Broadoak Group of Care Homes

St Marys

Inspection report

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Tel: 01623795231

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 25 January 2016.

St Marys is a care home with 23 places for older people and people living with dementia. On the day of our inspection 13 people were living at the service.

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 10 June 2015 we identified the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
There were not effective systems to assess monitor and improve the quality and safety of the service. 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.

A new breach of Regulation was identified, this was Regulation 18 of the Health and Social Care Act 2008 Regulations 2014: Staffing. The provider had not ensured staff had received appropriate training, development and support. You can see what action we told the provider to take at the back of the full version of the report.

People told us that they felt staff, and the environment supported them to remain safe. Whilst staff knew what their responsibilities were in protecting people from abuse, not all staff had received appropriate training. Risks had been assessed and plans were in place to advise staff of the actions required to manage and reduce known risks. Appropriate action had been taken when accidents or incidents had occurred.

People said that they received their medicines safely. Medicines were administered, managed, stored, ordered and disposed of appropriately and in accordance with good practice guidance. Staff had received training and observational competency assessments to ensure they managed medicines safely.

There were sufficient staff available and deployed appropriately, to meet people's individual needs and safety. People told us that staff responded in a timely manner to requests for assistance, and that staff had time to spend with them. Safe staff recruitment practices were in place.

The principles of Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were understood by staff. Examples of assessments of people's mental capacity to consent to their care and treatment and best interest decisions were in place and we found MCA legislation had been adhered to with one exception. Whilst the GP had authorised the use of covert medicine a MCA assessment had not been completed. Covert

is the term used when medicines are administered in a disguised way.

People told us that they received sufficient to eat and drink. This included a choice of meals and their individual preferences and needs were known and understood by staff. Staff supported people where required with their eating and drinking needs.

People's healthcare needs were known by staff and monitored. When people's health needs changed, timely and appropriate referrals were made to healthcare professionals for advice and support. People told us that they were supported to maintain their health by having access to routine health checks and outpatient appointments that monitored their health.

People spoke positively and were complimentary about the approach of staff. They described staff as kind, caring and compassionate. People said they were involved in discussions and decisions about how they received their care and support as fully as they wanted. Staff were knowledgeable about people's preferences, routines and what were important to them. People received opportunities to participate in activities provided by external entertainers and visitors that visited St Marys. Staff provided some opportunities of social activities. People were supported to maintain relationships and interests external to the service. Information about independent advocacy services was displayed for people should they have required this support.

People who used the service and their relatives had been given an opportunity to share their views about the service by completing feedback questionnaires. A meeting had also been arranged to give people the opportunity to express their opinions about the service they received. People told us that they had not had to make a complaint, but felt able to do so if required. They said they were confident it would be responded to appropriately.

Staff were clear about the values and aims of the service. Not all staff felt valued by the provider and staff had limited opportunities to be involved in the development of the service. Regular checks and audits were in place that monitored the quality and safety of the service. Further improvements were required to enable the provider to have a better oversight of the action required to continually improve the service.

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.

There were systems in place that ensured staff knew what action to take if they had concerns of a safeguarding nature. Not all staff had received appropriate safeguarding adult training but were aware of their responsibilities.

The provider operated safe recruitment practices to ensure suitable people
were employed to work at the service. There were sufficient staff available to meet people's needs safely.

Risks had been assessed and individual risk plans for people, the environment and equipment were in place. People received their medicines safely and they were managed appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received appropriate training and support to enable them to meet people's needs effectively.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were
understood by staff. Where appropriate assessments had been completed.

People were supported to access external healthcare professionals when
needed. The provider ensured people maintained a healthy and nutritious
diet.

Is the service caring?

Good

The service was caring.

People were given opportunities to express their opinion and felt respected

and supported to do so. Independent advocacy support was available for people.

There were no restrictions on friends and relatives visiting their family.

People were supported by staff who were caring and supportive. Staff were
knowledgeable about people's individual needs and treated people with
dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care plans provided staff with information to provide a responsive service, based on people's preferences and routines.

People received opportunities to participate in activities provided by external visitors and entertainers. Staff provided some activities for people based on known preferences and likes.

People knew how to make a complaint and information was being updated by the provider of the procedure and contact details.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff understood the values and aims of the service. Not all staff felt valued and the opportunity for staff to contribute to discussions and decisions about the development of the service was limited.

