and records showed that since our last inspection the registered manager had notified CQC of changes, events or incidents as required.

The registered manager said that staff meetings were not frequent. We looked at meeting records and found there had been one staff meeting during 2016 and one senior staff meeting in 2016. Records showed that there was very limited discussion about how the service could continually improve. The service had no action plans in place to drive forward improvements that would demonstrate the provider had a commitment to improve the service people received.

There was some confusion amongst people who used the service and visiting relatives as to who the registered manager of the service was. Most assuming that the home manager was in fact the registered manager. However, all people we spoke to told us that the home manager was approachable and that they did listen to them. One visiting relative told us "The manager is definitely approachable." Another said of the home manager, "They are very approachable, always tells me how [family member] is getting on but if there are any issues they tell me straight away anyway."

Staff were positive about the support they received from both the home manager and registered manager. They said whilst the registered manager was not at the service daily they had made it clear to staff they were always contactable. Staff described the management team as, "approachable and supportive." One staff member said, "The registered manager is clear about their expectations. Supervision meetings are more frequent."

Since our last inspection the home manager's office hours had been greatly reduced to one day a week. We were aware that the registered manager was not present at the service daily. We were concerned about how the service would make the required improvements with the current management hours. We discussed this with the registered manager who showed a commitment to wanting to make the required improvements to the service. They agreed to discuss management time and responsibility with the provider as a matter of priority.

A whistleblowing policy was in place. Staff told us they would be prepared to raise issues using the processes set out in the policy.

The provider's values and philosophy of care were in the guide provided for people who used the service. We observed staff demonstrated these in their care and support they provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess, monitor and improve the quality of service that people received. 17 (1) (2) (a)