Senex Limited

Bloomsbury House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 November 2017 and was unannounced. At the last inspection carried out on 14 September 2015 we found that the provider was meeting all of the legal requirements set out by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and those associated with their registration and was rated as 'Good'. At this inspection, we found that the provider continued to provide a good standard of care to people, but there were some areas that required improvements.

Bloomsbury House is a 'care home'. People in care homes receive accommodation and nursing or 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. The care home is registered to provide accommodation and personal care to up to 24 people. The home provides care for older people, including those living with dementia. At the time of our inspection we were told that there were 21 people living at the home.

Bloomsbury House 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 and associated Regulations about how the service is run. At the time of this inspection a registered manager was in post. People knew who the registered manager was and felt able to speak with them to raise any comments or concerns they had.

There were some systems in place to monitor the quality of the service; however we found that some improvements were required to the oversight and management of the service. This included the need for continuous development, in accordance with evidence based practice, particularly relating to specialist dementia care.

We found that people were protected from the risk of abuse and avoidable harm because safeguarding systems and processes were in place and implemented effectively. People were supported by sufficient numbers of staff who had the knowledge and the skills they required to care for people safely and effectively.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, reviewed and monitored. This ensured that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff. This ensured that care was person-centred and any decisions made in respect of their care and support needs, were done so within their best interests and in accordance with the Mental Capacity Act 2005. Where people were assessed to lack the capacity to consent to the support they received, the provider had followed key processes to ensure that care was provided in the least restrictive ways possible. Applications had been made to safeguard people against the unlawful deprivation of their liberty, where necessary. People's privacy, dignity and independence were

respected at all times.

The premises and equipment were well maintained and clean but would benefit from being adapted to ensure people were supported to remain as independent as possible, particularly those living with dementia.

People received support from staff to take their prescribed medicines as and when required. Systems and processes were in place to ensure medicines were managed safely and only senior members of staff who had undergone specific training and supervision were permitted to administer medicines within the home.

People were supported to maintain a healthy diet and all health needs were met with the support from staff. It was evident that people had developed positive relationships with staff and there was a friendly, calm, relaxed atmosphere within the home. Staff knew people's likes, dislikes and preferences well and the deployment of an activity co-coordinator meant that people had the opportunity to engage in activity. However, improvements were required to ensure that activities were age-appropriate and relevant to people's hobbies and interests.

Systems and processes in place to monitor the safety and quality of the service included the involvement of people and relatives. The provider ensured that information was available in different formats to meet the needs of people and promoted their involvement in providing feedback on the care and support they received. Everyone we spoke with knew how to complain and were confident that any concerns they rose would be dealt with efficiently and effectively. Staff were complimentary of the leadership and management style of the registered manager and provider; they found them to be supportive and approachable with an 'open-door' policy.

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.

People were supported by enough members of staff, who had been safely recruited, to ensure that they were kept safe and their needs were met.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People received care and support with their consent, where possible and people's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care from staff who had received training and had the knowledge and skills they required to do their job effectively.

People's nutritional needs were assessed and they had food that they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, respectful and caring.

People received the care they wanted based on their personal preferences, likes and dislikes because staff spent time getting to

know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were supported to maintain positive relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

People were encouraged and supported to engage in activities but these were not always considered age appropriate or tailored to people's interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager or provider had not always ensured that they had kept up to date with their knowledge and skills to ensure that the service was continuously developing in accordance with best practice guidelines, particularly in relation to dementia care.

The provider had systems and processes in place to monitor the safety and quality of the service, although some improvements were required.

Everyone we spoke with were complimentary of the management team and reported there to be an open and inclusive leadership culture within the home.

Staff felt supported and appreciated within their work and reported both the registered manager and provider to be approachable.

Bloomsbury House

Detailed findings

Background to this inspection

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

This inspection took place on 23 November 2017 and was unannounced. The inspection was carried out 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. The Expert by Experience involved in this inspection had experience of caring for an older relative who used regulated services including care homes.

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. The PIR was completed and returned to us as requested.

As part of the inspection we looked at the information that we hold about the service. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We asked the local authority and Healthwatch if they had any information to share with us about the care provided to people by the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also reviewed information that had been shared with us by members of the public.

During our inspection we spoke with seven people that used the service, two relatives, five members of staff, the registered provider and the registered manager. Not all of the people living at the home were able to tell us about their experience of the service provided to them. Therefore we spent time observing day to day life and the support people were offered. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We reviewed the care records of two people to see how their care was planned and looked at the medicine administration processes overall but in greater detail for seven people. We looked at training records for all staff and at two staff files to check the provider's recruitment process. We also looked at

records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Good

Is the service safe?

