HC-One Limited

Dovedale Court

Inspection report

Holyhead Road
Wednesbury
West Midlands
WS10 7PZ

Tel: 01215026444
Website: www.hc-one.co.uk/homes/dovedale-court/

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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

Our inspection was unannounced and took place on 24 July 2017.

At our last inspection in June 2015 the service was rated as good in four of the five questions we ask: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? And requires improvement for the remaining question; Is the service well-led? This was because the provider had not notified us and the local authority of incidents where they should have done. At this inspection we found that those specific issues had been addressed but some new issues were evident regarding protecting people from harm, medicine safety and a lack of a registered manager for a long duration. As a result the questions; Is the service safe? and Is the service well-led? have been rated as requires improvement.

The provider is registered to accommodate and deliver nursing and personal care to a maximum of 76 people. At the time of our inspection 71 people lived at the home. People who lived there were elderly and had needs associated with old age and dementia.

The manager was present on the day. They told us that they had only commenced work at the home two weeks previously. 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.

Processes were not always followed by staff to prevent people from the risk of harm and abuse. Medicine systems, although improved, needed to be strengthened to further enhance safety. Staffing levels needed to be reassessed to give assurance that people's needs could be met. Recruitment systems prevented unsuitable staff being employed. People felt safe and action had been taken to promote safety.

Induction processes were in place to provide new staff with the knowledge they needed to provide appropriate support to people. Staff confirmed that they were adequately supported in their job roles. However, one to one formal sessions had been lacking but were being addressed by the new manager. People received care in line with their best interests and processes were in place to ensure they were not restricted unlawfully. People were offered and supported to have the food and drink that they enjoyed.

Staff and people who lived at the home had a positive relationship. Staff were friendly and polite to people. People were enabled and encouraged to make everyday choices and were supported to maintain their independence skills. People's dignity, privacy and independence were promoted and maintained by staff

People needs were reviewed regularly to ensure that they could be met. A complaints system was available for people and their relatives to use if they had the need. Activities were available for people to engage in.

There was an unacceptable duration of time when there was no registered manager in post. People knew

who the new manager was. The new manager was visible within the service. Quality monitoring processes, the use of provider feedback forms and meetings helped to ensure that service was being run in the best interests of the people who lived there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff had not taken the action required to keep people safe and prevent the risk of harm and abuse.

Medicines processes had improved but required some more me strengthening to ensure consistent safety.

Recruitment systems prevented the employment of unsuitable staff.

Is the service effective?

Good

The service was effective.

People and their relatives felt that the service provided was good and effective.

Staff were trained and supported for them to carry out their work effectively.

Staff ensured that people were not unlawfully restricted and that they received care in line with their best interests.

Is the service caring?

Good

The service was caring.

The staff were kind, caring and attentive to people.

People's dignity, privacy and independence were promoted and maintained.

Visiting times were open and flexible.

Is the service responsive?

Good

The service was responsive.

People needs were reviewed to ensure that their needs and wants could be met.

The staff knew the people well enough to meet their needs.

Complaints processes gave people assurance that complaints would be appropriately dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was an unacceptable length of time when no registered manager was in post.

There was a leadership structure in place that staff, people and their relatives were aware of.

Quality monitoring processes were in place and action was taken where issues were identified.

Dovedale Court

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 was unannounced and was carried out on 24 July 2017 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 care service.

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. The form was returned so we were able to take the information into account when we planned our inspection. We asked the local authority their views on the service provided. We also reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke with eight people who lived at the home, seven relatives, four care staff, two senior care staff, one nurse, a cook, the handy person, the manager and a senior manager. As some people were unable to tell us their views of the service, we used a 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 looked at care files for three people and medicine records for eight people who lived on the residential unit. We observed some medicines being given to people on the nursing unit. We viewed recruitment records for two staff and staff training records. We looked at the systems the provider had in place to audit and monitor the quality of service provided including provider feedback forms that had been completed by people and their relatives.

Requires Improvement

Is the service safe?

