Willowbrook Healthcare Limited

Bourn View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 16 and 18 October 2018. Bourn View provides accommodation and support for up to 80 adults with personal care needs. The home comprises of four units, Althorpe, Balmoral, Chatsworth and Danesfield. At the time of our inspection visit 47 people were living there.

This was the home's first inspection since its registration with CQC on 07 March 2017. Bourn View is registered as a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

There was 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.

The provider's quality monitoring processes required some improvement to ensure people's care plans and risk assessments were completely up to date with the practices being applied by care staff. There were mixed opinions on whether there were sufficient numbers of staff available to meet people's support needs. There were occasions when people were left unattended over periods of time.

Some improvement was required on the monitoring of medicines to ensure the provider had appropriate processes in place to make sure people received their medication as required and prescribed by healthcare professionals. The home environment required some improvement to ensure it was 'dementia friendly' with appropriate signage to support people to navigate themselves around the home. The use of adapted cutlery, where appropriate, would enable people to eat independently.

People were kept safe. Staff understood how to protect people from risk of harm. People's risks were assessed, monitored and managed to ensure they remained safe. Processes were in place to keep people safe in the event of an emergency such as a fire. People were protected by safe recruitment procedures to ensure suitable staff were recruited. Staff understood their responsibilities in relation to hygiene and infection control.

People told us they received support from staff they felt had the skills required to support them safely. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. People were encouraged to eat healthily. People had access to healthcare professionals when needed in order to maintain their health and wellbeing.

Staff encouraged people's independence where practicably possible. People received a service that was

caring and respected their privacy. People were supported by staff who knew them well.

People received a service that was responsive to their individual needs. Care plans were personalised and contained details about people's preferences and their routines. People were supported to pursue hobbies and activities that interested them and processes were in place to respond to any issues or complaints. Where people's faith was important to them, they were supported to continue with following their beliefs. This included their end of life (EOL) wishes.

The registered manager understood their role and responsibilities and staff felt supported and listened to. People and staff were encouraged to give feedback and their views were acted on to enhance the quality of the service provided to people. People and staff were complimentary about the leadership and management of the home and said the registered manager was friendly and approachable. The provider worked in conjunction with other agencies to provide people with effective care.

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

People were not consistently supported by sufficient numbers of staff.

People received their medicines from staff but processes required some improvement to ensure staff were consistent in their practice and responded promptly when issues were identified.

People were protected from the risk of abuse and avoidable harm because staff knew how to report concerns and processes were in place to support safe practice.

People were supported by staff that had been safely recruited.

People lived in an environment that was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective

Some people living with dementia were confused about their environment because the provider did not have effective dementia friendly signage and communication aids in place to support people.

People were supported by staff that had the skills and knowledge to deliver effective care and support. People's needs and choices were assessed and personalised to meet people's individual requirements.

People were supported to maintain a healthy and balanced diet. People were supported to access healthcare services to ensure they received effective care and treatment.

People's consent was sought by staff and they were involved in making decisions about their care. Staff understood when it was appropriate to
make best interests decisions that were made in line with the

Mental Capacity Act.

Is the service caring?

Good

The service was Caring

Staff treated people with kindness and respect.

People were involved in making decisions about their care and support and felt they could express their views.

People were supported to be as independent as much as possible by staff that respected people's privacy.

Is the service responsive?

Good

The service was Responsive

People received personalised care that was regularly assessed to include their interests, hobbies, cultural and religious needs.

People knew how to complain and processes were in place to learn and make improvements where required.

People's preferences and choices were discussed to ensure the service supported people at the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Improvements were required to the monitoring of care plans and risk assessments to make sure they were up to date and accurate.

Staff were supported by a management team that had the skills and knowledge to encourage and motivate.

People and their relatives felt involved in the developing of the service that worked in partnership with them, local community services and agencies.

