Care Quality Commission

Little Brocklesby House Limited

Little Brocklesby House

Inspection report

51 High Street
Limber
Grimsby
Lincolnshire
DN37 8JL
Tel: 01469 561353

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Ratings

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

Overall summary

We inspected Little Brockelsby House on 09 June 2015. This was an unannounced inspection. Our last inspection took place on 02 June 2014. The service provides care and support for up to 36 people. When we undertook our inspection there were 26 people living at the home.

People living at the home were mainly older people. Some people required more assistance either because of physical illnesses or because they were suffering from memory loss.

There was no registered manager in post. The service had been without a registered manager for two and a half months. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have

Summary of findings

capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. There was no one subject to such a restriction.

Medicines were stored in an unclean environment with poor stock control. Record keeping for the receipt of medicines and administration was poor.

Current records were stored in a secure environment, but archived records were stored in a damp environment. They were in insecure boxes, many of which were not labelled. People who did not need to know what was in those records had access to this area.

People had been consulted about the development of the home, but no quality checks had been completed to see whether the quality of the service was acceptable. Lessons learnt from any events had not been passed on to staff to improve their practice.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to poor medicines administration and storage of medicines, poor storage of records and testing the quality of the services provided. You can see what action we told the provider to take at the back of the full report

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care but had not signed their care plans. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. Staff did not always record the dietary intake of people who required to have their weight monitored.

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?

Requires improvement

The service was not consistently safe.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse. However analysis of events did not take place so staff did not know whether lessons required to be learnt.

Medicines were not stored safely and were in an unclean environment. Record keeping and stock control of medicines was poor.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. However, staff did not always record how well people were maintaining a health diet.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not understood by staff and people's legal rights were not protected.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care was planned but not reviewed on a regular basis with them.

People were not supported to develop their own interests and hobbies.

People knew how to make concerns known and felt assured anything would be investigated in a confidential manner but did not receive feedback.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Checks were not made to review and measure the delivery of care, treatment and support against current guidance.

People's opinions were not always sought on the services provided but they felt those opinions were not valued when asked.

There had not been a registered manager in post for two and half months.

Requires improvement

Little Brocklesby House

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 09 June 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service for older people.

Before the inspection the provider completed 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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We spoke with the local authorities who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. Before and during the visit we spoke with other health and social care professionals.

During our inspection, we spoke with seven people who lived at the service, six relatives, five members of the care staff, a cook, an administrator and the manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at five people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and questionnaires which had been sent to people who used the service.

We asked the manager to send us some information after the visit, which could not be accessed on the day. This included training records, the maintenance plan, the service users guide and welcome back, the supervision planner, certificates for fire and electrical equipment, the business continuity plan for when utilities failed, the analysis of questionnaires to people who used the service, analysis of the medicines audit. We asked this to be sent within 48hours of the end of the visit and all items were sent as requested.

Requires improvement

Is the service safe?

Our findings

People told us they received their medicines at the same time each day. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken. People were happy with the explanations given about their courses of medicines.

Medicines were kept in a locked area, which was also an access area to the cellar. Staff told us no one entered the area without someone being with them who had received medicines training. No temperatures of the room had been taken, so staff did not know whether medicines were being stored at the correct temperature and were safe to use.

We looked at eight people's medicine records and found they had not been completed consistently. There were gaps on the medicine administration sheets (MARS), so we did not know whether people had received their medicines. One person was capable of taking their own medicines, which was recorded in their care plan. However, regular assessments had not been completed to ensure they were safe to do these themselves. One person, who could not make decisions for themselves, was having their medicine disguised in food. This is called covert giving. This means it should have been agreed by a medical practitioner that medicines can be hidden when being given as to not have them would be detrimental to a person's health. There was no evidence in the care plan that this best interest decision had been made. Staff did not understand about giving covert medicines.

