

# Alphonsus Services Limited

# Charles House

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This unannounced inspection took place on 31 October 2018. At the last inspection on 18, 24 January 2018 and 02 February 2018 breaches of legal requirements were found. This was because repairs were required to the home environment to ensure it was clean and safe for people to live in. There was improvement required involving people in the planning of their care and delivery of personalised activities. The provider's systems in place to assess and monitor the quality of the service provided to people were not always used effectively and also required improvement. During this inspection, we found the provider had made the necessary improvements to meet the breaches.

Charles House is a care home registered to accommodate up to 10 people who have a learning disability. The home is not purpose built or modified. At the time of our inspection five people were living at the 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.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post at the time of the 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 home environment had undergone some repairs and improvements. However, there were areas of the home that required further improvement. There was also some improvement required to ensure people received equal opportunities to engage in individual and personalised interests in an environment that was suitable for people living with learning disabilities. Systems and processes in place to monitor the safety and quality of the service required further improvement.

People were protected from the risk of abuse and avoidable harm because staff knew what action to take and the provider had safeguarding systems and processes in place to keep people safe. People were supported by sufficient numbers of staff who were kind and respectful and had the knowledge they required to care for people safely.

People were also protected against risks associated with their health and care needs because risk assessments and associated care plans were in place and had been reviewed within the last 12 months. People received support from staff to take their prescribed medicines. Systems and processes were in place to ensure medicines were managed safely and only staff who had undergone training were permitted to

administer medicines.

People and their relatives were involved as much as practicably possible alongside healthcare professionals, to ensure that 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 followed key processes to ensure the care being provided was in the least restrictive way 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.

People were supported to maintain a healthy diet with choices of different foods available and all their health needs were met with the support from staff and healthcare professionals. Staff knew people very well. The provider ensured that some information was available in different formats to meet the needs of people. There was a complaints process in place although there had been no complaints since the last inspection. People and relatives were complimentary about the management and staff.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe:

People were safe with the staff that provided them with support. Staff recognised signs of abuse. Systems were in place to protect people from the risk of harm and staff knew how to report any suspicions of abuse.

People were safeguarded from the risk of harm because risk assessments were in place to protect them.

People were supported by sufficient numbers of staff that were recruited safely, to ensure that they were suitable to work with people.

People were protected from infection and cross contamination because staff members were provided with sufficient personal protective equipment.

People were supported by staff to take their medicines safely and as prescribed by the GP.

Good 

### Is the service effective?

The service was not consistently effective:

There had been some improvement to the home environment but further improvements were still required.

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 that had the knowledge they required to do their job.

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

Requires Improvement 

necessary.

### **Is the service caring?**

The service was caring:

People were supported by staff that was caring, kind and respectful.

People's independence was promoted as much as possible and staff supported people to make some decisions about the care they received.

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

**Good** ●

### **Is the service responsive?**

The service was not consistently responsive:

People were not always offered opportunities to engage in activities or hobbies that interested them.

Some people and their relatives were involved in the planning and review of their care.

The provider had a system in place to manage complaints to ensure they were dealt with to the satisfaction of the complainant.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well-led:

Although the provider had systems and processes in place to monitor the safety and quality of the service, there was further improvement required to ensure the service operated effectively.

Relatives spoken with were complimentary of the management and staff members.

**Requires Improvement** ●

# Charles 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.

The inspection took place on the 31 October 2018 and was unannounced. The inspection team consisted of one inspector.

As part of the inspection process we 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 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. We also reviewed the Healthwatch website, which provides information on health and social care providers. This helped us to plan the inspection.

We spoke with two people living at the home and three relatives to gather their views on the service being delivered. Some of the people living at the home were not able to speak with us due to their health conditions and communication needs. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, deputy manager and four care staff. We used this information to form part of our judgement.

We sampled two people's care records to see how their care and treatment was planned and delivered. Other records looked at included two staff recruitment files to check suitable staff members were recruited. The provider's training records were looked at to check staff members 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.

## Is the service safe?

### Our findings

At our inspection in January 2018, we rated the service under the key question is the service safe as 'requires improvement'. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of safe to at least good. At this inspection we found there had been sufficient improvement to rate this question as 'good'.