Our findings

People we spoke with were confident that people were protected against the risks of abuse and avoidable harm. One person we spoke with told us, "I feel safe and happy here and in the way that I am treated". A visitor to the home said, "I have never seen any actions towards anyone which causes me concern". A relative we spoke with confirmed this and told us, "I know [person] is safe here". Staff we spoke with were able to explain their understanding of safeguarding practices and knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "Safeguarding is about protecting people from danger in lots of ways, like making sure no strangers come in to the home without us [staff] knowing who they are or why they are here, looking out for worrying signs such as bruises or if someone suddenly becomes withdrawn or tells you something of concern, like money going missing, I have to report it straight away". Another member of staff confirmed that if they were concerned of any safeguarding practices within the home, they had a duty to report it and record their concerns and actions.

All of the staff we spoke with were confident that the registered manager would follow procedure and take the necessary action to report any concerns that they raised. However, they also told us that they were aware of the external agencies such as the local authority or CQC that they could contact independently, if they were concerned that things were not being dealt with effectively by the provider. We saw that people looked relaxed and comfortable in the presence of staff and in the home environment. Records showed that staff had received safeguarding training. The registered manager was also aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that any safeguarding concerns that had been raised had been reported to the relevant agencies and had been investigated thoroughly with appropriate action taken.

People were also protected against any risks associated with their health and care needs because risk assessments and associated care plans were developed holistically, followed, reviewed and monitored. This ensured that people received the support they required to remain safe. People and their relatives were involved in this process alongside any key professionals and care staff, to ensure that any risk management and care plans were person-centred and that any decisions made were done so lawfully and in keeping with best practice guidance. Staff we spoke with were familiar with people's individual care needs and any health related risks, such as poor mobility leading to a risk of falls or specialist dietary needs. Risk assessments and care plans were accurate, complete, legible and regularly reviewed and updated to ensure that staff had all of the information they needed to support people to stay safe.

Staff we spoke with were also able to tell us what action they would take in an emergency situation, for example, in the event of a fire. One member of staff said, "We have regular fire drills and practice evacuations; we get as many people out as possible and call the fire service". Another member of staff told us that fire training was considered a priority during their induction but they recognised that due to the significance of their responsibility, they lacked confidence. They said, "I know what to do, I know I need to raise the alarm and as a team evacuate as many people, by any means as possible, I just worry that I would panic". They went on to tell us that the provider had supported them to engage in refresher training and that practice fire drills and evacuations would help them to develop their confidence. We fed this back to the

registered manager at the time of the inspection. They assured us that fire safety was a high priority and they had recently introduced practical fire evacuation drills to support staff to develop their confidence and skill in this area. Records we looked at corroborated what we had been told. We saw that people had personal emergency evacuation plans (PEEPs) in place to ensure staff had the information they required to maintain people's safety in the event of an emergency.

We found that some people presented with behaviours that staff found challenging to manage at times, such as aggression. One person we spoke with said, "There are some people here who have dementia and they can be aggressive which makes me feel uncomfortable and unsafe sometimes". Most of the people, visitors and staff we spoke with and observations we made showed that staff had the knowledge and skills they required to support people who presented with complex behaviours, such as aggression, in order to promote people's safety within the home. For example, one member of staff told us that sometimes people can be changeable in their mood and staff had to be flexible in their approach when providing support. They said, "Sometimes a person will let you assist them and other times they won't. If they are not happy we will leave them be and come back to them. If they are still not happy, another member of staff will try; it changes day to day". We saw one person became upset with a member of staff. The staff member remained calm, apologised and walked away in order to provide space for this person. Shortly after, another member of staff approached the person and suggested they went for a cup of tea which the person agreed to. This demonstrated the staff team's ability to quickly de-escalate a situation, respond to a person's change in mood and work as a team. This showed that the provider was pro-active in looking for ways that lessons could be learned and improvements made from incidents that occurred within the home. Records we looked at showed that any such incidents were analysed and risk management/care plans were reviewed and updated accordingly with ways in which staff could minimise the risk of repeated events, all of which staff were familiar with.