The provider had notified CQC of reportable information required of them.

Systems and processes to monitor the quality and safety of the service were in place. The registered manager discussed the need for a refurbishment plan and was in discussions with the provider about this.

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 25 January 2016 and was unannounced.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information the provider had
sent us including statutory notifications. These are made for serious incidents which the provider must inform us about. We also contacted the local authority, the GP and Healthwatch for their feedback.

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 care service.

During the inspection we spoke with three people that used the service and one visiting relative for their experience of the service. 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. We also saw the way staff interacted with the people who used the service throughout the day.

We spoke with the registered manager, the assistant manager, the cook, two senior care workers, and two care staff. We looked at all or parts of the care records of four people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and abuse. One person told us they felt safe because staff, "Always come in the night to have a look, I tell them to come in and do that." A visiting relative said they felt their family member was safe in the home saying, "I know [family member] is safe here and know if I can't get in she's alright."

Staff we talked with were able to identify the signs of possible abuse and they told us if they had a concern they would report it to the registered manager or assistant manager. 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.

We observed staff responded sensitively if people showed signs of anxiety, they were quick to respond and offered reassurance to the person and others before their agitation increased to ensure people were safe.

The staff training matrix showed that most staff had received safeguarding adults training. We discussed the fact that not all staff had received this training with the assistant manager. They told us why this had occurred and assured us they would take action to get this training arranged. The provider had a safeguarding policy and procedure available to staff.

People we spoke with including visiting relatives did not raise any concerns of how risks were managed.

Staff spoken with told us that they used information in people's care records, risk plans and daily staff handover meetings to be aware of people's needs and the support required. Staff also gave examples of how risks were managed. For example sensor mats were used for some people at risk of falls to alert staff when they were walking around in their bedroom.

Care records contained risk assessments for each person to assess their risk of falls, developing pressure ulcers and nutrition. These had been reviewed monthly. Risk plans provided details of the actions being taken to reduce these risks for people and we saw the interventions identified were in place. For example, some people used a pressure relieving cushion to protect their skin; we saw food supplements prescribed by the GP were available for people who had been assessed as being nutritionally at risk.

Accidents and incidents were recorded and body maps were used to record any injuries sustained as a result of the accident or incident. This allowed staff to record any injuries and to monitor the healing of those injuries. Records showed what action had been taken such as when the GP or district nurse had been contacted to visit the person. Personal emergency evacuation plans were in place and provided detailed information for staff about the person's needs. Staff we talked with said they had fire alarm tests and fire drills on a fortnightly basis. Additionally, staff had information available of the action to take if an incident affected the safe running of the service. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events.

Checks were in place to monitor the safety of equipment and the environment. We saw there were two defective wheelchairs on the day of the inspection and received conflicting information as to whether one had been taken out of use. There had been intermittent problems with one of the wheelchairs over an extended period. We were told this was the person's own wheelchair and as such the family were responsible for repairs, the consequence was that the wheelchair was unsuitable for use for a period of time. The assistant manager told us the person had been provided with an alternative wheelchair but all staff did not appear to be aware of this. We discussed this with the registered manager who contacted the provider immediately and arranged for one wheelchair to be delivered in the afternoon and two new wheelchairs were offered.

People we spoke with including a visiting relative did not raise any concerns about the availability of staff to meet people's needs and keep them safe. One person said that when they pressed their call bell in their room, "They [staff] come immediately."

Staff we spoke with told us they felt there were enough staff rostered on duty to meet the needs of the people currently using the service. They said when there was short notice sickness, other staff would normally provide cover through working additional hours. One staff member said, "We all work together and cover each other."

On the day of the inspection we observed people's needs were responded to in a timely way and the staff team worked well together to ensure people's needs were met and people were safe. The assistant manager told us how people's dependency needs were monitored and that informed them of the staffing levels required. The assistant manager said, "If a person's needs change I can be flexible and rota additional staff on if required."

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included criminal records check and employment history.

People we spoke with told us they received their prescribed medicines safely. One person said of their medicines, "They [staff] look after them and give me them." Another person told us, "They dish them out morning and night," and when asked if they were on time said, "You get them when they give them but that's ok." A visiting relative told us that the home handled her family member's medication and said, "They [staff] do keep me informed if there are any changes."