At the last inspection, there was some improvement required to the cleanliness of the home. We completed a visual check of the environment and found there had been an improvement. The home was clean and fresh. At the time of our inspection, care staff continued to be responsible for cleaning tasks. This had the potential to reduce the quality time spent with people because they were focused on task led duties. The provider did not employ domestic staff so this situation was unlikely to change. We saw staff used personal protective clothing such as gloves when providing care. We looked at the laundry and found it was organised. We also observed the kitchen area was clean and suitable to prepare food.

We asked the registered manager what lessons had been learned and improvements made when things had gone wrong. We saw from records we looked at there had been no incidents since the last inspection and the registered manager shared with us their learning from past events. In addition, we saw there was a process introduced to record, identify and monitor for trends.

People we spoke with told us they felt safe living at Charles House. We could see from the body language and gestures of people they were comfortable with the staff that supported them. A relative said, "Oh yes definitely [person's name] is safe, they (staff) make sure everything is in place for them." Another relative explained, "The staff are very safety conscious." The provider had systems in place to protect and safeguard people from the risk of abuse and staff knew what action they needed to take to keep people safe. A staff member told us, "We've done lots of training that included safeguarding. If we thought anyone was being hurt or abused we would let the manager know straight away." We saw from records there had not been any reportable incidents since the last inspection.

Risks to people had been assessed and reviewed within the last 12 months. Staff we spoke with were aware of the potential risks to people and gave us examples of how they kept people safe. For example, one person was at risk of choking and their risk assessment stated that food should be cut up into 'thumb size' pieces to reduce the risk of choking. Our observations confirmed this to be happening. There were also measures in place to keep people safe in the event of an emergency. For example, a fire. We found people's personal evacuation plans had been reviewed within the last 12 months.

We found on the day we visited, there were sufficient staff numbers on duty. One relative told us, "Whenever I have visited I have never seen anyone left on their own, there has always been a staff member around." Staff we spoke with told us when there were three on duty this was sufficient to meet people's needs; but on the occasion when only two staff were available this could be challenging. This was because a staff member should be with people at all times and when only two staff were on duty this was not always possible. The provider did not use agency staff and planned and unplanned absences were covered by existing staff.

members. Records we looked at showed during the last two months, on average there were three staff members on duty during the day to support people.

Staff members working at the service were established with no-one new having been recently recruited. At the last inspection we found Disclosure and Barring checks (DBS) had not been reviewed and the provider's own recruitment policy stating staff should have their suitability reviewed annually had not taken place. At this inspection we reviewed two recruitment records and found the provider had revised staff suitability and were in the process of submitting new DBS checks for staff. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

People received their prescribed medicines safely. An audit showed the medicines in stock balanced with the records and there was a process in place to ensure medicines stocks were kept secure and managed effectively. On checking medicine administration records (MAR) we found they were completed accurately and regularly audited by the deputy manager. Medicines that were no longer required had been returned to the pharmacist. Medicines that were administered on an 'as required' basis had plans in place that gave staff the information they needed on how and when these medicines should be appropriately administered to people.

## Is the service effective?

### Our findings

At our inspection In January 2018, we rated the service under the key question is the service effective as 'requires improvement'. The service was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of effective to at least good and to meet this breach. At this inspection the provider had met the conditions of the breach because the major repairs that were required to make the home safe were completed. It is acknowledged the major repairs had been addressed, however, further improvement was required because some repairs and decorations had not been completed.

At the last inspection, we found there were some significant issues with the upkeep and maintenance of the home. For example, the conservatory, evidence of damp with a wall covering buckling, cracked floor tiles, evidence of leaks, stained carpets, bedroom furniture was damaged and a bedroom window would not close properly. The local authority had also visited the home following our inspection and requested certain repairs be completed. At this inspection there had been positive steps taken by the provider to rectify some of the repairs we had identified. For example, the conservatory had been removed, new external doors fitted to the rear of the property, three new windows, some carpets and bedroom furniture replaced, light decoration in the communal lounge and the personalisation of at least one bedroom had been completed. There was further improvement required with one bedroom ceiling bowing and showing signs of damp, a heater that was not keeping the bedroom sufficiently warm. We recorded a temperature of 19.7 degrees at the time of our visit and on a day that was not particularly cold. The person had recently been ill with flu symptoms and was still recovering. We were told the carpet on the stairs and first floor was due to be replaced. There had been sufficient work completed to meet the terms of the breach but there was further improvement required.