Our findings

Staff told us that they had received safeguarding training. A staff member told us, "No abuse any concerns we [staff] have would report to senior staff or the manager". We witnessed an incident where a male person inappropriately touched a female person on their leg. The person was distressed and shouted. Staff we spoke with told us that there had been one previous similar occurrence with a different person. There were no care plans in place, risk assessments or instructions to staff relating to the management of this behaviour to prevent people being placed at harm. A staff member told us, "That should not have happened. The person should not sit by people who they may touch". This meant that the staff had not taken sufficient action to prevent person experiencing this abuse. We spoke with the manager who immediately notified the local authority safeguarding team and told us that they would address the situation. Other people we spoke with told us that they had not experienced any bad treatment or incidents with other people who lived there. One person confirmed, "No I have not been abused in anyway".

We looked at the medicines and Medicine Administration Records [MAR] for eight people and found that their prescribed medicines were available to give to them as prescribed. We found that the majority of MAR had been completed appropriately. However, staff had entered a code for 'hospitalised' on one MAR and the person had not been supported to take their tea time tablet. The person had been to an outpatient appointment so were not hospitalised. We discussed this with the staff to determine if the person's doctor had been contacted to see if their tablet could have been taken later. The staff confirmed that the person's GP had not been contacted. One MAR highlighted that a person had been prescribed a medicine on a short term basis. Staff told us that there was no short term care plan in place for this medicine. A short term care plan would make staff aware of issues that they should be aware of for example, allergic reactions or interactions with other medicines. This showed that medicine systems needed some strengthening.

A person shared with us, "They [staff] give me my medicine. I have nothing to do with that. I am happy with that". A relative said, "They [person's name] are on medication. It is administered well". Another relative told us, "They [staff] give her [person's name] pain relief when she is in pain. They can tell by her facial expressions". We saw that 'as required' protocols were in place for medicines prescribed in that way to ensure that staff knew when they should support people to take the medicines. We heard a nurse asking a person if they needed their pain killers. Staff told us that they had received medicine training and that their competence had been assessed. Records and certificates that we saw confirmed this. We saw that medicines were stored safely in locked cupboards and trolleys to prevent unauthorised people accessing them. We found that ordering and receipting procedures were in place and that a record was made when medicines that had not been used were returned to the pharmacy.

In 2016 we were notified by the service that a number of falls resulting fractures had occurred. A number of these had been investigated by the local authority safeguarding team. With two of the falls there were no staff in the lounge areas at the time to support people. Concerns were also identified that following one fall health care services were not called upon for a number of days that meant that a fracture remained unidentified. Following this incident the provider implemented systems for staff to follow that included staff being in lounge areas at all times and protocols following falls. Although falls had occurred since that time

we had not received any concerns about the management of these. A relative confirmed, "He [person's name] has had no falls here". A person told us, "I have fallen. I am not too steady on my feet. They [staff] helped me up. They phoned the doctor and I had checks and that sort of thing". Other relatives told us, "The carers [staff] are always in the room with him [person's name]" and, "They [people] are never left in the lounge alone". A staff member told us, "Falls have decreased. A staff member must be in the lounges to prevent falls". We observed that there were staff in the lounge areas throughout the day to support people. We saw that where incidents and accidents had occurred these had been documented highlighting what had happened and the action taken to minimise the risk of a further fall.

People told us that they felt safe. They and their relatives made the following comments, "The whole place makes me feel safe", "She [person's name] can't walk. She is either permanently sitting or lying down. They [staff] use a hoist. There are two staff in charge of the hoist. I have seen the staff hoisting her and she is quite happy, she smiles" and, "I think she is safe. I like the home". We saw that assessments had been undertaken relating to the prevention of sore skin and moving and handling. A relative told us, "They [staff] look for pressure sores. They [person's name] have got mats that they sit on. They are black cushions". We saw that where people had been assessed as being at risk of developing sore skin pressure relieving mattress were used on their beds and cushions on their chairs. We found that the risks were regularly reviewed and updated as required. The manager and handy person told us and records confirmed that weekly and monthly checks were carried out on equipment. These included checks on the fire alarm system and water temperatures. We saw certificates that confirmed that the lift received and hoisting equipment had regular services by an engineer. These actions helped to keep people safe.

