Little Brocklesby House Limited

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Inspection report

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16 November 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Little Brocklesby House on 15 and 16 November 2016. This was an unannounced inspection. The service provides care and support for up to 36 people. When we undertook our inspection there were 23 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 experiencing difficulties coping with everyday tasks, with some living with dementia.

There was not 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. A new manager had just been appointed.

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 capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect them. At the time of our inspection there was no one subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service, but that this would need constant reviewing as people's needs changed. The provider was taking into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed and care planned and delivered in a consistent way. People and relatives were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear but staff did not at times keep some records up to date. Risks associated with people's care needs were assessed and the plans were followed by staff.

People were treated with kindness 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.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information. Activities were on offer for people to take part in, which some people declined, but others enjoyed.

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.

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 had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements. However, some checks were not robust enough, such as those for fire safety and senior staff did not highlight mistakes to staff to ensure people were safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Checks were made to ensure the home was a safe place to live. However, the manager needed to ensure all work had been completed to ensure no one could be at risk of harm.

Sufficient staff were on duty to meet people's needs. However, staffing levels would need to be reviewed as people's needs were constantly changing.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

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 understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

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

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?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance. However, these were not always robust and lessons learnt were not always passed on to staff.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

There was not a registered manager in post which is a condition of the provider's registration.

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 the 15 and 16 November 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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. 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 also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to a social care professional during the site visit.

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.

During our inspection, we spoke with four people who lived at the service, two relatives, four members of the care staff, a domestic, an activities organiser, a cook, the assistant manager and the manager. We also spoke with the area manager. We observed how care and support was provided to people.

We looked at four people's care plan records and other records related to the running of and the quality of the service. These included maintenance files, staff files, minutes of meetings and audit reports the manager

had completed about the services provided.

Good

Is the service safe?

Our findings

People gave us mixed views about the staffing levels, but all said their needs were currently being met. One person told us, "Yes, they are always here when I need them." Another person said, I think there are enough staff on duty. They do work hard though." A couple of people expressed their personal opinions about staffing levels. One person said, "Yes most of the time, but they can be short at night times." Another person told us, "There seems to be usually, may be a little short at the weekends." We passed this information to the manager who told us they would look at the staff rota, along with their calculations on people's needs and daily requirements.

Staff told us that the staffing levels were sufficient, but there were sometimes insufficient staff on duty to meet people's needs during certain periods of the day. Staff said as people's dependency had increased at night the numbers of staff on duty could currently meet people's needs, but they had asked the manager to review the figures so they were not so rushed in completing people's wishes. One staff member said, "Nights could may be do with three staff on duty. We manage pretty well and if we asked for more help the manager would adjust the staffing levels." Another staff member told us, "At the moment we can meet people's needs. We've not had a lot of sickness amongst staff and people have come back to work here who know the people, which is a help." Staff told us they could voice their opinions about staffing levels and felt their opinions were valued and the manager would listen to any concerns. They told us when people required an escort to go to appointments outside the home extra staff would be brought in.

The manager told us how the staffing levels had been calculated and this was reviewed at least monthly. These and the staff rota confirmed what people and staff had told us were the current staffing levels each day. The rota also indicated the times staff were not involved in meeting people's care needs, such as time to take part in training, supervision of staff and reviewing care plans. Staff told us this ensured they could keep up to date with their training needs and ensure all records were maintained to an adequate standard without compromising the needs of people.

People and relatives told us they felt safe living at the home. One person said, "Yes I feel very safe here. They look after me very well." Another person said, "I am safe this is my home." A relative told us, "My relative is very safe here, I think. [Named relative] can be difficult, but they are very good and keep an eye on [named relative]. There are key codes and alarms so [named relative] can't wander off." People and relatives told us they could have the numbers to the key codes on doors if they requested them, but most would ask staff each time they exited the building.

Staff had received training in how to maintain the safety of people and 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 manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was no

process in place for reviewing accidents, incidents and safeguarding concerns to identify trends and ensure remedial action was taken to prevent a reoccurrence. However, staff told us that each individual accident, incident and safeguarding concern was discussed at each shift handover and also discussed at staff meetings. We saw the minutes of the staff meeting for May 2016 and April 2016 where such matters as possible poor practice had been discussed with staff.

