In Safe Hands Home Care Limited

Bluebell House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 28 September and 4 October 2018 and was unannounced.

Bluebell House Residential Care Home is registered to provide accommodation for up to 19 older people. There were 18 people, some living with dementia, at the home at the time of the inspection. The home is situated in a residential area of Ventnor. It is an adapted building with bedrooms, many with en-suite facilities, provided over two floors in single occupancy rooms. A stair lift provides access between the floors. There is one communal lounge, a dining room and appropriate toilet, bathing and shower facilities. Externally there is a level enclosed decking area to the rear of the home and a small seating area to the front of the home.

Bluebell House Residential Care Home is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in place. 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. The service was also owned by the registered manager.

Where we identified concerns in respect of the time some people were receiving non- essential personal care and recruitment checks the registered provider reacted to address the issues and took action to amend staff shift times and daily routines. However, we cannot be assured that, had we not identified the concerns that this would have occurred.

Risks to people were assessed and measures had been taken to mitigate these. Incidents and accidents were reviewed and action had been taken to reduce the likelihood of any reoccurrence. The premises and equipment were safely maintained.

Sufficient numbers of care staff were deployed to meet people's needs. Staff were trained, supervised and felt supported and valued. Recruitment checks were made to ensure staff were suitable to work in a care setting.

People received personalised care which was responsive to their personal and healthcare needs. Medicines were safely managed. The home was clean and hygienic.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food.

Staff spoke with people in a polite and caring manner Care was individualised and reflected people's preferences and changing needs. People's privacy and dignity were promoted.

Some activities were provided and the registered manager was acting to improve staff availability to provide activities.

There was an effective complaints procedure in place. People and their relatives confirmed they were listened to and changes were made when requested.

People and their relatives had opportunities to express their views about the service and were consulted about their care. Audits were carried out to assess and monitor the quality of the service, and identify areas for ongoing improvement.

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 requires improvement.

The registered provider acted to address our safeguarding concerns that some people were being provided with non-essential personal care early in the morning.

Individual and environmental risks to people were managed effectively. Accidents and incidents were monitored and action was taken when necessary to reduce the risk of recurrence. People were involved in risk-taking decisions to help them retain their independence.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Arrangements were in place for the safe management of medicines and people received their medicines as prescribed.

There were appropriate systems in place to protect people by the prevention and control of infection.

Is the service effective?

Good

The service was effective

People received effective care from staff who were competent, suitably trained and supported in their roles.

Staff followed legislation designed to protect people's rights and freedom.

People were supported to eat and drink enough and had access to health professionals and specialists when needed.

When people were transferred to hospital, staff ensured key information accompanied them to help ensure their received ongoing healthcare support.

Adaptations had been made to the environment to make it supportive of people who lived at the home.

Is the service caring?

Good

The service was caring.

People were usually treated with kindness and compassion however some morning care routines were not person focused.

Staff interacted positively with people and promoted their independence. Staff protected people's privacy and respected their dignity.

Staff supported people to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Care plans were reviewed regularly and staff responded promptly when people's needs changed.

The provider was looking to increase the range and amount of activities available to people to ensure they received an adequate level of mental and physical stimulation.

Staff had the necessary training and commitment to support people to receive end of life care that helped ensure their comfort and their dignity.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider had failed to identify that people were not always being treated in a proper way.

There was a management structure in place and staff understood the roles and responsibilities of each person within the team structure.

People and their relatives were happy with the service and felt able to approach the registered manager should the need arise.

Bluebell House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 28 September and 4 October 2018 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people living at the home and five visitors. We spoke with the provider, the registered manager, the deputy manager, four care staff and ancillary staff including, the cook and housekeeping staff. We also spoke with two visiting healthcare professionals and one social care professional. We looked at care plans and associated records for four people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance.

We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We were informed that night staff were providing personal care, administering medicines and assisting some people to get up and get dressed, early in the morning. Records viewed confirmed that some people were assisted to wash, dress and receive medicines as early as 5.20am. We discussed this with the registered provider who told us this related to people who were cared for in bed and required repositioning at this time. However, for one person, we saw they were being assisted out of bed into a chair, by using moving and handling equipment at 5.45am. A staff handover book included a note night staff should get up a named person and 'as many as possible' and directed night staff to administer medicines for four named people although only one was prescribed to receive these before 7am. The night shift finished at 7am, which meant that night staff would have needed to get people up before this time, in order to complete people's personal care which for some people would have required two care staff. Daily records did not show that people had consented to receiving personal care at this time of the morning.