Bourn View

Detailed findings

Background to this inspection

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

This inspection took place on the 16 and 18 October 2018 and was unannounced. The inspection team consisted of two inspectors, one pharmacist inspector and two experts by experience on the first day and two inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

The inspection was scheduled. However, the inspection was brought forward and prompted following concerns received from whistleblowers and members of the public that included but is not an exhaustive list:

-Falls
-Unsafe medicines management
-Staff shortages
-Poor training for staff

CQC was aware of safeguarding referrals raised. Because of these concerns notified to us, we explored aspects of people's care and treatment during the inspection site visits. This included reviewing current risks to people and the action taken by the provider to mitigate those risks. We examined the likelihood of any impact on people living at the home and whether the provider was in any breach of their legal requirements.

As part of the inspection process we also looked at information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We also reviewed the Provider Information Return (PIR) the

provider had submitted to us. A PIR is a form that asks the provider to give key information about the home, what the service does well and improvements they plan to make. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. There were no additional concerns raised. This helped us to plan the inspection.

We used a number of different methods to help us understand the experiences of people who lived at the home. We spoke with 18 people, four relatives, two healthcare professionals, ten staff members that included care, domestic and catering staff , a regional manager and the registered manager. We also spent time observing the daily life in the home including the care and support being delivered. As there were a number of people living at the home who could not tell us about their experience, we undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

We sampled seven people's care records to see how their support was planned and delivered and 13 medication records to see how their medicine was managed. We looked at three recruitment files to check suitable staff members were recruited. The provider's training records were also looked at to check staff were appropriately trained and supported to deliver care that met people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

We received information of concern regarding staffing levels at Bourn View. We spoke with people living at the home, relatives and staff and their feedback about staffing levels was mixed. We were told by two people, staff initially arrived promptly but switched the alarm activations off and informed them they would have to wait because staff were busy elsewhere in the home. One person said, "I can press my (call) button and occasionally have to wait for 30 minutes and staff will come and tell me they are busy and turn the (call) button off." Whilst neither person had been put at any risk of harm, we did inform the management team this practice had been identified in concerns notified to ourselves and now confirmed by two people. The management team said they would discuss this practice with staff at their next staff meeting to ensure this was not to be continued.

All the staff we spoke with told us they thought there was sufficient numbers of them to support people, however, our observations did not corroborate this. For example, the home had experienced a high number of unwitnessed falls. We sampled three care plans where people were at high risk of falls. We found risk assessments were in place with one incident being reviewed by another agency. The information contained within the provider's risk assessment stated that for those at high risk of falls should be 'constantly supervised' every time the person mobilised. We saw people mobilised without staff in the vicinity to supervise them and on two occasions the inspection team had to locate staff to help one person. In Balmoral dining area, one staff member was administering medication but we saw they were regularly taken away from medication administration to support people who had requested assistance because there were no other staff members around. This had the potential to increase medication errors and a delay in people receiving their medicines.

On day two, we saw one person was in a state of undress and there was no care staff in the immediate vicinity to support them. Two people were displaying signs of distress and were trying to encourage the person to return to their room. A catering staff member came onto the unit and supported the person back to their room to get dressed. A member of the care staff did not arrive on to the unit for a further ten minutes. During this time, one person had become anxious and was displaying behaviours that could have begun an altercation with others and the inspection team had to intervene and distract the person.

The provider's PIR stated staffing levels were reviewed on a daily basis taking into account people's health, increased occupancy and reviewed following any accidents or incidents. However, this did not explain how this method influenced staffing levels. We discussed with the management team our observations and asked how staffing levels were decided. We were told the provider based staffing levels on the number of people living at the home and budgets and did not use a 'dependency tool.' It is important to have a system that accurately assesses people's dependency levels and to be able to use the information in deciding how many staff should be on duty at given times during a working day; this is vital for any care home. Short staffing compromises care both directly and indirectly.