People and their relatives had mixed views about staffing levels these included: "I have to ring the bell to get the staff. They come when they have time. Some come quickly; it's not a long time, not too bad. They are quicker during the day time"; "I think there is enough staff. In the past they have had agency staff. Now they seem okay staff wise", "It's very rare you hear the buzzers [call system] going off" and, "They could use a lot more staff". We observed that staff were available to support people when in the lounges and at meal times. We saw that staff were continually busy however, we did not hear call bells ringing for unreasonable amounts of time which highlighted that staff were available to respond to people when they were needed. We spoke with the manager about staffing levels. They told us that they provided staffing to meet people's assessed needs and dependency levels. The manager confirmed that they would re-evaluate staffing levels to evidence that they were adequate.

A staff member shared with us, "All checks were done for me before I could start work". The Provider Information Return [PIR] stated, "We have robust recruitment processes". We checked staff files and found that the required checks had been completed and included, the scrutiny of staff job application forms, the obtaining of references and a check with the Disclosure and Barring Service [DBS]. The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. We also found that checks had been undertaken to evidence that the nurses employed were all currently registered to practice. These checks would reduce the risk of unsuitable staff being employed.

Good

Is the service effective?

Our findings

A person shared with us, "I seem to be getting on alright", "I have not been here for long but I like it. I think it is good". Another person said, "They [staff] look after you alright. They always look after you. They are very good to me that way". A relative told us, "She [person's name] was in another home before. I wasn't happy with it at all. Here's completely different". Another relative said, "I am glad she [person's name] is here. She seems calmer here than in the other home she was in". Staff told us that the service provided to people was effective. A staff member said, "We [staff] provide good care".

Staff told us that induction training was undertaken when any new staff started work. A staff member said, "I had induction training. I looked at policies and worked with staff who were experienced". Staff files that we looked at demonstrated that induction processes were in place. The manager told us that the Care Certificate was used for new staff who had no previous experience. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and compassionate care.

Staff told us that there was always support available from managers, nurses and senior care staff. A staff said, "There are nurses and a manager or senior on duty at all times". Staff told us that they had one to one supervision to discuss their role and performance although this was not always on a frequent basis. Records we viewed confirmed this. We spoke with the new manager and senior manager about this. The senior manager told us, "The frequency of staff supervision is an issue we have identified that needs improvement and we are addressing that". Records confirmed where there had been issues with individual staff performance this was dealt with formally through the supervision process. We saw that action points had been made for staff to change and improve their practice.

People told us, "The staff are all trained well" and, "Anything that they [staff] do is good". A relative told us, "I think they [the staff] are well trained. He [person's name] kept on having problems with a medical device. I was always in discussion with staff. When the doctor suggested having a different medical device they [the provider] organised a training course for the staff. I felt better with that. Even the nursing assistant went on it as well. It made me feel better, I was pleased". Another relative told us, "The cleaning staff are fantastic. I do stop and talk to them and commend them on the job they are doing". A staff member told us, "We [staff] have had the training we need". Records highlighted that staff had generally received the training they required however, two staff had not. This related to some online training the staff had not completed. Records highlighted that this had been raised with the staff and the manager told us that they were monitoring the situation to ensure that the training was completed.

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).

A person shared with us, "I can walk around to my heart's content and go in the garden". We saw that people went in and out of their bedrooms and the lounges as they wished to. Staff we spoke with knew of MCA and DoLS and were aware that they could not restrict people unlawfully. The Provider Information Return [PIR] highlighted, "All relevant DoLs applications have been submitted for people who may be being deprived of their liberty and some are currently with the DoLs assessors pending further assessment". Records that we looked at confirmed this and showed that the provider had taken action to prevent people being unlawfully restricted. A person confirmed, "They [staff] ask my permission". We heard staff ask people before they commenced support tasks and waited for a response before they started these tasks.