We checked the medicine systems and processes within the home and found that people received their medicines as prescribed. People we spoke with told us that they received their medicines when they needed them. One person said, "They [staff] never forget my medication as far as I know". We saw staff supported people to take their medicines safely and effectively. We found that medicines were stored appropriately and staff were aware of the disposal policy for unwanted or refused medication. Processes were in place to identify missed medication early and there was a good rapport between the provider, GP and pharmacy to ensure people received their medication as prescribed. Some people were prescribed medicines on an 'as required' basis, for example for pain relief. We saw that protocols were in place to support staff to administer medicines to people safely in this way.

Most of the people we spoke with and observations we made showed that people were supported by sufficient numbers of skilled staff to ensure people received the care and support they required. One person we spoke with told us, "There are always staff about which makes me feel safe". Another person said, "I never have to wait too long". A relative told us, "There is always someone around to make sure the residents are alright". However, some people told us that staff appeared to be 'rushed'. One person said, "The staff are lovely but there just aren't enough of them". We discussed this with the registered manager and found that staffing levels were assessed based on the dependency of people who lived at the home. Observations we made showed that there were sufficient staff on duty to keep people safe and their needs met, but due to the size and layout of the home, people's perceptions of staffs availability may be influenced by how staff were deployed and organised. This was fed back at the time of the inspection.

We checked two staff files to check that the provider was adhering to safe recruitment practices. We found that the provider had ensured that all pre-employment checks had been completed prior to the staff starting work. These included identify checks, previous employment references and criminal history checks

via the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions and prevents unsuitable people from working with people who require care. Staff we spoke with confirmed that all of these checks had been completed before they had starting working with people and that they had an opportunity to shadow experienced staff before working independently. One member of staff said, "It was a very thorough, they [provider] made sure my references and DBS were okay and I had training and shadowing opportunities to make sure I was confident before I started supporting people on my own".

We saw that the property was well maintained and clean, with parts of the home under-going modernisation. Records we looked at showed that regular infection control and maintenance checks were carried out; where any actions were required, these were followed up effectively and efficiently. Staff we spoke with were aware of the infection control practices within the home and we observed them adhering to this throughout our visit. For example, we saw staff washing their hands regularly and wearing protective clothing where necessary. Health and safety checks within the home were also carried out to protect people from risks such as legionella and fire.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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 that staff were able to tell us about people's capacity to consent to the care that they were receiving and that people were being cared for in the least restrictive ways possible. Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent. There was a system in place to support the management team to monitor the validity of the authorisations and ensure that where additional applications were required; these were applied for in a timely manner.

It was evident that there was a clear understanding of the principles and practices of the MCA within the service. People we spoke with and observations we made within the home showed us that staff were working in accordance with the MCA. One person said, "The staff ask my permission to do things for me and they respect my wishes. They listen to how I want to be cared for". We saw staff engaged with people in a way that they understood in order to gain consent and to promote independence as much as reasonably possible. One person confirmed this and stated, "The staff help me to stay independent". Other people we spoke with told us that staff respected and promoted their autonomy. One person said, "I get up and go to bed whatever time I like and I choose what I want to wear".

Records we looked at showed that people and those closest to them and/or professionals involved in their care, had been involved in decisions relating to their support needs and, where necessary best interests' decisions had been recorded comprehensively. One person we spoke with said, "They [staff] listen on how I am to be cared for". We saw that information was presented to people in pictorial and written formats where necessary to enable them to engage and promote their involvement in making day to day decisions and choices. For example, we saw that one person was deaf. Staff used communication cards with large clear text to inform them that the district nurse had arrived to see them and to ask them if they wanted to see the nurse in their bedroom. The person responded well to this and it was evident that they were familiar with this way of communicating with staff. However, we found that the adaptation and design of the environment was not as accommodating to meet the varying needs of people living at the home. Whilst we saw some evidence of signage within the home, this was not consistent throughout and did not comply with the recommended guidance and evidence based practice, concerning dementia-friendly environments. This could potentially disadvantage people's autonomy and independence, especially those living with dementia, within the home environment. We fed this back to the registered manager at the time of our inspection. We recommended that they looked in to how simple changes within the home can create a more dementia friendly environment, which has been evidenced to have a positive impact on a person living

with dementia's emotional and psychological well-being as well as their independence.