To ensure people's safety was maintained a number of risk assessments were completed. For example, where people had a history of falls. Staff had recorded when advice had been sought from the NHS falls coordinator and what advice had been given. We observed staff assisting people whose mobility was poor, ensuring they had the correct walking aids to assist their movement around the home. The home had hoists and slings to aid with mobility. An external company had undertaken examinations to ensure the hoists were safe to use. Staff also had a record of how they checked each hoist and sling to ensure it was safe before using either. One person told us, "I can have falls, but staff are always on hand if I need them." A general risk assessment was in place for each person regarding bathing and showering. This referred to water temperatures and the risk burns and scalds.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because of poor mobility or memory loss. There was also a photograph of each person to aid identification should an evacuation took place. A plan identified to staff what they should do if services such as electricity and other equipment failed. This was currently being revised due to changes in evacuation processes. Staff were aware of how to access this document.

We were invited into six people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision. This ensured rooms were free of trip hazards from trailing wires and ensured furniture was in a good state of repair.

Some areas of the garden were unsafe to walk in due to uneven paving slabs and pathways. There was a plan in place to correct areas which were uneven. Staff told us people rarely used the garden unless a staff member was present who could direct them away from uneven surfaces. We saw staff helping one person to negotiate an area of garden they wished to walk in and another person being helped to use a safe area in which to smoke, outside the building.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. Some people choose to have pictures on their doors which meant they could recognise them quickly. There were also signs on the doors indicating what each room was used for, for example, a toilet. The signs were in words and pictures. There were directional signs in corridors to direct people around the home, such as to fire exits and the dining room. This could mean that people who had a poor memory could find their way around the home.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were some current staff vacancies, but there was a recruitment drive in place with local agencies to find new staff.

People told us they received their medicines each day. One person said, "I have never had a problem. They are always on time." Another relative told us, "It is important [named relative] has [named relative] tablets

regularly. There has never been a problem."

Medicines were stored in line with current guidance. A record book was in place for those medicines requiring special storage and administration. Staff told us since the medicines storage area had been moved to a bigger room this had helped them keep the area clean and tidy. They said when re-ordering they could do so uninterrupted and shut themselves in the room to ensure they did not make mistakes. Records about people's medicines were accurately completed. Each medicines administration record (MAR) had a photograph of the person, which bore a resemblance to that person plus other information such as allergies. Protocols were in place for the use of medicines such as paracetamol, which the GP requested be given when required.

Medicines audits we saw were completed by staff at the home. We were told the pharmacy supplier no longer completed audits, but a senior member of staff had been allocated to discuss any on-going issues with them. We saw the last audit under taken by staff at the home was in October 2016. Any actions had been completed.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Their competence was tested during spot observation checks as part of the staff supervision process. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Good

Is the service effective?

Our findings

People told us they felt staff were well trained and competent to do their job. One person said, "Yes they are very good. They know what they are doing." A relative told us, "I think staff are well trained. They always act quickly."

The staff we spoke with had not recently been recruited. However, they told us that the induction programme at the time suited their needs. They told us what the programme had consisted of, which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The manager was not aware of the Care Certificate and was unsure whether all staff would be encouraged to complete this or just new staff. The provider had embraced the National Care Certificate which sets out common induction standards for social care staff.

Staff said they had completed training in topics such as manual handling, health and safety and infection control. Some staff had completed training in particular subjects such as dementia awareness, incontinence management and challenging behaviour. They told us training was always on offer and they had been encouraged to complete courses to enhance their knowledge about how to look after people. The training calendar gave details of all the courses staff had completed and highlighted those that staff required to update. Any shortfalls of staff not attending courses were addressed at staff supervisions. There were several topics of training advertised for staff to attend.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the manager, assistant manager and care co-ordinator at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. Staff had received at least two formal supervisions since January 2016 and their yearly appraisal. Staff told us at the yearly appraisal their previous year's record of service, training, conduct and goals were discussed. They told us there was opportunity to voice their concerns and views.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our visit there was no one subject to such an authorisation.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS guidance where necessary. The provider had properly trained and

prepared their staff in understanding the requirements of the MCA and DoLS. Staff were able to explain how a person could be deprived of their liberty and what steps to take if people could not make decisions for themselves.