People and their relatives told us, "There are lots of food we can choose from. I do like the food", "I like most foods but sometimes I want something different and they [catering staff] give me what I want", "I don't like the food. I like choosing things. I am the one who chooses different things. They [staff] are good to me that way. They give me choices", "He [person's name] enjoys his food. It always smells nice. He likes the chocolate cake. The menu is always on the board [pointing to the white board]. You can request a salad. He is a good eater. He always says he has had a really good breakfast", and, "She is fed very well. The food is fantastic. It is five stars. I have had the food. The cook is brilliant". The cook said, "If a person does not like what is on the menu they can ask for something else and we will provide that". During breakfast and lunchtime we heard staff asking people what they would like to eat and drink. We saw that they showed people different plated meals so that they could make an informed choice. We saw that two main meals were offered at lunch time and that where people did not like what was offered alternatives were provided. However, two people told us that they would like a more sandwich variety at teatime. We fed this back to the manager who told us that they would look into this.

The cook told us that menus were set by the provider and that they were assessed by a dietician to ensure they were nutritionally adequate. A relative told us, "The staff give him [person's name] milk and makes sure he drinks it". The [PIR] highlighted, "Our chef fortifies meals where appropriate". The cook told us how they fortified foods [more calories in food by adding butter to potatoes and using cream in puddings and using full fat milk]. The cook told us how they managed special diets for conditions including, diabetes, soft and pureed meals for people who had difficulty swallowing or who were at risk of choking.

We saw that people's food likes and dislikes were documented in their care records. We identified that nutritional assessments had been undertaken to determine if people were at risk of malnutrition or obesity. Where people were at risk of choking this was highlighted in their care plans and staff we spoke with were aware of people's risks. A relative shared with us, "They [staff] all know that she [person's name] is nil by mouth [cannot eat or drink by mouth because of choking or other reasons]. They all know that. They put a notice up in case someone doesn't know like agency staff". We saw that staff were available to support people who were at risk of choking to prevent that risk or who had difficulty eating due to poor dexterity. Staff told us and records confirmed that where there were risks of weight loss or choking referrals were made to the dietician and speech and language services. A person said, "There are drinks all day". A relative told us, "You can hear them [staff] saying 'Have your drink'". Throughout the day we saw that drinks were available and were offered to people. We saw that staff encouraged and assisted people to drink to prevent a risk of ill-health from dehydration.

Relatives shared with us, "He [person's name] has seen an optician", "He [person's name] has seen a G.P for water infections. The staff know when it's happening". [meaning the staff are aware of the symptoms so look out for them]. "He [person's name] has seen a chiropodist", "She [person's name] had a sore under her breast. The staff noticed that and she saw a doctor for that and, "They [staff] told me the bridge of her [person's names] glasses had broken off. They have got her a new pair of glasses". A staff member told us, "If people are not well we refer them to the GP or other health agencies". Records that we viewed showed that

staff worked closely with a multi-disciplinary team of healthcare professionals to provide effective healthcare support. This included GP's, the dietician, occupational and speech and language therapists.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind. Their comments included; "The staff cheer me up", "They [staff] are alright. They are kind", "She [staff member] is a joker. They make you laugh", "There are a lot of nice staff", "A lot of the carers [staff] are quite bubbly. He can be off with us but fine with them", "The staff are really caring, very approachable", "They [staff] are very, very good, very caring, very attentive and very willing to do anything you ask to do" and, "I don't think there is any person who doesn't respond to the kindness of the staff". Staff told us that they and their peers were caring. A staff member said, "We [staff] all understand that we need to have a kind and caring approach".

A person told us, "I have got no family. It's lonely but I am friends with a lot of people here". Relatives shared with us, "There is a lovely atmosphere here", and "I like it here. The carers [staff] are down to earth. You can talk to the nurses and the carers" and, "I feel relaxed here myself". We saw that interactions between staff and people were friendly and positive. We heard staff asking people how they were. We saw that staff smiled and gave their full attention to people. We saw that people who lived at the home were friendly towards each other. We heard people chatting in the dining room and lounge and people showed an interest in each other. This showed that the provider promoted a positive atmosphere within the service.