Everyone we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "I think the staff have the skills to look after me, they listen to me". Another person we spoke with told us that they were confident that most of the staff had the skills they required. We found that new staff engaged in an induction basis which included the opportunity to shadow experienced staff. They were also signed up to complete the Care Certificate training which is based on 15 identified set of standards that health and social care workers should adhere to in their daily working life, in order to support them to further develop their knowledge, skills and experience. We spoke with a new member of staff during our inspection. They told us that the training and support they had received from the provider and the wider staffing team when they first started gave them the skills they required to do their job safely and effectively. They said, "This is my first job in care and the training prepared me enough to know what I need to know to support people properly, I now just need to build on my experience and confidence but [registered manager] and [provider] are very good and very supportive; I have been signed up to do my [nationally recognised care qualification] level 2 in care too". Another, long-term member of staff we spoke with said, "The training is good". We saw that the manager kept a training matrix which detailed the dates when staff had completed various training as well as a rolling programme of updates that staff were registered to undertake throughout the year. There was a comprehensive induction programme and new staff were supported and monitored throughout their probation period to ensure they had the knowledge and skills they required. We also found that staff received regular supervision meetings with management which provided an opportunity to discuss learning and development opportunities. Staff we spoke with told us that the registered manager was always visible within the home and would offer constructive feedback and praise following observations of their work. Records we looked at confirmed this.

People we spoke with were mostly complimentary of the food that was available and prepared for them. One person said, "I am never hungry, the food is usually good and we have enough to eat". Another person told us that the food was generally very good and nutritious but they would like more of a choice of an evening meal time. This was fed back to the registered manager and taken on board. We observed a meal time during our site visit and saw that people had a good choice about where and what they ate. We saw that the food looked nutritious and smelt appetising and people appeared to enjoy their meals. It appeared to be a relaxed and well organised event; staff were readily available to support people where necessary and people were offered extra servings and drinks were regularly re-filled. We saw that people's specific dietary needs were also catered for. The registered manager showed us that they were in the process of developing visual/ pictorial menu's to ensure that all people, including those living with dementia, were able to activately participate in meal choices more accessibly.

People we spoke with, observations we made and records we looked at showed that people were supported to access health and social care services, such as GP's and any other medical appointments where required, including specialist practitioners relating to their specific health conditions. One person we spoke with said, "The doctor comes to see me when I need them to". We also saw that any health care concerns were followed up in a timely manner with referrals made to the relevant services. One visitor we spoke with told us that their loved one had experienced a bad reaction to the flu jab and the staff had called them straight away to let them know that the person had been taken to hospital. They told us that they appreciated this call as it meant they could meet the person to support them at hospital. During our site visit we saw the GP and a District Nurse visited people in the home. People also had access to hairdressers, opticians, chiropodists and dentists.

Good

Is the service caring?

Our findings

Everyone we spoke with and observations we made showed that people were treated with kindness, respect and compassion. One person we spoke with told us "The staff are kind and they respect my privacy". Another person said, "The staff treat us with respect". A third person stated, "The staff are approachable, I like to have a laugh with them".

Throughout our time at the service, we saw positive interactions and staff spoke about people with genuine compassion. One member of staff said, "I love working here and helping people, they [people] are all lovely". Another member of staff said, "People are well looked after here, the girls [staff] are all lovely; we work hard and together to make sure people are cared for. I'd be happy for my mum to live here if needed, it's a lovely home". A relative we spoke with told us, "I am really happy that mom is here. She was on respite here for just a short time; she was well looked after and happy here so we fought to get her back here".

People were treated with the utmost dignity and respect. Staff we spoke with gave us examples of how they protected people's privacy and dignity within the home. For example, one member of staff told us that when they supported people with personal care, they ensured any doors or curtains were closed, and where possible would turn their back to allow for some privacy. A relative we spoke to gave us another example and told us, "We can be private if we wish when I visit". We saw that people received both practical and emotional support from staff at all times and were treated as individuals. Staff we spoke with knew people well and were able to tell us about different people's care needs, any associated risks as well as their interests, likes, dislikes and preferences. People's bedrooms were personalised and reflected them as individuals and we saw that people were supported to maintain their individual differences in relation to their personal appearance and style preferences. Staff told us how important it was to promote people's personal identities. One member of staff said, "We treat people fairly but respect that everyone is different. Making sure people are involved and given choices, like showing them different clothes options, so they can decide themselves what they want to wear, is really important".

People were involved in all aspects of their care as far as reasonably possible and were supported to make day to day choices because staff made every effort to communicate with them in ways they could understand. We saw information was presented to people in various formats in accordance with their needs. Written information was available in large text which was accompanied by pictorial illustrations to aid understanding. This collectively enabled people to be more involved and promoted their autonomy and independence within the home. One member of staff said, "Communication can be a huge barrier but we have training in different communication styles to help people to tell us what they want, need and to help them to be as independent as possible".