There was poor stock control. Some medicines in the trolley were out of date. Staff told us five bottles of liquid medicines had not been used for some time as the people concerned no longer required that type of medicine. The bottles had not been removed and could have been past their usable date, as they had been opened. There was no record of when the prescriptions had ceased. Staff told us the local pharmacy did not always send medicines on time, but this had not been challenged. This could mean people may not receive their medicines when required. Some medicines had been left on a shelf. Staff told us they had been received two days before, but they had not recorded their entry to the home. This could mean, if not noticed, people may go without their medicines if staff did not look in other places than the trolley.

Entries in one record book had not been correctly recorded. The dosages on the medicine packets did not match the entries in the record book for three people. The running total of tablets was not correct in one entry. Staff were aware of the need to keep correct records and an investigation was commenced on why the entries were wrong. We did not know whether people had received the correct dosage of medicines.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff stayed with each person until they had taken their medicines. Staff who administered medicines had received training.

We were given a copy of the medicines audit which was in place. Staff told us the last one had taken place in February 2015 but the results could not be produced. Staff were not aware whether the pharmacy supplier completed an audit and none was produced. This could mean that if lessons needed to be learnt this was not passed on to staff.

These matters were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe living at the home. They were aware of the need to tell staff when they were going out, to ensure staff were not looking for them. We observed push button keypads at entrances and exits. Staff told us people could have the numbers to exit the building. However, there were no details in the care plans of who was capable of retaining this information and who could safely leave the building. The manager told us they were in the process of assessing people's capability to safely leave the building as some people had memory problems. One person told us, "I just ask the staff, it's easier."

Staff were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right route to safeguard people. Notes were on display in staff areas informing staff how to report a concern.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, risk assessments were in place when someone had memory problems and could not remember how to look after themselves. Staff had been given instructions on how to

Is the service safe?

make sure they were safe when having a bath. Another person had mobility problems and their ability to walk unaided outside the building had been assessed and a plan put in place to ensure they were safe to walk alone.

Plans were not in place for each person in the event of an evacuation of the building. There was only a statement of what staff should do to exit the building and gather people together. This could prevent people leaving the building quickly in the event of a fire. A plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency.

People told us their needs were being met and staff were available to meet those needs. One person said, "I am quite happy with the care." However one relative said, "The only noticeable criticism was a bigger turnover of staff." They clarified this was only recently.

Staff told us there were adequate staff on duty to meet people's needs, but there had been some turnover of staff recently. They told us it had been hard to manage short term sickness absence. One staff member said, "Those of us that are here will pull together. The residents never go without." The manager calculated the required number of staff when they looked at the dependency of people who used the service.

We saw on the staff rota the numbers of staff required reflected the staff on duty that day. The home had recently won an award for supporting apprentices in the work place. Two were currently working at the home. They were extra to the staff required each day. They did not give personal care to people who used the service but supported them in other ways, such as helping at meal times, taking part in activities and making beds.

The manager told us there were vacancies for care staff. Some new people had been interviewed and we saw the provider was waiting for safety checks to be completed before they could commence work. Until this happened the calculated staffing levels were difficult to maintain without permanent staff working extra hours over their contracted hours.

We looked at two staff files which showed security checks had been made prior to their commencement of employment to ensure they were safe to work with people. These included information on their past career history, qualifications and references from other employers and character references. Safety checks had been made with the disclosure and barring service to ensure they were safe to work with people at the home. These measures helped to ensure only suitable staff were employed.

Staff said they had received training in how to maintain the safety of people who spent time in the service. However, according to the training matrix very few staff had received this training.

We had been informed prior to our visit that other health and social care professionals were concerned about the prevention and control of infection at the home. We did a tour of the building and saw some progress had been made in improving the environment. Work had commenced in the laundry to ensure it was clean and there was a better use of space. There were adequate supplies of protective clothing for staff to use.

The manager had appointed a staff member to be the infection control lead. They had commenced the role in May 2015 and were completing some training. Information was available to staff on how to report infection outbreaks. The infection control policy had been updated in April 2015. We saw a copy of the new cleaning audit which was to be commenced later in June 2015. A new rota for cleaning equipment was now in place and staff signed to say when items had been checked.