A person told us, ""I have a care plan which lists all my needs". Another person said, "We all have care plans I think. They tell staff what we like and what to do". A relative told us, "I have been very much involved in care plans and everything else". The care plans that we looked at highlighted that people had been involved in their care planning by the staff. Where people were not able or did not want to be involved in their care planning their relatives had given their input. Care plans confirmed how people liked to be looked after and their likes, dislikes and preferences. Staff we spoke with knew people's individual likes and dislikes and how their preferred their support to be delivered. A relative told us, "They [staff] know she [person's name] always needs a blanket. She has a blanket on her during the day and as well as when she is in bed". A person told us, "The staff know I like sitting here. Look at that view". The person pointed to the garden that had lots of nice flowers. This showed that staff knew the importance of involving people and their relatives in care planning to ensure that their needs would be met.

People and their relatives shared with us, "They [staff] say he [person's name] is a gentleman. It's nice he's kept that and the staff are definitely respectful of him. I think they respect that about him", "They [staff] speak to you and they respect you", "The staff are polite. They knock my door before they go in", "I have my privacy. I can go and have some time to myself in my bedroom", "They [staff] take her [person's name] into her bedroom for some privacy" and, "We speak to him [person's name] in here, it's the quiet lounge". Staff told us how they promoted people's privacy and dignity by ensuring doors and curtains were closed when supporting people with their personal care. We saw that staff ensured that toilet doors were closed when being used. We saw that people went to their bedrooms for privacy when they wanted to. We heard staff addressing people in the way that they preferred. This showed that people were treated in a way that promoted their privacy and dignity.

People and their relatives shared with us, "I asked the staff to pick me out something light to wear today

because it is hot and they did" and, "He [person's name] is always clean and shaven". We saw that people looked well-presented and wore clothing and accessories that reflected their individuality. Examples were, formal shirts, short sleeved shirts, dresses, skirts and necklaces. A person told us that it made them feel good having their hair styled. They told us that the hairdresser was due the following day and this was confirmed by staff. We heard staff telling people that they looked nice and how they liked their clothing and their hair. This showed that staff ensured that people were happy with their appearance and their self-esteem was promoted.

We observed that information was on display that gave people contact details for independent advocacy services. An advocate can be used when people may have difficulty making decisions and require this independent support to voice their views and wishes. Staff told us that advocacy services were secured for other people on request or on an as needed basis.

A person and their relatives told us, "My wife and other family members visit me every day. I look forward to and enjoy their visits", "No restrictions on visiting I can come anytime", "We can stop over lunch time if we want. We have been offered food" and, "The assistant manager made us a cup of tea and she was very welcoming". Staff confirmed that family and friends could visit when they wanted to. During the day we saw that staff made visitors feel welcome by smiling to them and chatting politely to them. We heard staff ask visitors if they would like a drink in a friendly way.

Good

Is the service responsive?

Our findings

A person told us, "My family came to look here to see if it would be alright for me here and it is". A relative told us, "I looked at lots of places. This one was the best for him [person's name] they [staff] got all the details they needed so they knew they could look after him". We saw that an assessment of need had been completed before people were offered a place to ensure that the staff could deliver support appropriately and as people preferred.

A person shared with us, "A meeting was held to see if was happy. I was happy and told them [staff] so". Relatives told us, "The social worker did the care plan. We had a meeting in April [2017] to review the care plan", "I did the care plan review ten days ago. I was asked if I had any complaints or if I wanted to alter things. I am happy with [person's name] being here" and, "I was asked my opinions as part of the care plan review in the last fortnight". Staff told us that people's needs were reviewed regularly. The care plans that we looked at had been reviewed and updated to ensure that they were current and reflected people's needs and wishes.

A person told us, "I enjoy the church services". A relative said, "Her friends at the church have been in". A relative told us, "He [person's name] has never been a church goer". Staff told us that a church service was offered on a regular basis. Staff also told us that they had, when requested, secured input from specific denominations to meet individual people's needs. This highlighted that people were enabled to practice their religion if this was their wish.