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 also been consulted. These covered areas such as maintaining their personal hygiene and control over their personal finances.

People told us that staff always asked for their consent before treatment commenced and support was given. They said staff knocked on doors before attempting to enter a room and we observed this practice. They told us they had freedom of movement, but always told staff when they were going out with friends and relatives. This ensured they maintained their independence.

People told us the food provision was good. They told us that if they wanted a different choice to the menu staff would obtain it. One person said, "The food is very good and we have a choice. We have drinks whenever we want." Another person told us, "Yes the food is good." People told us how staff were helping them to maintain a healthy diet for specific needs such as diabetes and how staff had encouraged them when they wanted to lose weight. One person said, "They have supported me to lose a lot of weight, which is better for my diabetes." A relative told us how their family member had gained weight, which they felt was good for them.

Staff 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 when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet. People told us staff, including kitchen staff asked them about the meal provision.

Menus were on display in dining rooms, which were used by people as a reminder to the day's choices. We observed people going into the dining room and reading the menu to pass on to other's whose sight was poor. One person said, "I like to know what the main meal is and I consider it one of my jobs to tell others. I don't think they mind."

Meals were taken to rooms by staff. Food all had covers on when brought from the kitchen. The food looked appetising and people appeared to enjoy their meal. No-one waited an undue length of time to be served. We observed staff assisting people to eat and drink in an unhurried way and maintaining eye contact. A staff member noticed someone was in pain and arranged pain relief for them so they could continue to eat their meal. We saw hot and cold drinks provided throughout the day and jugs of water or juice put in people's rooms.

People told us staff obtained the advice of other health and social care professionals when required. One person told us, "Yes they sort out GP's appointments and hospitals when I need to go. I see the chiropodist here." A relative said, "[Named relative] sees the chiropodist here. They are quick to call the doctor if there is a problem." They told us if their relatives could not escort them to appointments staff would attend.

In the care plans we looked at staff had recorded when they had responded to people's needs and the actions taken. There was evidence that people were being referred to the wider multi-disciplinary team such as a chiropodist, opticians and dentists. Several people had hospital appointments which they had

attended. Staff had recorded outcomes of those visits.

Good

Is the service caring?

Our findings

People told us they liked the staff who were kind and helpful. They felt supported to make choices and their preferences were listened to by staff. One person said, "Staff are wonderful. They have been a great support to me over the past few months. They are kind and caring. They are my friends." Another person told us, "Yes they are very kind to me." A relative said, "Staff are very caring. [Named relative] can be very difficult, but they always treat [named relative] with respect and kindness."

People were given choices throughout the day if they wanted to remain in their rooms or bed or where they would like to sit. Some people joined in events in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff. Staff offered each visitor refreshment.

All the staff approached people quietly and calmly. If a person was hard of hearing and could lip read staff positioned themselves in front of the person and spoke clearly. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone was anxious about their state of health and in pain. Staff asked whether the person would like to speak in private and offered them a drink and pain relief. A staff member was seen in a corridor talking animatedly with a person who was telling them of about their working life. We observed staff taking care when using hoists and slings to preserve people's dignity.

Throughout our visit 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. One person said, "They know when I want to be left alone and know when I need a cuddle. If I need any advice I just ask them." We saw one staff member helping someone to communicate with a visitor, as the person had a speech impediment due to an illness. They were patient with the person and encouraged them to speak in their own way, only interpreting if the person started to become frustrated. The person told us how much they had appreciated this act.

People and relatives told us they could have visitors whenever they wished and this was confirmed by relatives. We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families and friends visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. They said if they wanted privacy with their family member there were quiet sitting rooms or the person's bedroom.