We saw quotes had been obtained for the renewal of some carpets. The main corridor carpet was dirty and worn in places, but did not constitute a trip hazard. Some toilet and bathroom areas needed painting, but the wash basins and toilets were clean. We looked in six bedrooms, with people's permission. They were clean and personalised.

The cellar area was unclean and smelt musty. A recent infection control inspection stated staff should wear masks when entering the area. We observed staff wearing masks and we were offered them before visiting the area. Some progress had been made in controlling the dampness in the cellar. Access was through the medicines storage area. This was not a clean environment and the room was cluttered with items not related to medicines. This could cause a risk of infection and a trip hazard. Some equipment such as masks for inhalers and other breathing equipment was not covered and was dusty.

An action plan was in place for all risk areas to maintain good prevention of infection. This was a working document

Requires improvement

Is the service safe?

which the local authority commissioners were overseeing. Time scales and responsibilities had been included. Some items had been completed, such as obtaining more advice and purchasing protective clothing for staff to use.

Requires improvement

Is the service effective?

Our findings

People told us they thought the staff knew what they were doing and able to meet their needs or their family member's needs. One person said, "This is one of the better homes." A relative told us, "I'm quite happy how [named relative] is being looked after."

One staff member told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling and bathing people. They told us it had been suitable for their needs. This had ensured the person was capable of completing their job role before being offered a permanent post.

Staff said they had completed training in topics such as basic and intermediate food hygiene, fire training and manual handling. They told us training was always on offer and it helped them understand people's needs better. Some staff did not like the distance learning sessions and had fed this back to the manager. The training records supported their comments. The manager was aware which topics staff required to complete and we saw the training planner and statistics for 2015. This identified training not required for some staff, training completed, training booked and where they were still waiting for certificates.

Staff told us that in the last few months they had not received so much supervision as they had last year. They told us the sessions which had taken place had helped them. The supervision matrix showed staff had received supervision at least once or twice since the beginning of 2015. More sessions had been booked. This was in line with the provider's supervision policy. Supervision ensures staff are aware of where they may need to improve their skills and voice their opinions.

Staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected, in practical terms. Such as, giving people choices, understanding people's communication needs and seeking out other agencies who could help a person to make decisions. However, some staff did not understand how the MCA legislation worked and what to do if they thought someone was being deprived of their liberty. More training had been booked by the manager, we saw on the training matrix.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted.

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty. There was no one subject to such a DoLS authorisation during our visit.

People told us that the food was good and varied, which was echoed by relatives. One person said, "The lasagne was lovely." We observed people having breakfast in the dining when we arrived. Staff told us people could have their breakfast at any time. However, one person told us, "Oh, breakfast time is 8am. If you have an appointment you can ask to have it earlier though."

We observed the lunchtime meal in the dining room. We saw the meals were presented well and looked very appetising. There was a lot of social interaction between staff and people eating their meals. Staff served the meals, ensuring people also had hot or cold drinks of their choice. Staff helped people who required assistance to eat their meal. We heard staff explaining what was on plates, for those with limited sight and encouraging people to eat and drink. People told us they were asked about meals by the cook.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their weight and when a person required a softer diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans. However, where two people were having a problem

Requires improvement

Is the service effective?

controlling their weight staff did not always record their food and fluid intake as the care plan stated. This could mean that the people's nutritional needs were not always monitored to help their health and well-being.

People told us they liked the staff and said if they required to see a doctor or nurse staff would respond immediately. Interaction with people and their relatives was recorded in the care plans. They told us staff tried to obtain the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when a person started to have lots of falls. The GP was contacted and advice given about the person's medicines.

Good

Is the service caring?

Our findings

People and their relatives told us they were well cared for in the home. One person said, "The care I have had I think is wonderful." Another person said, "I must admit the carers look after us well."

The relatives felt involved and fully informed about the care of their family members. One relative said, "The carers are all nice." Another relative remarking on the attitude of staff said, "Polite and welcoming."