The service is specifically for people with learning disabilities and/or sensory impairment. At our last inspection we found the home environment lacked stimulation for people with more complex or sensory needs and knowledge on where to go for specialist guidance required some improvement. We discussed with the registered manager how they had tried to address the shortfalls we had previously identified. We saw agencies had been contacted to support one person with a sensory impairment, however, there remained a lack lustre environment to provide stimulation for people with more complex needs. On the day of inspection, the lounge area was out of use for most of the day as it was being re-painted. We were told due to three residents either currently ill or recovering from illness, the day out that was supposed to occur had been postponed. This meant people were restricted to the dining area for most of the day with no stimulus. We witnessed one person was considerably unsettled, their usual daily pattern had been interrupted and they had nothing to occupy their time. We saw them smacking another person, on their hand, in an unprovoked incident. We informed the deputy and registered managers straight away what we had seen and instructed them to raise a safeguarding alert. We asked the registered manager if they had tried to introduce sensory equipment to provide mental stimulation that had the potential to ease boredom. They told us they had tried but it had not been accepted by people. However, conversations we had could not corroborate seeing this equipment. The registered manager also shared the provider's plan to consider

the construction of a small building in the garden area to be used as a sensory room. This would benefit the provider's two homes; Charles House shares a garden area with its sister home. Charles House has limited space due to the structure of the home and its limitations to modernise, however, more could be done to provide a meaningful, sensory environment for people living with more complex, learning disabilities needs.

At the last inspection we found that staff had not received refresher training in safeguarding, behaviour support, supporting people with learning disabilities/sensory impairments or had their competencies re-assessed in medicine administration. At this inspection we found there had been an improvement. Staff we spoke with told us they have received training since our last inspection that included safeguarding, moving and handling, food hygiene, health and safety and basic first aid. One staff member told us, "The training is good, we are given lots of training dates so it's flexible for us to choose. Since the last inspection we've had lots of refresher training, always good to refresh your mind." Relatives we spoke with told us, "They're (staff) doing a good job," "I think the staff have the skills, they're all very supportive of [person's name], know what they're (staff) doing and manage [person's name] really well, they understand what [person's name] needs are."

Staff spoken with explained how people's needs were assessed. A relative told us, "I am told if there are any changes to [person's name] needs, I speak with them [the staff] all the time." We sampled two care files and saw evidence to support that elements were individualised for people. Staff we spoke with gave us examples of how they supported people and how they managed their behaviours. One staff member explained what techniques they would use to distract people if they were becoming upset or presenting with behaviours that challenge. We also saw care plans contained information about people's medical needs, for example diabetes, what the person should eat and how to support a healthy diet. People were supported with their health care and support needs and records we looked at demonstrated that people accessed local health care services. For example, the GP, dentist, the optician, podiatrist and community nurses.

People living at the home received routine drinks and snacks. We asked staff how they offered people meal time choices, particularly for those with limited verbal communication. One staff member told us, "[Person's name] can't tell you but they know what they like and because we have worked here for a long time, we know their likes and dislikes. But if [person's name] pushes their food away we will get something else and keep trying until they like what they are given." We saw one person asked for a snack and the staff member bought it to them straight away. We reviewed the menu available for people and noted main meals were culturally appropriate and prepared by staff on site at the home.

We reviewed people's weight records and noted they were stable. Appropriate referrals had been made to healthcare professionals. At the last inspection, we saw care plans contained information relating to low or high Body Mass Index (BMI)'s and weight. However, it remained undetermined what people's healthy weights were because their height had not been verified. At this inspection, we found the heights were recorded in people's care plans and staff used an appropriate monitoring tool to effectively calculate people's weights.

Staff sought consent before supporting people with their care needs 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.

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. At the last inspection we found some of the staff members we spoke with were unable to explain why DoLS might be applied to some people or the implications of this on the way they provided care and support to people. At this inspection we found this had improved. One staff member explained "DoLS is about restricting people in their best interests from doing something that might cause them harm." At the time of this inspection only one application had been approved with a condition and when we checked, the condition had been met.