Staff always acknowledged people when walking around the building. They greeted people with their first names if this was their wish. They know lots of information about each person so could open a conversation easily with each person. Staff not only enquired about a person's health that day, but also about the person's family members and friends. Staff showed genuine concern when people told them of illnesses within their family and offered to help in different ways. People told us they did not have to divulge

information about themselves to staff, but did so willingly. One person said, "Always kind and yes they are lovely."

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities about maintaining confidentiality.

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 could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of the visit.

Good

Is the service responsive?

Our findings

People said they were involved in the care planning process. There was a section in the care plans where people or their advocate could sign to say they agreed to the care plans. In the care plans we reviewed none had been signed, however staff had recorded the discussions they had with people in another part of the care plan.

We saw that care was delivered in a way that was not task-focused but person centred. For example, people told us they could have baths and showers when they wanted them. We observed staff respecting people's wishes for when they wanted a bath and returning at the time the person had requested. Staff told us people could have them whenever they wished and this was recorded in the daily records.

The care plans we looked at included assessments such as people's mobility, nutrition, communication needs and hygiene needs. They were person centred and contained sufficient information to ensure staff followed safe procedures when delivering care. For example, when people had specific dietary needs due to a medical condition. Staff had consulted with medical personal to ensure the correct medication was in place and staff were aware of how certain foods could exacerbate a person's condition.

Charts were in place to record different aspects of a person's care. For example, if people required to be repositioned in bed. Staff kept these up to date and recorded when people had refused to be repositioned as this could result in them developing pressure ulcers. When people's behaviour was challenging to others staff kept an incident log and recorded what action had been taken. Staff said this was useful as it showed which advice calmed the person. For example, giving reassurance to one person appeared to calm them very quickly, whilst others settled with the offer of a drink.

The care plans had been updated monthly, which was the minimum frequency the provider required, unless a person's needs changed. The entries were legible and the daily report notes gave a variety of information about each person's day. Each person had a key worker who was someone the person could get to know and who would help them with specific events such as shopping for personal items, updating the care plans with them and planning goals and social events. People knew their key worker's name. One person said, "[Named staff member] is my key worker. They've got to understand me over the months and have helped me a lot." Another person said, "They have been a wonderful support since my [named event] earlier this year."

Staff were quick to respond to call bells and any situation arising. For example, when people were upset or unsettled. Staff spoke calmly with them, offered alternatives for them and did not leave them until the person indicated they were well enough.

We observed staff attending to an emergency situation during our visit. They comforted the person and screened them from others in the room. They ensured people nearby were safe before summoning further help. Once the situation had been resolved staff wrote in the person's daily notes to show what had happened and the action taken. The manager reassured staff about their appropriate actions.

Social care professionals we spoke with told us staff were capable of following instructions and knew when to ask for advice. They told us staff knew what to do, and recorded the actions taken. Each person told us staff were always pleasant and helpful and knew a lot about the people they helped look after.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was a good method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use for reminding staff of tasks yet to complete, such as calling a GP or ordering medicines.

People told us about their involvement in activities. Some people told us they liked their own company, others enjoyed certain activities. They told us of visits to shops, playing dominoes and the entertainers. People were aware of activities which we saw advertised on notice boards about forthcoming events. People who preferred to stay in their rooms described that staff spent quality time with them. One person said, "I do all kinds of things. There are plenty of activities if you want to join in. I am making Christmas cards at the moment." Another person told us, "I like to sit and watch people doing things. I also watch TV in my room." A relative told us, "There is always something going on here, entertainers, music and dancing. My relative likes to join in."

An activities co-ordinator was employed and we saw them during our visit. One room had most of the activities equipment in and various pieces of art and craft work in progress on display, which people told us they enjoyed doing. We saw records of a variety of activities and events which had been recorded as having taken place. Recent events had included craft sessions, quiz nights, chair exercises and tasting sessions for different foods on themed days. There was some involvement with people in the local community, such as with summer fetes. The care plans did have a section on people's social, cultural and religious needs which staff were adhering to. Saff showed us details of the organisations they had recently contacted who people may like to have involvement with, such as local churches, social clubs and organisations such as the Alzheimer's Society. Staff had begun to explore events which would help to stimulate people's memory such as a reminiscent event, visiting pets and doll therapy. There was a notice board describing the current local weather conditions and the date. All the clocks displayed the correct time of day. Staff had explored whether people would like to pursue individual hobbies and interests. For example, one person was interested in aircraft and described how staff were encouraging them to watch programmes about them, collect books and magazines. They were planning a visit to a local air craft museum with staff.