All the staff approached people in a kindly, non-patronising manner. They were patient with people when they were attending to their needs. For example, one person liked to walk around independently but was unsteady doing so. Staff ensured they were nearby when the person was walking.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, staff knew when several people wanted to remain in their bedrooms for most of the day. Staff ensured they were in a safe environment and we saw they made numerous visits to them during the day.

People's wishes were recorded in their care plans so staff understood what each person liked to do each day and night. Some people liked to visit a communal lounge and staff ensured they sat with the people they had made friends with whilst in the home.

Staff knew the people they were caring for and supporting. They told us about people's likes and dislikes. For example, when they liked to get up in the morning and when they liked to dress. This was confirmed in the care plans. Practical action was taken when people were distressed. We observed not just care staff, but administration and ancillary staff responding to people who were worried and anxious. If they could not answer a person's query the manager was called to assess each situation. One person was concerned about their family member visiting and were continually reassured until the relative arrived.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was anxious and staff took time to explain treatments and ensured the person understood the treatment required. We heard staff speaking with relatives, after obtaining people's permission, about hospital visits and GP appointments. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

Staff responded when people said they had physical pain or discomfort. When someone said they felt unwell, staff gently asked questions and the person was taken to one side. When the emergency call bell was sounded we saw staff respond to the people's needs immediately. The minimum amount of staff stayed with the person so as not to frighten and worry them.

We observed four people for 30 minutes who were in a sitting room using SOFI. Everyone either engaged with staff or were just watching everyone in the room. Staff engaged well with them. The atmosphere was quiet and peaceful with people enjoying a morning snack, reading newspapers or dozing.

People told us that staff usually knocked before entering a room, which we observed. Staff described the actions they took to preserve people's privacy and dignity. They said they would knock on bedroom doors before entering and closed curtains when providing care. Staff spoke quietly to people and were unhurried in their approach and always giving time for people to respond to questions.

Relatives we spoke with said they were able to visit their family member when they wanted. They said there was no restriction on the times they could visit the home. One relative said, "Staff are very welcoming." Another relative said, "I try and avoid early morning. [Named relative] doesn't rise early so I give the staff a chance to help them get up."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires improvement

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs, but this was in the form of conversation rather than a formal meeting. They told us they were aware staff kept notes about them and relatives informed us they also knew this. Views were mixed about people's involvement in the care planning process and if they had seen their care plans. One person said, "I know staff keep notes on me." A relative said, "I take part in discussions, but don't know whether they are recorded."

However, the care plans had not been signed by the people being looked after, their relative or other advocate. Therefore, we do not know if people agreed to the care which was planned. One person had been admitted five days before our visit and there was very little documentation about the person's needs in the care plan. Staff told us about the person. One staff member said, "We haven't got around to writing this yet but [named person] is known to our sister care agency so we can ask them. They are only next door."

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. We observed part of the afternoon handover. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten.

There was very little signage around to guide people around the home. For people who did not have English as their first language there was no signage. Some signs had words and pictures, such as, the toilets. Titles on notice boards were in small print and would not be read by people with poor sight.

People told us there was always an opportunity to join in group events but staff would respect their wishes if they wanted to stay in their bedrooms. We did not see this recorded in the care plans. People told us about a lot of activities such as art classes, games and visits to local clubs. One person told us, "I go to the 3 in 1 club in the village, every other week on a Thursday." Another person said, "The hairdresser comes to us every week."

People in their rooms all day were watching the television, some had visitors for part of the day and some were reading magazines. We observed a game of bingo in the morning and people baking in the afternoon. There was a lot of banter and laughter during the sessions. The home was currently without an activities co-ordinator. The manager was recruiting for one as the staff felt this was a role which was missed.

There was an activities planner on display but it was very small print and out of date. There were lots of pictures of events which had taken place inside and outside the home. These included cake making and visits out. The care plans stated the type of interests people had been interested in prior to admission. There was very little in the care plans of how people would like to spend their days now and if they had any specific interests or hobbies. Only one person told us about leisure pursuits they were involved in.