## Is the service caring?

### Our findings

At our inspection In January 2018, we rated the service under the key question is the service caring as 'requires improvement'. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of caring to at least good. At this inspection we found there had been sufficient improvement to rate this question as 'good'.

People we spoke with told us that staff members were good. A relative told us, "The staff are very loving to [person's name] and I come away (from the home) happy knowing that [person's name] is happy." Our observations of the staff showed them to be patient and polite, talking kindly to people and offering encouragement. Three people we met were unable to tell us about their needs and wishes. Staff explained to us the different ways people communicated with them, for example, with gestures, movements and noises people used to express themselves.

At the last inspection we found there were missed opportunities to engage with people and sometimes staff were focused on tasks rather than the person. We found at this inspection there had been some improvement. Two people had the ability to complete some tasks for themselves such as personal care or getting dressed. We saw one person was encouraged to go to the barbers for a haircut and when they returned, they proudly showed the registered manager their new style. The meal time experience had improved from the last inspection with staff engaging more with people encouraging them to eat and offering choices of drinks We asked staff how they encouraged people to be as independent as much as possible. One staff member said, "[Persons] can do quite a lot for themselves but [persons] have less ability but we still encourage them to choose. For example, I'll show [person's name] clothes in their wardrobe and they will point to what they want to wear or I'll show them and if they don't like it, they'll shake their head or push it away." A relative told us, "I know [person's name] helps out with some of the cleaning around the home because they want to, they also help with the shopping." Another relative said, "[Staff name] is very good with [person's name] they always try to encourage them."

Staff we spoke with described how they promoted and maintained people's dignity. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. We saw that people were comfortable in the presence of staff that were friendly and had a clear affection for people. People approached staff for comfort or reassurance and staff responded by giving people verbal reassurances and hugs. One staff member told us, "I am so happy working here the residents are all lovely."

Staff we spoke with were aware of the individual wishes of people living at the home that related to their culture. The meals offered to people were culturally appropriate. We saw staff support one person to style their hair in a way that reflected their culture. People could be confident their individual preferences and choices relating to their culture, faith and gender would be respected by staff.

## Is the service responsive?

### Our findings

At our inspection In January 2018, we rated the service under the key question is the service responsive as 'requires improvement'. The service was in breach of Regulation 09 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of responsive to at least good and to meet this breach. At this inspection, we found there had been sufficient improvement to meet the breach. However, further improvement was required to ensure people with more complex communication needs received personalised support that was equal to people living at the home with less complex needs.

At the last inspection we had raised some concerns about the lack of personalised support for people to access the local community. The registered manager explained a staff member had been allocated to one person and they supported them to go out most days and showed us photographs where we could see from the person's facial expression, they had enjoyed the experiences. They had also been supported to obtain a bus pass and this had presented new opportunities for them. A relative told us, "Since the last inspection there has been an improvement, [person's name] gets taken out a little bit more which is better." We saw at the time of our visit two people were supported by staff to go to the shops and barbers. On reviewing their daily notes, we could see there had been improvements made for the two people to enjoy interests outside the home.

However, this was not consistent with three people that had more complex needs, which had been identified as an area for improvement at our last inspection. There had been some attempt by the provider to personalise activities for one of them. We saw additional building blocks and balls had been introduced for them and we could see from their expressions they enjoyed relaxing with these items. We discussed at some length with the registered manager about the lack of meaningful activities for two people which meant they had spent the entire day sitting in a chair with no stimulus. The registered manager explained that 'normally' everyone would have been out but due to illnesses this had been postponed. This still meant that for two people there remained a lack of meaningful activities to provide them with effective mental stimulus that had the potential to cause social isolation and required further improvement. We did speak with relatives and they told us they were happy with the support their family members had received and did not raise any concerns with us at the time of this inspection.

At the last inspection improvement was required to involve people in the planning of their care and support. Relatives we spoke with told us they were involved with reviews of their family member's care and support needs and confirmed they were contacted by staff if there were any changes to people's needs. Relatives confirmed their family member was allocated a key worker that would support people with their care needs. A keyworker is a staff member with specific responsibilities for a particular person. A staff member told us, "Monthly meetings are held and whenever possible relatives attend." One relative told us, "[Staff name] is very good with [person's name] I would be very surprised if they did not try to involve [person's name] in making choices or some decisions, I've seen them ask [person's name] and they have pointed to what they want." Another relative said, "[Person's name] tends to sit in the lounge when we meet, they could sit with us but they get bored." Records we looked at showed that family members were involved and we could see

input from health care professionals. We also saw meetings had taken place on a regular basis. The care plans we looked at did contain some personalised information and staff knowledge about people's needs and risks associated with their care was good.