Good

Is the service responsive?

Our findings

People and those that were closest to them alongside any relevant health and social care professionals were involved in the planning and review of their care, to ensure that care was specific to their individual needs, preferences and person-centred. One person told us, "I know I have a care plan and I was involved". Another person said, "I don't remember a care plan but they do ask my opinion". Records we looked at corroborated this and we could see that people's care needs and any associated risks were regularly reviewed. Care records we looked at were comprehensively detailed and person-centred. They reflected what staff and relatives had told us and our observations throughout the day.

We found that people had access to activities within the home because the provider employed an activity co-ordinator who was dedicated and passionate about their role. However, the activities offered were not always age-appropriate or tailored to people's individual hobbies and interests. We also found that people, particularly those living with dementia, would benefit from the opportunity to engage in evidence-based activities, designed specifically for people living with this condition. Nevertheless, most of the people we spoke with were complimentary about the enthusiasm and caring approach of the activities co-ordinator and the activities offered. We saw that people were encouraged to engage in activities both independently and/or as part of a group. For example, some people who preferred to remain in their bedrooms spent time with the activity co-ordinator engaging in meaningful conversations about topics of interest or enjoyed reading the newspapers or doing quizzes together. The activity co-ordinator said, "I make sure that everyone has the opportunity to participate in stimulating activities to keep their brains and bodies as active as possible, for some people, they just enjoy the extra company". The registered manager agreed to support the professional development of the activity coordinator to further enhance the activity culture within the home.

We found that people were supported to build and maintain positive relationships with people that were important to them. During the inspection we saw people spending time with visitors, friends and relatives. Relatives we spoke with told us that they were always welcome and that they were invited to join in with any social events that were arranged within the home.

People and their loved ones were supported to make decisions related to their preferences and choices about their end of life care. Records we looked at showed that staff had taken the time to discuss different choices, decisions and preferences that people had about the care and the arrangements they wanted at the end of their life. Funeral plans and arrangements were also documented, ensuring that person-centred care planning was maintained even after death. The registered manager told us that they had signed up to the Gold Standard Framework in end of life care. This is a systematic, evidence based approach to optimise care for people approaching the end of life that is being delivered by frontline care providers. It was evident from speaking with the registered manager and the staff that they all had a shared passion in making sure people and their loved ones received the care, support and compassion they required at the end of their life. The registered manager said, "We make sure that staff are available to sit with people who are imminently nearing the end of life 24/7, where necessary. We make sure they [people] have everything they need to keep them comfortable. Family are always welcome and our support extends to them too. We make sure

temporary beds are available so family can stay with their loved ones at this time, if they want to. We also recognise that staff grieve too because some of the people we care for have lived here for many years and become like second family, so we ensure that staff receive support too".

Records we looked at showed that the provider had a compliments and complaints policy which they adhered to. Everyone we spoke with told us that they knew how to complain and they were confident that their concerns would be dealt with appropriately. We found that where complaints had been made, the provider had responded either in writing or had offered the opportunity to meet with those raising the complaint, to discuss their concerns. It was evident that complaints had been taken seriously and investigated appropriately in order to address any issues that had been raised with the provider.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. 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 registered manager had been in charge of the service for many years and had maintained a consistently good standard of care within the home. However, we found that the growth and continuous development of the service was restricted by the provider's and the registered manager's limited knowledge and innovation for evidence based practice, particularly around dementia care, despite being registered as a dementia specialist service. This was evident in the absence of a dementia friendly environment, despite having recently refurbished parts of the home and the lack of specialist activities and interventions, which could be fostered and developed through self-directed learning, research and engagement with specialist services. This sits outside of the engagement required with external health and social care agencies to ensure people's care needs were met, which was evident within the service.

Furthermore, we saw that whilst there were systems in place to monitor the quality of the service and to get the views of people using the service, these had not always identified some of the shortfalls we found during our inspection in relation to record keeping. For example, we found that medicine audits had not always been overseen by management staff which meant that trends and themes relating to staff practices had not always been noted or addressed, such as missed signatures and incomplete body maps. We also found that protocols for medicines that were prescribed on an 'as required basis' would have benefited from some additional information to ensure staff had all of the information they required to administer these medicines more effectively and consistently. For example, information about the signs and symptoms a person may present with to indicate that they required the medicine if they were unable to ask staff for it independently. Audits of care records had failed to identify that daily records such as food and fluid charts were not always completed consistently or accurately. Staff records were not always comprehensively maintained or filled effectively to evidence the safe recruitment checks that were shown to have been undertaken. Some of these issues had been identified previously at the provider's other home and therefore, this showed that learning had not always been transferred to benefit the wider organisation.