We had received information of concern regarding medication errors which at the time of our visit was being reviewed by another agency. The provider had also notified us of three medication errors. We looked at

how medicines were managed and checked medicine administration record (MAR) charts for 10 people, spoke with staff and observed how medicines were administered to people. Nine days prior to the inspection, the provider had introduced an electronic operating system to record the receipt, administration and disposal of medicines. We found this system demonstrated, overall people received their medicines as prescribed by their doctor. However, we identified some specific administration concerns. For example, one person prescribed a medicine to treat Parkinson's disease should have had one dose administered daily at 6pm to ensure the medicine was effective. The records showed that this medicine was not being administered at the time specified. We also noted it was being administered at different times in the morning and lunchtime. Although the prescription did not identify a specified time for morning and lunch, it is known that for Parkinson's medicines to be effective, each dose should be administered at the same time each day. The potential effect of inconsistent timings could put the person at an increased risk of falls because the medicines are not treating the Parkinson's as effectively as they could. We also found discrepancies with prescriptions were not being addressed in a timely manner, which led to one person not receiving one of their eye drops for six days. Records of interventions with people's doctors were not being completed and therefore in the case of an antifungal solution staff were not sure where it was to be used and consequently on three out of five possible occasions, the solution was not administered.

We found where people had to have their medicines administered by disguising them in food or drink, the provider did not have all of the necessary measures in place to ensure these medicines were administered safely. For example, we found the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to inform staff how to carry out this process safely and consistently. We were concerned that a person had been prescribed a modified release medicine and staff informed us they were opening the capsule and sprinkling the contents over food. Modified release medicines are designed to release the active medicine into the body over several hours and therefore the medicine should be swallowed whole and not chewed. The actions of the staff could be placing this person at risk of experiencing unnecessary side effects.

Medicines were being stored securely and at the correct temperatures, for the protection of people using the service.

People were protected from the risk of abuse. One person told us, "I feel safe from the way staff act." Another person said, "I feel safe living here." Staff confirmed they had received appropriate safeguarding training and understood their responsibilities to safeguard people from the risk of abuse. People felt confident to approach staff if they had any concerns. The provider had effective safeguarding processes in place to protect people and staff knew what action they would need to take when reporting any suspicions of abuse.

People we spoke with, who could contribute to their support planning, told us they were involved in assessing risks to their safety and were assured that risks associated with their care had been properly assessed with management plans in place to reduce the risk of harm. One person told us, "Everything is in place for me and I use my wheelchair." Staff were aware of risks to people and how to support people effectively. We saw risk assessments for all people had been reviewed and were up to date. We had noted for one person whose behaviour had the potential to put themselves as well as others at risk did not have a risk assessment in place. We discussed this matter with the senior and management team at the time and they gave us their reassurances a relevant risk assessment would be implemented immediately. Emergency plans were in place including information on the level of support people would require in the event of a fire.

The provider's recruitment processes ensured relevant checks had been completed before staff started to

work with people. These checks included two references and a Disclosure and Barring Service (DBS) check. The DBS check helps providers reduce the risk of employing unsuitable staff.

We saw the home was clean and well maintained. Staff had access to personal protection equipment (PPE) as required. Systems were in place to manage emergency situations such as fire. The provider had systems and processes in place for ongoing maintenance and repairs to the building. We saw records to indicate regular safety checks were carried out for examples on the fire alarm and hoists. A system to monitor accidents and incidents that happened in the home was also in place, when any issues occurred it was recorded in the daily notes and an incident/accident sheet completed. This allowed the provider to identify any patterns or trends.

Requires Improvement

Is the service effective?

Our findings

On the 16 October 2018, we walked around the home to assess the environment for people living with dementia. The provider's brochure offered dementia care and referred to a separate 'memory care floor' at Bourn View that incorporated Chatsworth unit and Danesfield unit. We found the home lacked some consistency across all the units for people living with dementia. For example, there was limited dementia friendly signage across all the units, bedroom doors were the same colour as the communal bathrooms and we saw a number of people trying different doors looking for their own room or the bathroom. On Althorpe two people approached us asking where their room was. There were some bedroom doors that had been personalised and memory boxes were outside some rooms containing photographs and ornaments important to the person. One person proudly explained to us about their memory box and what it meant to them. We discussed the lack of dementia friendly signage with the registered and regional managers who agreed this could be improved upon. On the second day of our visit, the management team explained they had already started to purchase dementia friendly signage.