People told us their pastoral needs were cared for by a monthly communion service. Staff were aware who to contact in the community if people had beliefs and faiths with which they were not familiar. Staff told us one person was being encouraged to maintain their links with a local church, but this had not commenced yet.

People and relatives told us they were happy to make a complaint if necessary and felt their views would be respected. No-one we spoke with had made a formal complaint since their admission. People knew all the staff names and told us they felt any complaint would be thoroughly investigated. The current complaints policy could not be produced. The only one available had not been updated since 2010 and referred to the name of the predecessor organisation from CQC. However the service users' guide gave directions to people on how to make a complaint.

The complaints log detailed one formal complaint the manager had dealt with since our last visit. It recorded the details of the investigation and the outcomes for the complainant. Lessons learnt from the case had been passed to staff at their meetings.

Requires improvement

Is the service well-led?

Our findings

People who used the service and relatives were unaware whether any concerns they had raised had been feedback to staff. They did not know and could not see whether this had improved the practice of staff. They told us they had been told initially they could raise concerns but they felt these were not listened to. This was affecting how they perceived what control they had about their needs and the environment they lived in.

There was no evidence to show the manager had completed audits to test the quality of the service. Where actions may be required these had not been clearly identified. We were shown an audit tool but it had not commenced yet. There was no system in place from complaints investigations to ensure the quality of the service could be improved. This meant the provider did not know whether the quality of the services being offered were suitable for the people living there and could correct staff practice where necessary.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. However, there were no methods in place for reviewing accidents, incidents and safeguarding concerns. This could result in staff not learning from events and improving the needs of people who used the service. This could put people at risk if their needs required to be changed after an accident or incident.

The leadership is reactive rather than proactive. The way the service is managed does not always identify risks and did not have strategies in place to minimise those risks. Key decisions were made without the full involvement of people and staff.

There was confusion amongst senior staff of where and how records were kept. There was no robust system in place to ensure staff knew about data management and record keeping. People's care records and staff personal records currently in use were stored securely which meant people could be assured that their current personal information remained confidential. However, the storage of archived records was poor. These were stored in a damp cellar in unlocked boxes and containers. Boxes had not all been labelled. One staff member said, "I really don't know what is down here." The records were mixed with disused furniture and equipment, activities equipment and Christmas decorations. This meant that staff and contractors working in the cellar had access to people's confidential records which breached data management. Staff could not easily access people's records in the cellar and would not be able to track whether previous treatments had worked for that person and whether a person's previous medical history was relevant to their current care needs.

These matters were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they were unsure of who was managing the home, as there had been several changes recently. They told us they could approach staff with any problems.

There was no registered manager in post. The post had been vacant for two and a half months. The manager from the sister service was currently overseeing this home. They were open and transparent about the work required and were co-operative during the day.

Apart from questionnaires for people who lived at the home there was no other formal method of obtaining opinions from people about the quality of the service. People who used the service and relatives told us they were not aware of any other methods of obtaining their opinions. However, the staff were available at any time and they felt confident in going to them for advice and support. We saw the results of questionnaires which had been sent to people who used the service in October 2014. The results were predominately positive about the food, the environment, cleanliness and attitude of the staff.

Staff told us they worked well as a team. One staff member said, "It is a good place to work. I love it here." Another staff member said, "There have been lots of changes recently but I can see they are for the better." The majority of the staff had worked at the home for many years. This gave good continuity for people who lived at the home.

Staff told us staff meetings were held occasionally. They said the meetings were used to keep them informed of the plans for the home and new ways of working. Team leaders told us they met monthly to go over the care of people who used the service. No minutes of meetings could be produced.

Requires improvement

Is the service well-led?

Staff were aware of the whistle-blowing policy. No one had used this. The whistle-blowing policy was revised in April 2015. However, there was no reference to how staff could refer to an external body if they were not satisfied with the internal investigation.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. However, some senior staff were unaware of which events CQC were required to be informed on.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Record keeping for administration and receipt of medicines was poor and the storage area unclean. Regulation 12 (2) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no system in place to test the quality of the service being provided. Regulation 17 (2) (a)