People are actively encouraged to give their views and raise compliments, concerns or complaints. People told us they were happy to make a complaint if necessary, knew how to do so and felt their views would be respected. People told us when they had raised a complaint and if they had received a satisfactory outcome. One person said, "The manager and her staff listen and any concern I've raised has been resolved to my satisfaction. They are good at explaining things."

We saw the complaints procedure on display, but it was not in an obvious position. The manager told us it would be moved to a different area where other information about the home was on display. The complaints procedure contained information about CQC and about the local government ombudsman who could help people with their concerns. There had been no formal complaints logged in the record book since our last visit. There was a suggestion box on display in the main reception area, which staff told us was checked on a regular basis. People knew it was there and one person told us, "We can suggest anything. Someone will always come back to us and say what is feasible."

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. This had been the case for a number of month. A new manager had recently been appointed and the provider was re-organising the lines of responsibility of senior staff to see how they could best support other staff groups at the home. Then they would submit a new manager application. It is a requirement that a service such as this has a registered manager in position and registered with CQC. People and relatives told us they could express their views to the manager and senior staff and felt their opinions were valued. They told us the manager was visible and approachable. One person said, "They seem ok. Yes I think they are quite open about what is happening." Another person said, "Yes they are good." A relative said, "The management are helpful. It has changed recently. They are very approachable."

There was evidence to show that both the previous registered manager and the current manager had completed audits to test the quality of the service. These included infection control and cleaning. Where actions were required these had been clearly identified. However, but there was no method to ensure these actions were passed on to staff and whether lessons had been learnt from them. For example, there was no analysis of the hand hygiene test to show whether staff had learnt from their training about infection control. There was an action plan for the domestics to follow after the cleaning audit, but no record of whether any of the actions had been completed.

There was currently no maintenance audit, but the manager told us work had commenced in the summer on the drive and refurbishment of the kitchen, which we saw had taken place since our last visit. A maintenance plan was in place for 2016 and into 2017, but no dates of when work would take place. People and staff told us they had been asked their opinions about the refurbishment of communal areas and bedrooms. The last fire and rescue services report was in November 2015. The provider was not aware that many of the actions listed had not been completed, as this had been given to a previous employee to complete and had been assured nothing was outstanding. The provider, however, had not checked the evidence given to them. This included ensuring the laundry door could be closed correctly, escape routes being checked regularly and the risk assessment being reviewed. The provider's representative told us they were not aware that all the actions had not been completed and started to action them during our visit. They would let us know when these had been completed. A failure to comply with fire and rescue requirements could put people at risk.

Senior staff had recently recommenced weekly checks to ensure people were satisfied. This was in the form of walking around the building and noting actions regarding the premises and talking with people and their advocates. This was saved on a document and discussed with staff at handovers.

People and relatives told us they did not have group meetings, but could talk with the staff at any time. There were minutes of a meeting in October 2015, but staff told us they had not had one for some time as so few people attended. The provider's policy stated meetings should take place monthly, but this was under review in light of different ways of working with people. A survey had been sent out in October 2016 to people using the service, relatives and advocates and staff. The manager showed us some which had been

returned, which contained positive comments. They said these would be analysed after the final return date and results displayed.

Staff told us they worked well as a team and felt supported by the manager and other senior staff. One staff member said, "I'm happy to come to work I really enjoy it." Another staff member said, "I always have a good time at work, they all really care." Staff told us staff meetings were held, but not very frequently. They said the meetings they had attended had kept them informed of the plans for the home and new ways of working. We saw the minutes of the staff meetings for April 2016 and May 2016. The meetings had a variety of topics which staff had discussed, such as the upkeep of the building and grounds, staff rotas and menu planning. Staff had been given opportunity at the meetings to voice their opinions, which had been recorded. Staff were aware of the whistleblowing process and would not be worried about putting this to use if a need arose.

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.