People told us staff would seek their consent before supporting them with their care needs. Throughout the two days we were on site, we saw staff sought their consent and offered and respected people's choices. We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that mental capacity assessments had been carried out, although people deemed to have mental capacity had also had assessments. We discussed with the management team when it was appropriate for mental capacity assessments to be conducted and that they should always be decision specific and time relevant. Where assessments had been appropriately completed, we could see a best interests process had been followed.

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). Appropriate applications had been submitted and at the time of our inspection the provider had acted in accordance with the law.

The home was spacious, clean with safe access to landscaped garden facilities. There were quiet areas for people to sit and relax and an on-site bistro where people could meet with their visitors and enjoy a selection of snacks, hot and cold drinks. One relative told us, "It's (the home) absolutely marvellous here, the facilities are excellent, they even have a cinema for people to watch a film."

We had received information concerning the lack of training provided to staff, particularly around behaviours that challenge and medication. We found people were supported by staff that had the skills and knowledge to meet their needs. One person said, "Yes they (staff) have the skills. They help me get up and

know what they are doing. I think they are well trained". We could see from the reactions on people's faces they felt secure with staff and we could see from how the staff supported people that they understood how to care for them. Staff spoke positively of the training they received. One member of staff said, "It's good quality training, I found it beneficial especially the dementia training, it put you into their (people's) perspective." The provider's PIR stated they had adapted their induction programme to reflect the Care Certificate. The registered manager confirmed all new care staff now completed the Care Certificate during a training programme. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors and should form part of a robust induction programme.

People we spoke with told us they enjoyed the food. One person said, "The food is good. If I don't like it then I get other stuff offered me." Another person told us, "It's good (food). We get enough to drink and eat. No complaints." Care plans we looked at showed people's nutritional needs and preferences were assessed and where appropriate, referrals had been made to healthcare agencies. The home did not make use of pictures to assist people with their choices at mealtimes. We saw menus were on display but in small print. The mealtime experience was not consistent throughout all the units. On day one on the Balmoral unit there was initially only one staff member in the dining room with 12 people. We saw some people struggled to cut up their meal into smaller manageable pieces and there was not enough staff at the time to support them. Fifteen minutes later additional staff arrived and proceeded to ask people if they required assistance to cut up their food and five people said, "Yes please." On Chatsworth and Danesfield units, there were sufficient staff to support people.

On all units, we saw people received food which met their dietary requirements and choices of meals were verbally offered by staff and where people had changed their minds or did not like what was offered to them, alternatives were provided promptly. Staff were attentive and gave lots of gentle encouragement to people that needed it. The food looked and smelt appetising. The kitchen staff were aware of people's dietary requirements and were able to ensure those that required specialised diets could be catered for. For example, gluten free, vegetarian or allergens.

People and their relatives had been involved in the assessment of their care, treatment and support needs. People told us their care was delivered in line with their preferences and care plans we looked at showed people's needs and choices were assessed. One person told us "They (staff) have the skills and I had a say in what (care and support) I needed." Staff were given information about people's illnesses and a description of side effects that people may experience with some medicines. For example, there was a description for some drugs that caused dizziness or drowsiness and for staff to be mindful when this was administered to people and to be more observant of the person when they moved around independently.

People we spoke with confirmed they received effective care and support from healthcare professionals to maintain their health and well-being. One person said, "I've been fortunate so far I haven't needed the doctor but if I needed one, they (staff) would sort it out for me." We saw people's care plans had documented visits from professionals such as doctors, nurses, dentists, optician and podiatrist. One visiting professional told us, "It's a lovely home, the staff are very good and do act on any instructions I give them."

Good

Is the service caring?