There was evidence that staff administering medicines had had a competency check completed within the last six months and staff told us they had completed training. A medicines policy was in place but it was undated, however, we found it was appropriate and included good practice guidance. A medicines audit completed by the pharmacy supplier in November 2015 had identified the refrigerator used to store medicines was not locked and there was no key which fitted the lock. However, the room the fridge was kept in was locked. The assistant manager told us they had liaised with the pharmacy for a replacement but to date the issue had not been resolved.

We observed the administration of medicines and saw staff checked the medicines against the medicines administration record (MAR) and stayed with the person until they had taken their medicines. However, we observed on one occasion the staff administering the medicine left the medicines trolley unlocked and unattended briefly. We advised the assistant manager of this who said they would speak with the staff. There were plans for how PRN medicines should be given. These are medicines that are given when needed, for example for pain, illness or anxiety.
This meant that care workers had clear guidance to follow to ensure these medicines were being given

safely.

Systems were in place for the timely ordering and supply of medicines. We did a sample check of medicines which tallied with the medicines administration record. Staff had the required information that advised them of important information about the person such as allergies and the how the person liked to take their medicines. Some people had specific healthcare needs and records confirmed staff followed good practice guidance and recommendations made by visiting healthcare professionals.

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. Whilst, there had been a request for a review by the pharmacist this had not been completed at the time of the inspection. The assistant manager was following this up. This is important to check the effectiveness of the medicine given covertly has not change.

Requires Improvement

Is the service effective?

Our findings

We identified concerns with the training, development and support provided to staff. From talking with the assistant manager, staff and looking at the staff training records we found three staff that had been employed for five months and had not received any training other than training in medicines.

The assistant manager said training was provided in June of each year. They confirmed that if staff started after this time they had to wait to receive training until the training was provided again. The staff training matrix also showed some gaps in refresher training staff had received. This is important training for staff to support them to keep up to date with good practice. For example, eight staff required refresher training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Three staff had received training in nutrition and hydration; no staff had received training in end of life care. However, the assistant manager told us they, and a senior care staff member had recently enrolled on a course. Not all staff had received training in dementia care. This meant that there was a risk that people's needs may not have been fully understood by staff due to a lack of training.

In addition we found the support provided to staff to formally meet with their line manager to discuss and review their work, training and development needs was insufficient. One staff member said, "One to one meetings with staff don't happen."

We saw records that showed staff had received an induction into the service that consisted of looking at policies and procedures and how the service was managed. This also included shadowing more experienced staff. From the last three newly appointed staff members, we found that only one had met with the assistant manager during their probationary period at the frequency the provider had stated was required to review their practice. This told us that new staff were not supported adequately enough.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent to care and support had been appropriately gained. For example, a document within people's care records had been signed by the person using the service to say they understood their rights to such things as how to make a complaint and access to their care file. Staff had recorded within this document for one person that they were able to make their own choices and decisions and had been able to participate in compiling their care plan.

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 checked whether the service was working within the principles of the MCA.

From the sample of care records we looked at we found examples that when people were not able to make

some decisions for themselves, mental capacity assessments had been completed and best interest decisions were documented. However, we noted there was no mental capacity assessment and best interest decision for the administration of covert medicines, although the person's GP had been involved in the decision.

We saw examples of do not attempt cardio-pulmonary resuscitation orders (DNACPR) in place. From the sample we saw these had been completed appropriately. Staff told us there was a list of people with a DNACPR in place so they were clear on the action to take.

The assistant manager told us that 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. The assistant manager told us that where a 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). Records showed that an application to the authorising body had been made for people that required them.

Staff were aware of the basic principles of the MCA and DoLS. They were able to talk about best interest decision making and the importance of involvement in the decision making process.

People were supported to eat and drink and maintain a balanced diet based on their needs and preferences. This included consideration to people's religious or cultural needs. People told us that they were satisfied with the meal choices. One person said, "The meals are lovely, sometimes I eat a lot, sometimes I don't." Another person told us, "They'd [cook] what you want if you didn't like the choices." One person had a particular preference to their food and said, "They [cook] me what I want, look after me."