Where people require repositioning or other personal care during the night, this should be provided with minimum disruption to the person, who should then be able to return to sleep as soon as possible. Minimum care would include attending to any continence needs and repositioning requirements. The provision of more than essential care at a very early time in the morning is inappropriate and does not respect the person's right to have a good night's sleep.

Staff had received safeguarding training and told us they would have no hesitation reporting concerns to the registered manager or deputy manager. Staff were aware of external organisations, including CQC, they could go to for additional support. However, staff including management, had not identified that providing more than essential care at the times detailed above was a safeguarding concern. We notified the local safeguarding team about our concerns who have undertaken an investigation. The registered provider has subsequently provided information to confirm that there have been changes to staff shift patterns and that people are only receiving morning care where necessary and with their agreement

People felt safe living at Bluebell House. When asked if they felt safe one person told us, "Yes, very safe. They [care staff] look after my needs." A family member told us, "The staff are constantly around. [My relative] wanders, but I know he is safe."

Appropriate recruitment procedures were in place however these had not always been followed. Checks included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. DBS checks had been completed for all staff prior to their commencing employment. However, although two references had been sought for all new staff, this had not always included seeking a reference from the applicants existing or previous employer. Therefore, the provider was unable to confirm the staff member's reason for leaving or their conduct at their previous employment. Following the inspection, the registered manager sought the missing references and undertook to ensure these were always in place before new staff commenced employment.

Risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided. There was a process in place to help ensure they remained at the right setting according to the person's weight. Records showed people were supported to change their position regularly to further reduce risks of pressure injury. Where people were identified as being at risk of choking, action was taken to ensure these risks were minimised. For example, we saw specific guidance provided by a Speech and Language Therapist (SaLT), which was being followed. Staff ensured food and drinks were of the correct consistency, according to the guidance and they remained with the person whilst they ate or drank.

When people experienced falls, their risk assessments were reviewed and additional measures were considered to keep them safe. The registered manager and deputy manager had attended falls champion training. They said this had provided them with a greater insight into possible causes of falls and action they could take to prevent falls. For example, they explained how a person had slipped from their chair on several occasions. They had changed the person's bedroom armchair which had improved the person's posture and resulted in no further incidents. If people sustained a head injury, staff were guided to seek immediate medical advice and monitored the person closely to check for signs of a brain injury. The registered manager reviewed all falls in the home monthly to identify any patterns or trends; none had been identified, but they described the action they would take if a common theme emerged. Staff had been trained to administer first aid and described immediate action they would take should the need arise.

People were involved in risk-taking decisions to help them retain their independence and avoid unnecessary restrictions. For example, when one person moved into Bluebell House they expressed a wish to go to the town centre on their own. Staff had gone with them the first few times until the person was confident about the route there and back. The registered manager had also provided the person with a card with the home's name, address and phone number on it, which they could use if they became unsure. The person was now able to independently access the town.

Environmental risks were managed effectively. Gas and electrical appliances were serviced routinely and fire safety systems were checked regularly. A fire safety risk assessment had identified action required to improve the home's fire prevention and management systems. All required tasks had been completed and a visit by the local fire authority in March 2018 had found no further action was required. Staff were clear about what to do in the event of a fire. Each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated. Should the home need to be evacuated, arrangements had been made to use a neighbouring care home and to call in additional staff to support people.

There were enough staff deployed to meet people's needs. When asked if they thought there were enough staff one person said, "I do." Other people commented that at times staff were busy, but said staff came promptly when required. For example, one person said, "They come reasonably quickly. They are busy in the mornings. If I ring the buzzer they come quickly." A relative said, "I think there's normally enough carers. There is always someone around. He [relative] is well attended." Another visitor said, "They [staff] come if he steps on the mat [movement alert mat] or presses the bell." Throughout the inspection, we saw staff were available to support people and call bells were responded to promptly. The registered manager assessed staffing needs by observing staff and listening to feedback from people and staff. In response to feedback, they had amended staff shift times to provide more staff first thing in the morning and were recruiting additional care staff to increase the number of staff on duty during the afternoon and early evening. Care staff said there was usually sufficient staff on duty. They were aware of the plans to increase staffing in the afternoon and identified this would enable them to provide more individual support for people.

People were supported to receive their medicines safely and as prescribed. When asked if staff gave them their medicines, everyone confirmed staff remembered these. One person said "Yes, every day." People also confirmed they were offered pain relief should they need this and that staff remembered to apply any prescribed topical creams. One person said, "Yes. They always do that [apply topical creams]."