Our findings

Everyone we spoke with told us that staff were kind to them. One person told us "The staff are wonderful with me, I think they know me very well." Another person said, "They (staff) will find time to sit and speak with me, I know they are very busy." A relative told us, "They (staff) all deserve a medal, they are fantastic with [person's name], I can't fault them." We saw some lovely examples where all staff would come down to the level of the person they were speaking with, their tone of voice was quiet and calm and there were lots of reassurances given to people. For example, one person was being transferred from their wheelchair to a lounge chair and staff took their time, explained what they were doing and gave clear instructions to the person. We saw people were supported by staff that had got to know them and this had enabled people to build positive relationships with them. Staff told us they enjoyed working at the home and spending time with the people who lived there. One staff member said, "I love it here, it's the best home I've worked in." Another staff member told us, "We (staff) are honoured to be coming into their home."

People we spoke with told us they were involved in day to day decisions about how and where they spent their time. One person told us, "Staff discuss with me what care I need." There were areas throughout the home where people could choose to relax, for example, in television lounges, dining areas, in the garden area or quiet time on their own in their rooms. All of the people living in the home resided in individual bedrooms with en-suite facilities which gave them privacy. Everyone we spoke with told us they could contact friends and family when they wished. One person said, "Staff make visitors feel very welcome." People we spoke with confirmed they were supported to be independent. One person said, "I try to be independent." We saw that people were visited by relatives and friends and had opportunities to attend local community events. We saw that people were actively encouraged to be independently mobile around the home and had their walking frames close by to support them to walk.

We saw staff respected people's privacy and ensured they asked people's permission before supporting them. People told us that staff treated them with dignity and were respectful of people's cultural and spiritual needs. Information regarding people was kept securely locked away so that people were assured their personal information was not viewed by others.

Staff were aware of the individual wishes of people living at the home that related to their culture and faith and respected people's individuality and diversity. We found that people were given choices and were asked whether they had any special dietary requirements in association with their spiritual, religious or cultural beliefs and whether they joined in with any religious ceremonies or celebrations. The management team explained how they created an inclusive environment and people encouraged to be open and comfortable within a safe and supportive environment.

Good

Is the service responsive?

Our findings

People we spoke with told us they had a care plan that was tailored to meet their individual needs and could make decisions about their support. One person told us "Staff discuss with me what care I need." Another person said, "I know about my care plan." We saw that people's care plans contained information about their likes, dislikes, preferences, social history and family relationships. The provider's PIR stated 'life histories' were completed so staff would get to know people well and find out about their history. The care plans we looked at showed the life histories had been completed with input from the people and their relatives and friends. Staff we spoke with were knowledgeable about people and knew what was important to them. The provider had introduced 'resident for the day' and this meant there were at least monthly reviews of the care plans. One staff member had explained that some care plans were not consistently completed across the units but measures were being taken by the management team to have all care plans reviewed.

The communication needs of people had been considered. We saw one person being asked if they wanted some information printed in a larger print size so they could read it. The person agreed saying it would help them. We saw playing cards that were large and clearly depicted the different numbers and symbols so the two people playing could do so without struggling to read. The provider's PIR stated staff would also use 'talking mats' for people who had difficulties with their verbal communication, although this was not seen to be required at the time of our inspection.

People we spoke with told us they could visit the local areas of interests and they were accompanied by staff to ensure they were kept safe. We found people were supported to take part in hobbies and interests of their choice. One person told us about their day out to a safari park and seeing the animals. Another person explained all about their visit to Cadbury World. The home had staff that were employed specifically to review hobbies and interests for people. One staff member explained about the 'Daily Sparkle' a reminiscent newspaper that was offered to people. There was an opportunity for people to take part in 'pet therapy' that involved staff taking small animals (rabbits) for people to touch and stroke. People told us they enjoyed a range of different activities to meet their personal choices. We saw people were reading newspapers, listening to music, relaxing in the lounge watching television and were offered an opportunity to watch a film in the cinema.

People we spoke with told us that the registered manager and staff were approachable and they felt confident to speak with them if they had any concerns or issues. One person told us that although they had no complaints they were certain they would be listened to and said, "I wouldn't hesitate to speak with the staff." Where complaints had been raised, we saw the provider had processes in place that recorded and investigated concerns and monitored for trends.