We talked with the cook who we found to be very knowledgeable about people's needs and preferences. The cook told us they liked to spend time in the dining room talking to people, obtaining their feedback and finding out more about their preferences. We saw the cook asking people for their choice of lunch during the morning. They told us if someone changed their mind at lunchtime there was always flexibility to provide a different option.

We saw there were good stocks of food and food was freshly prepared on the premises. We saw there was a menu with a five week rotation. This included a choice of two main dishes at lunchtime and a choice of a hot snack or sandwiches at tea time. Additionally, people could have a hot or cold breakfast or both.

We observed the lunchtime meal in the dining room. Staff sat with people who needed assistance and supported them with their meal, explaining what they were doing and did not try to rush people. Staff identified when a person was not eating their meal and went over to them to encourage them to eat and asked if they wanted any assistance. People told us their meals were hot and the portion sizes looked appropriate. When the cook served people we saw that they ensured they had drinks, with one person they made sure the person had a spoon in their hand before leaving them.

People's nutritional needs had been assessed and planned for. This included monitoring people's food and fluid intake and weight to enable action to be taken if concerns were identified.

People told us that they were supported to maintain their health. One person said, "The doctor comes to us, we have a very good service, and the district nurse comes twice a week." Another person said, "The optician comes and someone for my feet."

We received feedback from a healthcare professional who told us there had been, "significant improvement" in the service meeting people's healthcare needs. From the sample of care records we looked at we found records confirmed the involvement of external healthcare professionals. It was evident from the records that staff consulted with healthcare professionals when there were early indications of health issues to obtain their advice and support.

Good

Is the service caring?

Our findings

People we spoke with, including a visiting relative, were positive about the care and approach of staff. One person told us, "They [staff] are very good, everything's nice and warm and comfortable." Another person said, "They [staff] help me a lot, wash me…I can't grumble they are very good." A visiting relative told us, "All the staff are really nice here, really friendly. [Family member] has never said she didn't like anyone here."

Feedback from a healthcare professional described staff as, "Caring, good at their job and knowledgeable."

Staff we spoke with showed a good awareness of people's individual needs, preferences and personal histories. We observed how staff spent time with a person living with dementia, the staff were seen to be reassuring them and answering their questions, encouraging them to talk about the people they mentioned and reminiscing about. This told us that positive caring relationships had developed with people who used the service.

We saw that staff spent time with people and whilst they had tasks to complete, this did not distract them and they took time to interact socially with people. We saw one staff laughing and joking with a person in the lounge, in a kindly manner. The person was seen to be relaxed and enjoyed the attention. Staff showed good communication skills when talking with people, this included crouching down to the same eye level of the person. Staff were seen to be patient and offered additional explanation when talking with people.

During our observation of staff interacting with people we saw how staff showed concern for a person's wellbeing. For example, a member of staff was helping a person to drink but was concerned about the person's responses. The staff member checked with a colleague who asked the person if they were cold and fetched a blanket for them. We then saw that the senior staff member was called to check on the person. They asked permission of the person to check their blood sugar. The test was carried out by the senior member of staff in a kind, gentle way, fully explaining what they were doing or going to do. This person was then monitored closely.

People were given choices and staff supported people with these. For example, we saw that two people said they wished to sit in easy chairs in the lounge area and eat from occasional tables. Staff accepted this and ensured both people were seated comfortably at small tables and had cutlery, napkins and drinks to hand.

We observed people being supported to prepare to have their lunch. All staff with the exception of one, asked people if they wished to wear an apron. They respected the person's decision and if the person said they wanted an apron, the staff put it on for the person, speaking kindly and reassuringly explaining what they was doing.

We saw an example where the action of a member of staff could have been better. For example, when a table needed to be moved to accommodate people, the staff member pulled back the seat of a person already sitting at the table, without talking to that person or explaining what they was doing or going to do.

People told us that staff involved them in discussions and decisions about the care they received. We observed staff throughout our inspection involved people as fully as possible with day to day decisions. This included where they sat, what they had to eat and drink and how staff could make them comfortable.

Staff gave good examples of how they involved people in expressing their wishes about the care and support they received. Staff said how they valued and respected people's decisions and choices. One staff member said, "We involve people as much as possible with everything, it's important we do, it's their life and we should respect that."