There were clear processes in place to obtain, store, administer, record and dispose of medicines. Medicines were only administered by suitably trained, senior staff, who had their competence to administer medicines assessed every year. Where people were prescribed a blood thinning medicine and were at an increased risk of bleeding, information was available for staff which described specific action to take if the person had an injury. There was a clear process in place to help ensure topical creams were not used beyond the manufacturers' 'use by' date. Staff recorded the application of creams to people and had clear information as to where each prescribed topical cream should be applied and when this was required.

There were appropriate systems, policies and procedures in place to protect people by the prevention and control of infection. These included infection control risk assessments, cleaning schedules and regular audits. The registered manager was recruiting an additional cleaner and had increased the hours worked by the existing cleaner until the second one was in post. People commented that the home was always clean and tidy, including one person who said, "It's certainly clean and tidy." Whilst a visitor commented, "It's spotless".

Staff had completed infection control training. They had access to personal protective equipment (PPE) and wore this whenever appropriate. They described how they processed soiled linen, using special bags that could be put straight into the washing machine to avoid the risk of cross contamination. A system was in place in the laundry room to help prevent cross contamination between soiled linen entering the laundry and clean linen leaving the laundry. A sluice room was available and systems were in place to ensure commodes were cleaned following use. The registered manager was aware of the action they should take should there be an infectious condition within the home. The deputy manager was aware of the need to complete an annual infection control statement.

Good

Is the service effective?

Our findings

Prior to admission, the registered manager undertook an assessment of people's individual needs to ensure these could be met at the home, including any equipment or specific adaptations that may be required. Relatives told us the registered manager had met with them prior to their family member's admission to identify care needs and other things which were important to the person. We saw copies of assessments in people's care files which showed there had been consultation with family members and health or social care professionals prior to their admission. This would help ensure all needs were known and met on admission.

People were supported to access healthcare services when needed and people received the personal care they required. A family member said, "Any little problem, they get the doctor for her. No problem." Care records showed staff identified people's health needs, sought appropriate medical care and kept family members informed when necessary. The service worked well with other organisations to provide a coordinated approach to care. Records showed there was joint working with community psychiatric services and confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. Care plans contained a hospital transfer form with people's specific details, which would help ensure they received appropriate care should they need to be transferred to hospital.

Most people told us they enjoyed the food provided at Bluebell House. One person said "Excellent". Another person said "It's all right, passable. Sometimes it's better than others, there's always enough for me." Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet and we saw this was provided, with the cook able to state who required specific diets and how these were met. People had a choice to eat either in the dining room, lounge or their bedrooms, according to their personal preference. When people did not want either of the main cooked meal options, an alternative such as an omelette or jacket potato was provided. Staff were attentive to people during meals and where people needed support to eat, this was done in a dignified way. Throughout the inspection we saw people had hot and cold drinks. Where needed staff were recording all fluids, people received. These records showed people were receiving regular drinks and their hydration needs were being met. Staff monitored people's weight and action was taken when people had unplanned weight loss.

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. People consistently told us they received effective care from experienced and competent staff. When asked if they felt staff were trained and knew how to support them one person said, "They are, yes." A visitor said "They [staff] have training sessions, they are all very good, I can't fault any of them." New staff completed an effective induction into their role. This included training and time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. There was a system to record the training that staff had completed and to identify when training needed to be updated. The registered manager and two senior staff had completed moving and repositioning train the training and were planning to undertake first aid train the trainer courses so they could provide these courses in the future.

Staff received supervision and appraisals of their work and felt supported. Written records of observational

and formal supervisions were kept, showing staff received these approximately every three months. Supervision is an opportunity for the registered manager to meet with staff, to discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal to assess their performance and identify development needs. Staff members confirmed that they received supervision regularly and spoke positively about the support they received from management on a day to day basis.

Staff followed the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. A formal mental capacity assessment had been completed for all people. This covered all aspects of care required such as personal care and medicines. Where the assessment showed people lacked capacity to make decisions, the registered manager had discussed this with relevant people such as the person's relatives. The resulting best interest's decisions were recorded as required by the MCA.

Staff described how they sought verbal consent from people before providing care and support. They said they were led by the person and always acted in the person's best interests. One staff member who administered medicines described what they would do if someone declined their medicine. They said, "I would explain what the medicine is, and if they still didn't want to take it I would record this and inform their GP".

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). 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 the registered manager had applied for DoLS authorisations where needed and acted appropriately where conditions had been applied to DoLS.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed. Wi-Fi had also been installed to allow people to connect to the internet. Staff used walkie-talkies to enable them to communicate with each other when required.