A person was smiling when they told us, "I love horse racing. On the same line we went out from here last week to the dog racing. I loved it". Another person said, "They [staff] know I support [name of local football team] and I listen to the matches on the radio". Relatives told us, "They [staff] asked about his [person's name] hobbies and his history. He was very interested in Black Country history and still is. They [staff] had a couple in talking about it and he really enjoyed it", "He [person's name] likes music and doing the bingo". During the day in one lounge music was playing and we observed a staff member dancing with a person. The person was smiling and laughing and clearly enjoyed the experience. The provider employed two activity coordinators who were in the home on the day. We found that people were offered a range on in-house and external activates that included planting in the garden and trips. A relative told us, "She [person's name] has been out to garden centres. I went one with them. I assume she enjoyed it. She was happy and smiling". The manager told us that they had plans to offer a greater range of activities in the future. This showed that the provider knew activity provision was important to prevent people getting bored and to enhance people's well-being.

A person said, "I have not made any complaints I have not had a need. My daughter would deal with anything like that". Another person shared with us, "I've got nothing to complain about".
A relative told us "I have never complained about but would know how to". Another relative told us, "If we weren't happy we would have moved him" [person's name]. We found that the complaints procedure was available within the home for people and their relatives to access if they had the need to. Four complaints had been documented, investigated and the outcome had been feedback to the complainant.

Requires Improvement

Is the service well-led?

Our findings

A relative told us, "This place has struggled with managers especially in the last six months. Managers have started and left within a couple of weeks. Since our previous inspection the registered manager had ended their employment and de-registered with us in October 2016. This meant that there had been an unacceptable time interval without the service having a registered manager. It is a requirement of the law that a manager is registered with us. The new manager told us that they had applied for registration but their registration had not been completed. A staff member said, "Things have changed here for the better. The new manager is good".

At our previous inspection we found systems for the management of medicines and the notifications to us and the local authority of incidents that had occurred needed some improvement. We found that medicine administration and management system audits had now been improved upon. However, some further strengthening was needed. The new manger was aware of this and had increased audits and checks to engender this. We had been informed by notification of any deaths, falls or other issues that the provider is required to notify us of by law.

The provider had a leadership system that staff understood. A manager was supported by an area manager, unit managers, nurses and senior care staff. A person said, "I have met the new manager". A relative told us, "I have no problem with the managers". The manager was visible within the home. We saw that she spoke with people and their relatives who were comfortable in her presence.

There were governance processes in place that included, audits undertaken by the provider's compliance team and internal checks that included: medicine safety and management, health and safety and record keeping. Where shortfalls were identified these were highlighted for corrective action. We saw that an action plan was in place and being worked to.

We saw that a comments book was available in the reception area and that provider feedback forms had been used to get the views of people and their relatives. We saw that there were numerous positive comments about the service that included positive feedback on the care, support and staff. Where issues had been raised the manager knew about these and was in the process of taking action to address them. These included better nail care, sampling the times of relative meetings to ensure a greater attendance and looking at ways in which activity provision could be further enhanced. This showed that the provider had systems in place to enable people and their relatives to make their views known about the quality of the service provided.

A person said, "I think it is a good home". Two relatives told us that the home was better than others they made a comparison with. Other relatives made the following comments, "I think the home is okay overall. I would recommend the home. It's the care and the overall feel about the home", I have recommended this home because of its care. Food and cleanliness", and "I can't believe how good this place is".

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations

2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. The manager and area manager were open and honest in their approach to our inspection by telling us plans for the home and where they felt improvements were needed. Where issues had arisen people's relatives told that they been informed. One relative said, "I am informed and kept up to date with any issues".

It is a legal requirement that the current inspection report and our rating is made available. We saw that there was a link on the provider's web site to our last report and rating and the report were also displayed within the service.

Staff we spoke told us what they would do if they were worried by anything or witnessed bad practice. A staff member said, "I would report any bad practice. The issue would be addressed". We saw that a whistle blowing procedure was in place for staff to follow. Staff told us that they were familiar with the policy. The whistle blowing process encourages staff to report occurrences of bad practice or concern without fear of repercussions on themselves.