We saw from people's care plans discussions had taken place about their personal preferences in the event of their health deteriorating. This included their end of life (EOL) wishes. Some people had declined to engage but the care plans we reviewed reflected people's wishes for their EOL care including spiritual support and family involvement.

Requires Improvement

Is the service well-led?

Our findings

There was some improvement required to the provider's governance systems. For example, the providers systems to audit people's records had not identified they were not always up to date. Two records we looked at for people at risk of losing weight, stated they should have had their food and fluid intake monitored on a daily basis and one person required an additional food supplement drink. When we checked if this was happening, staff told us the people were no longer at risk of losing weight and did not require this close monitoring because their food intake and weights had increased. We saw in one person's records, staff had been directed to weigh the person on a weekly basis; but on speaking with staff this was not correct and the person was weighed monthly. Systems to monitor medicines had not identified that there were gaps in the recording of when medicines were given. We also found the location of where skin patches were being applied to the body had not been recorded since the introduction of the electronic administration record. We examined the paper patch application records for two people and found the patches were not always being recorded correctly on body maps to ensure they were rotated around the body. Staff we spoke with told us they did rotate the patches around the body and it was the recording that needed to be clearer. Although there had not been an impact on people, this was important because the adhesive used on skin patches can cause skin irritation if placed on the same parts of the body. We also found for one person the staff had not recorded the administration of the patches on two occasions in the controlled drugs register.

Some people were prescribed medicines that were to be taken when they needed them and were known as 'when required' medicines. We found that plans to describe the use of these medicines were not readily available to staff because the information had not been inputted on to the electronic administration record system. We found copies of the 'when required' plans were still in the folders that had contained people's old paper MAR charts, which were stored in drawers in the clinic rooms and therefore were not readily available for staff to refer to when completing their medicines rounds. We reviewed some of these 'when required' plans and found they did not contain all the necessary information that would inform staff on how these medicines should be appropriately administered. However, we spoke with some of the staff on duty and found that they were knowledgeable about the people they were looking after and the appropriateness of when to administer the 'when required' medicines.

Systems to monitor and review recruitment checks had not identified there were administrative errors with two staff files made during their recruitment process, that should have been recognised at the time and amended. At the time of the inspection, the provider took immediate action to rectify their administration process concerning the application process for police checks.

There were systems in place to monitor incidents, accidents and complaints, to identify patterns and trends and develop any action plans to mitigate the risk of a reoccurrence. Checks were also completed on the environment and cleanliness of the home to ensure the home was a clean and safe place for people to live.

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 explained how they operated in an open and transparent way and we saw evidence of how they reflected this within their practice. The registered manager understood their regulatory responsibilities and appropriate notifications of incidents and accidents had been submitted to us. We saw evidence to show the service had worked in partnership with other organisations, stakeholders and healthcare professionals and had reviewed incidences in order to identify how the service could be improved.

People told us they were given opportunities to share information with the provider. We saw there were 'resident and relative' meetings, although not everyone we spoke with could recall attending one. Feedback about the provision of care at Bourn View was available to read on the provider's website, some of the comments included, 'Bourn View is like a big happy family. Staff are so caring and are excellent with the residents, it is really like a home from home. Bourn View Care Home is a beautiful, caring place. The staff are extraordinary, highly skilled, efficient and most importantly, compassionate. Moving to Bourn View Care Home has been an incredible benefit to my mother's health and well being.' People we spoke with also told us they were happy living at Bourn View. One person said, "Compared to other homes I've been in, this place is good. I think its (the home) run well." Staff we spoke with agreed they were provided with supervision and confirmed the management team were open and approachable. One staff member said, "[Registered manager's name] is hands on, she'll roll her sleeves up and help us if its needed. I would have no problem going to her if there were any problems." Another staff member told us, "If there were any concerns, I would speak to [registered manager's name] or the regional manager, the door is always open." Staff we spoke with confirmed there was a whistle-blowing policy within the organisation which they felt empowered to use if necessary.

The provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.