Adaptations had been made to the home within the structural limitations of the building. A stair chair lift was provided to enable people to access the first floor and the registered manager confirmed that only people able to manage the short flight of stairs to an upper level would be accommodated in these rooms. Bedrooms were personalised and people had their own furniture and items that were important on display. Hand rails were painted in contrasting colours to walls and toilet and bathroom doors were painted in bright colours with suitable signs to help people locate these. There was level access to a flat enclosed rear decking garden, which we were told people enjoyed the use of in warmer weather.

Good

Is the service caring?

Our findings

People were usually treated with kindness and compassion however, some morning care routines were not person focused. Records showed night staff were directed to provide personal care for some people and records did not show that this was only provided at the person's request. The registered provider has subsequently amended their procedures to ensure that this does not occur.

At other times interactions between people and staff were positive and supportive. Staff engaged with people, checked they were comfortable, bent down to their level and used touch appropriately to reassure them. Staff could tell us about people's life histories and this information was also available within care plans. A relative said, "They talk about his past. They talk about his old army days."

Everyone we met spoke positively about the attitude and approach of staff. Comments from people included: "The staff are really kind and friendly. I've not come across any unpleasant ones yet", "I think they [staff] are lovely people", "They [staff] are very kind" and "Very good. Excellent". Family members echoed these views, including one who told us, "Some [staff] are really really kind, He [relative] can get agitated and there's one of them who can always calm him down."

Care plans also contained information as to how the person's emotional and social needs should be met and what was important for them. For example, we saw some people had been supported to apply make-up and wear jewellery as this was their preference and reflected information in their care plan. Another person had requested to have bedrails provided as they were scared they may fall from their bed. These had been provided following a suitable risk assessment. People and their relatives told us they were involved in discussing the support they wished to receive. We heard people being offered choices throughout the inspection. For example, one person said, "They come in in the morning and afternoon and say, 'Do you want to come downstairs and play a game?' I don't like to play, I like to see the news. That's all."

Staff understood the importance of protecting people's privacy and dignity and ensured people were happy to receive care before providing this. People told us staff always asked their permission before providing care. A relative confirmed this saying, "Always. They [staff] say, 'would you mind?" A family member told us, "[My relative] is treated with dignity and respect." Privacy screens were used when eye drops or other medicines other than tablets were administered in communal areas.

A visiting healthcare professional told us, "People's privacy is protected. Staff always ensure people are taken back to their bedrooms before I see them." A staff member told us, "We shut doors and wash one half [of the person] at a time, so they're never completely naked." Some people had asked to receive personal care from female staff only and they confirmed this wish was always respected. One person told us, "There is a male care staff member. I'd sooner have a lady [staff member] for personal care, so I have a lady [staff member]. They've said that and they keep to it."

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "I feel free and easy to get on with my life." Another person said, "I'm left to

my own devices, but they [staff] come in when I want them." A family member commented, "[My relative] can get up and go to bed when she likes and there are no restrictions on her movements." People's care plans also included information as to what support they needed and what parts of personal care, such as washing their own face, they could do independently. At lunch time we saw a range of adapted crockery such as high sided plates and larger handled cutlery were provided when necessary, meaning people could continue to eat independently. Coloured plates, bowels and glasses were also provided which help people living with dementia and sight loss to better identify meals and drinks, increasing their independence.

During pre-admission assessments, managers explored people's faith needs and staff supported people to follow their faith. The registered manager told us they explored other aspects of people's cultural and diversity needs during ongoing discussions with people about their backgrounds, interests and beliefs.

Confidential information, such as care records, were kept in the registered managers office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People identified that they would like more activities. One person said, "I get terribly bored in here all the time. There are no activities." A visitor said, "A little bit more activity would be nice, they do try. Someone does music once a month. They did have an activities person but she left. They [staff] try to do a few things." The registered manager had identified a need to improve the activities to ensure people received the mental and physical stimulation they required. They were in the process of recruiting additional staff to enable them to increase the number of care staff during the afternoon and evening. The registered manager had identified that one of the roles for the additional staff member would be to provide activities during the afternoon. During the inspection, we saw several people joining a staff member for a board game in the morning and in the afternoon other activities occurred such as flower arranging, a person being encouraged to fold some tea towels and playing cards. The activities were provided to a small group of people who spent time in the communal areas. Other people, who chose to spend their time in their bedrooms, watched television or read newspapers.

Information from assessments completed before people moved to the home was used to develop a care plan in consultation with the person and their relatives where appropriate. Care plans contained detailed information to enable staff to provide care and support according to people's individual needs. They included information about people's normal daily routines, their backgrounds, hobbies, interests and personal preferences. For example, one person's care plan stated they liked to have a bath every day and we saw this was occurring. Another person needed to be supported to reposition in bed and records confirmed this was done regularly. Care plans were kept under review and staff said they could access these at any time if they needed to check any information.