Nevertheless, other quality monitoring practices were effective in identifying trends and themes in order to support the provider improve and learn lessons. For example, accident and incident records showed evidence of falls analyses. The registered manager had also collated and analysed the feedback data they had received from the surveys they had sent out to people and visitors. They had used this information to look at ways they could improve the experience of people living at the home and address any issues that may have arose.

There was a clear leadership structure within the service and everyone we spoke with were positive about the management culture within the home. People knew who the manager and the provider were and told us they felt comfortable speaking to them about anything they wished to raise. One person said, "I know who the manager is and she is approachable". We found that both the registered manager and the provider were

visible throughout the service and clearly knew all of the people who lived at the home, as well as their family and friends. They spoke of people with kindness, compassion and familiarity. One relative we spoke with said, "We can't thank [registered manager] enough for all of the help and support they have given us. They have really fought our corner, which you need sometimes when you're not familiar with certain systems and processes and they really look out for mum. Straight away we can see the difference in mum for being here and we are really pleased". Another relative told us, "It's a very good atmosphere here and I know who the manager is".

Staff told us that the registered manager had an open door policy so that they could go and speak with her at any time. Even when the registered manager was not at the home she or the provider could be contacted by telephone. Staff spoken with told us they enjoyed their work and worked well as a team. They told us they felt supported and that they were confident that they could approach the manager and that they would be listened to. One staff said, "It's a great place to work, [registered manager] is so supportive." Another member of staff said, "Everyone is friendly here and willing to help you any way they can. I can speak to [registered manager] or [provider] any time I need to, they are very supportive". This showed that the management of the home was available, accessible and supportive to staff. This was further evidenced by the 'managing stress at work' protocol which had a clear compassionate and supportive tone and it was clear that staff well-being was a high priority within the organisation.

We found that there was an open-minded and inclusive culture within the home whereby everyone was respected for their contributions and differences. No-one we spoke with raised any concerns about bullying or harassment within the workplace and staff we spoke with told us that everyone was treated equally and fairly. One person we spoke with said, "All of the staff seem happy in their work". Another person said, "I don't see anyone bossing anyone about here; it all runs smooth enough". We found that the provider promoted equality and diversity within the home and encouraged everyone to be their own person and express their individuality. One member of staff told us, "[Registered manager] is all for diversity here; I asked if I could dye my hair because I know some employers can be funny like that, but I was told 'definitely' as they like to encourage people to be themselves and promote diversity". We saw that the provider recruited a diverse staffing team, which included staff from various ethnic and cultural backgrounds. Admission processes we reviewed demonstrated that this inclusivity was transferred to people who used the service too. We saw that people's diversity needs were explored including their sexuality. Staff we spoke with were unaware of anyone living at the home who identified themselves as belonging to the LGBT (lesbian, gay, bisexual or transgender) community, but were able to evidence how the culture of the home fostered an accepting and inclusive environment. One member of staff said, "It [sexuality] can be a sensitive topic and people of a certain generation can be quite private, but we would refer to generic terms like 'partner' and explore this openly with people during life story, hopefully to enable them to feel comfortable with us". We discussed with the registered manager how this could be further developed by the use of LGBT imagery around the home.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and that there was a whistle-blowing policy in place. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly. All of the staff we spoke with told us that they felt comfortable raising concerns with the registered manager and/or the provider and were confident that any issues would be dealt with appropriately.

We asked the registered manager to tell us about their understanding of the Duty of Candour. 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. The registered manager was able to tell us their understanding of this regulation and we saw evidence of how they reflected this within their practice, for example through their complaints procedures. This was also evidence through their compliance with their CQC registration regulations by way of submitting statutory notifications. Providers are required by law to inform us of certain events that happen within the home (such as serious injuries, safeguarding concerns or deaths) by way of submitting a form called a statutory notification. We found that the statutory notifications we received from the provider were sufficiently detailed enabling us to have a sound understanding of events proceeding and actions taken following an event or incident within the home. Whenever we requested additional information concerning an event that they had notified us of, this had been provided to us.

Provider's are required by law to display their CQC rating awarded at their most recent inspection. We saw the provider had displayed the rating of our last inspection in the communal area of the home. This was seen to be conspicuous and legible as required.