From the sample of care records we looked at we saw examples of how people and or their relative if appropriate, had been involved in decisions about their care. The assistant manager told us that they regularly had discussions with people and visiting families but that these were not always recorded and that they would improve this.

Information about independent advocacy support was available. This meant that people had guidance of who to contact if they required additional support or advice and representation.

People told us that staff respected their privacy and dignity. One person said that when staff visited them in her room, "They [staff] just knock and walk in," but confirmed that they wanted this.

Staff told us how they respected people's privacy and dignity and gave examples of how they did this when providing personal care. Such as knocking on people's doors before entering, and keeping them covered during personal care. One staff member said, "Privacy and dignity is important, I treat people as I would want to be treated myself."

From the sample of care records we looked at we found each person's daily care notes had a document reminding staff about the dignity charter. We observed staff knocking on people's doors before entering their room and taking steps to protect their privacy. The importance of confidentiality was understood and respected by staff. Confidential information was stored securely. This told us that the provider promoted dignity, privacy and respect towards the people in their care.

We observed that the doors of the toilet and the toilet and bathroom on the ground floor either did not have a locks fitted, or the one in place did not work. We brought this to the attention of the assistant manager who agreed to have new locks fitted.

There were no restrictions on friends and relatives visiting their family.

Good

Is the service responsive?

Our findings

People we spoke with, including a visiting relative, told us staff provided a responsive service that was based on their individual needs, preferences and routines. One person said, "They [staff] get me up in a morning, I tell them about six o'clock and they say if they've anyone before me. I can go (to bed) what time I want, there's no fixed time for me." Another person told us, "I tell them [staff] when I want to go to bed and they take me. I get up about half past six, my choice. You can lie in." A further person said they were given a choice of how often they had a bath, they added, "For some people they have one every day."

Staff told us they were able to cater for the individual needs of people and they offered them choice where ever possible. One person said, "Their needs come first."

From the sample of care records we looked at we found people had received an assessment of their needs prior to moving to St Marys. This is important to ensure people's individual needs can be met. A document entitled "This is me" contained information about the person's previous life history and the things which were important to them. It provided personalised information about things that worried or upset them and things which made them feel better if they were anxious or upset.

Care plans were in place documenting each person's care and support needs. These were detailed and provided clear information as to the parts of their care they could do for themselves and the tasks they needed help with. This meant people were encouraged to be as independent as possible whilst providing support when it was required. We looked at the care being provided and saw it corresponded with people's care plans. When people had a long term health condition, care plans were in place to ensure staff had knowledge of how to manage the person's condition and when to call for assistance.

Care records also contained a care plan for people's religious and cultural needs. One person's care plan stated they liked to attend a church service held in the home every third Thursday afternoon. Staff told us the person and several other people attended the service regularly. An additional document entitled, "Choices" contained brief information about people's food preferences, interests and routine. This told us that staff had the required information available to them to support them in providing a responsive and personalised service for people.

A review of care plans and other individual records were completed by the assistant manager on a monthly basis. Staff told us that any changes to people's needs were documented in the person's care plans and were discussed in daily staff handover meetings. This ensured staff were aware of people's current needs.

We asked people if they were aware of, and involved in the care planning procedure. A visiting relative said of their family member's care plan, "I'm sure she does, I haven't seen that, but there is one." They added, "They [staff] are good though, they do ring me if [family member] is really bad."

We asked people what they did during the day. One person said, "Sit here in the chair and talk to different people, have bowls and skittles and that. We go and sit in garden." A relative we spoke with told us how their

family member was supported to continue with their community activities. They said, "[Family member] has told me staff can't do enough for them, that they are supported to do things of their choice."

We talked with staff about how people were supported to pursue their interest and hobbies. One staff member said, "We try our best to do activities." They went onto say that it was difficult to engage some people in group activities and, "It is about individual choice. [Name] will play skittles. [Another person] likes to colour."

We saw that the home served alcoholic drinks to people and during the inspection saw sherry being drunk by at least three people. One visiting relative told us, "[Family member] is used to drinking and so still has a drink here, as long as it's ok with her medication. If you can't have a glass of wine at 80 when can you?"

In the morning we found people were not given any opportunity to participate in any activities other than to watch the television. We were not sure if people had been given a choice of having the television on or if they might have preferred listening to music. We noted the subtitles were on the television which a member of staff said was at the request on a person.