People were unsure when asked about their involvement with their care plans, whilst relatives confirmed they had been involved in care planning. One visitor said, "There was one [care plan review] from [name of registered manager]. I was involved." We saw people and where appropriate their relatives had signed parts of care plans confirming they had been involved in decisions as to how their care needs would be met. The registered manager told us they were looking at ways to improve people's involvement in the formal reviewing of care plans.

At the time of the inspection no one living at Bluebell House was receiving end of life care. However, the registered manager provided us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Some staff members had received training in end of life care and we found that the end of life wishes and preferences for people had been recorded within care records. This should help to ensure that people's wishes were respected and acted upon. The registered manager also told us that they would work closely with relevant healthcare professionals and provide support to people's families to help ensure that they were fully involved.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are

supported with communication. People's communication needs were assessed and people had a communication care plan. People and their relatives said staff were good at communicating with people. Signs were provided around the home to help people identify communal areas and toilets.

Information about how to complain was available for people and visitors in the service user's information pack/guide located in the entrance hall. People and their relatives confirmed the provider was open to complaints, suggestions or comments which were responded to. For example, when asked what they would do if they had any complaints one person said, "I would start with the manager". People and their relatives said they felt comfortable raising issues and that when they did so action was taken. For example, one relative said, "I asked the other day if they could change his room so he has a view out of the window and look, they have done it already." One person told us, "A few of them [people living with dementia] wander in here, they go into people's rooms and take what they like." They said that when they had raised this with the registered manager it had been "taken seriously". The registered manager explained how they now provided a screen within one bedroom which had resulted in people with dementia no longer entering the bedroom but meant the rooms occupant could keep their bedroom door open as was their wish. No formal complaints had been received during the preceding year but there was a formal process to investigate and respond should these be received.

Requires Improvement

Is the service well-led?

Our findings

Where we identified concerns in respect of the time some people were receiving non- essential personal care and recruitment checks the registered provider reacted to address the issues and took action to amend staff shift times and daily routines. However, we cannot be assured that, had we not identified the concerns that this would have occurred

There was a clear management structure in place. Bluebell House Residential Care Home was owned by a limited company of which the registered manager was the owner and director. They were in day to day charge of the running of the service and it was evident from observations of interactions with people and visitors that the registered manager understood people's needs and preferences. The registered manager was supported by a deputy manager and senior care staff who lead each shift. An on-call rota was in place to enable staff to access management advice out of hours.

Staff said the registered manager operated an "open door" policy and held staff meetings to seek feedback and keep them up to date. In addition, arrangements were in place to help staff communicate effectively with one another. For example, staff kept a diary to remind each other of specific tasks such as ordering medicines or requesting doctors' visits for people that were required. Staff told us they were happy, motivated and worked well as a team. Comments included: "I'm happy in my work" and "I am very happy here and feel well supported". We found staff were organised and completed delegated tasks in an efficient and effective way, ensuring all the work got done at a relaxed pace.

Where we identified areas for improvement during the previous inspection, action had been taken to address the issues. Information from incidents and investigations was used to drive improvement in the service. For example, the arrangements to manage medicines had been reviewed and resulted in fewer errors. There were effective quality assurance systems in place. These were based on a range of regular audits, including infection control, medicines, care plans and the environment. When improvements were identified, action was taken. In addition to the formal quality monitoring processes, the registered manger identified that they informally monitored the quality of care provided as they worked some care shifts, including overnight, with care staff. This enabled them to directly observe how staff were working and helped them understand any issues raised by staff.

People and their relatives described an open and transparent culture within the home, where they had ready access to the management. Visitors were welcomed at any time. Following a food hygiene inspection, the service had received a lower rating than previously. The new rating was displayed prominently along with information as to the specific issues which had been identified and action which had been taken to rectify the deficits. The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall. Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred.

People were happy living at Bluebell House and felt the service was well-led. One person said, "I've been to other residential homes and it's the most comfortable." Another person said, "I think I get looked after very

well". Visitors were also positive about the home. One said, "Excellent. I can't fault it in anything. [Name of person] is well looked after and well fed. There's no problems at all. It's perfect. If it could be improved they would already have done it, they are very on the ball. A second relative said, "It's brilliant. It's a home from home. If he [relative] can't be at home, it's the next best thing." People were consulted in a range of ways about the way the service was run. These included regular "resident's meetings", yearly questionnaire surveys and individual discussions with people and their relatives.