During our observations of staff interacting with people who used the service, we saw one staff member assisting a person to walk back to the lounge from the dining room and that person began dancing. The staff member put on a music CD and began dancing with the person. Other people in the lounge enjoyed seeing this. In the afternoon we saw staff sitting talking with people and some people were supported to participate in a skittles activity, observations suggested that people were relaxed and enjoying themselves.

We asked people if meetings were arranged for people who used the service and their family members to share their views about the service. A visiting relative said, "Not that I know of but to be honest they are all so approachable and if they have any worries about mum they talk to me."

No one we spoke with who used the service said they had made any formal complaints, nor felt the need to do so. The registered manager told us that the complaints procedure and other information available to people advising about the service were in the process of being updated. They said that this information would be made available to people and a copy put in people's rooms.

Staff told us they had not experienced anyone wanting to make a complaint or raising a concern. They said that if they did they would take it seriously and write it down and pass it on to a member of the management team.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service we identified a breach with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the time of this inspection we found this regulation had been met. Daily, weekly and monthly audits were in place to monitor the quality and safety of the service which was carried out in large by the assistant manager. This included checks on care records, maintenance of the environment and equipment. However, during our tour of the building and conversation with staff we identified that not all bedrooms had a call bell plugged in. The registered manager took immediate action and the issue with call bells was resolved the same day.

The registered manager told us that they had regular discussions with the provider about the service and said they had raised the need for St Marys to have some refurbishment work carried out. Additionally, they advised that they were aware that they needed to do additional audits and checks to monitor how the service was improving.

The local clinical commissioning group visited the service in November 2015 to complete an infection control audit. The assistant manager showed us the report and the action required to improve standards and said that this had been implemented.

We looked at the provider's annual satisfaction questionnaire returns, dated July 2015, received from people who used the service and relatives. Positive comments received included, "The staff are excellent and always go beyond the call of duty." "Nothing to change, just like the family atmosphere." Several comments requested additional activities for people to participate in. Since our last inspection the provider had implemented a document to record activities people had been offered and had participated in. People received some social activities provided from external entertainers and visitors.

The assistant manager told us that they had introduced 'resident and family' meetings and had one since our last inspection. We saw the meeting record for September 2015. We noted that discussions were had about the choice and quality of food that was available. People were asked for their views and no concerns were reported.

People we spoke with did not raise any concerns about the service they received. One person told us their room was, "Lovely, a nice bed and a cleaner every day." Whilst not always recalling the registered manager's name, people said they felt they were approachable. One person told us that if they had any problems they would, "Talk to the manager, her who's just been in, I forget her name, she's alright, she always says hello."

Staff had a clear understanding of the provider's vision and values. They told us their priority was to provide good care. One staff said, "The residents come first. We have some brilliant staff here, nothing is too much trouble. The residents are like a second family."

There was a whistle blowing policy in place. A whistle-blower is protected by law to raise any concerns about an incident within the work place. Staff said that they would not hesitate to use the policy if required

to do so.

Staff told us staff meetings were very infrequent. Information was cascaded to them through the senior care staff and that daily handovers were used to provide feedback on areas for improvement from audits or accidents and incidents. Staff said they were able to discuss issues at staff meetings but, "Sometimes it doesn't get sorted." Another staff member told us, "We have ample opportunity to speak to [the assistant manager]. She is easy to talk to." Another staff member said that if they reported something to the registered manager or assistant manager they, "Would like to think" they would address the issues. Not all staff felt valued. They said they did not receive positive feedback and felt they were taken for granted.

The registered manager confirmed that regular staff meetings were not arranged. The last meeting they said was July 2015. This was arranged to discuss the outcome of our last inspection. The registered manager acknowledged improvements were required in relation to supporting staff. This included ensuring all staff received opportunities to complete appropriate training in a timely manner. Opportunities to review their work, training and development needs and be involved more in the development of the service through discussions in staff meetings.

Since our last inspection the provider had notified CQC of changes, events or incidents as required. At our last inspection the service was without a registered manager. A new manager registered with CQC in September 2015.

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 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 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 Regulations 2014: Staffing Staff employed by the service provider in the provision of a registered activity had not received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)