We looked at the complaints/compliments and noted there had been no complaints since the last inspection. Relatives we spoke with explained that they had always found the registered manager to be responsive to any feedback they had raised and was very happy with the service their family member had received. One relative told us, "I haven't had to raise anything but if I did, I'd raise it with the staff or [registered manager's name] and I know it would be sorted out." There was an easy read format of the complaints policy but as three of the people living at the home were unable to request this. However, we saw that other systems were in place including keyworker monthly meetings and resident meetings.

People were supported to maintain positive relationships with their family members. Relative we spoke with told us that they were always made to feel welcome and staff would update them on their family member's wellbeing.

At the time of our inspection, no-one living at the home was receiving end of life care. The provider had a process in place to review people's end of life wishes that involved their family members to discuss arrangements to ensure the choices, decisions and preferences of the person could be put in place.

## Is the service well-led?

### Our findings

At our inspection In January 2018, we rated the service under the key question is the service well-led as 'inadequate' and was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had been in breach of Regulation 17 for their last two inspections. This was because systems to monitor the service had not identified improvements were required to medicine audits, audits had failed to identify required staff training or maintenance of the building and recordings of incidents were a 'tick box' format that did not analyse or identify any trends. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of well-led to at least good and to meet this breach. At this inspection, we found there had been some improvement to rate well-led as 'requires improvement'.

There were people living at the home that displayed certain behaviours as a means to communicate their feelings or as a way of requesting support. At the last inspection these behaviours had not always been accurately or consistently recorded, therefore it was not possible to track if other people had been involved or affected by the behaviours. Although there had been some improvement with the recording of people's behaviours, this was not consistently practiced by all staff. Systems to monitor the service had not identified the inconsistencies. We spoke with the registered and deputy managers about how these incidents should be recorded to ensure consistency. The registered manager told us this would be discussed with staff at the next staff meeting and raised in supervisions.

The provider had a range of audits in place, including quality checks, which had been completed by the provider on a monthly basis. Records we looked at showed the provider's audits had identified issues and we could see some had been addressed but it was not clear if all issues had been resolved. This was because there was no process to highlight what had been completed and what had remained outstanding and carried forward to the following month. This meant there was the potential for issues being overlooked and not addressed in a timely way.

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 maintained the home along with another of the provider's homes. At the last inspection, we found that the growth and continuous development of Charles House was restricted by the provider's and the registered manager's limited knowledge and innovation for evidence based practice. This was evident in the absence of a 'user' friendly environment and the home lacked specialised activities and interventions, which could be adopted and developed through self-directed learning, research and engagement with specialist services. To support the registered manager, a deputy manager had been appointed. One staff member told us, "[Deputy manager's name] is really good, they have introduced new paperwork is much better than before." Another staff member said, "Since [deputy manager's name] came here it's been much better." We asked the registered manager what they had done since the last inspection to develop their learning and they explained they had attended training sessions provided by the local authority and had discussions with

other agencies around sensory impairment. The registered manager explained they were keen to develop the home into a more stimulating environment for people living with learning disabilities, however the decisions for any improvements of the service lay with the provider.

There was a clear leadership structure within the service and relatives we spoke with were positive about the management of the home. A relative told us, "I love [registered manager's name] they are very approachable and caring." Another relative said, "I can't fault anything how the home is run." The deputy and registered managers were visible throughout the home during the inspection and we could see people knew who they were and were comfortable to approach them. Staff we spoke with all enjoyed working at the home and this was supported by the number of years some staff had been there.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and 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.

Each month there were resident meetings and it was indicated in the minutes which method of communication was used to support people to make some choices. We saw the provider had tried to obtain feedback from people who lived at the home and their relatives about the quality of the service. One relative told us, "I do recall being sent a questionnaire sometime last year."

It is a legal requirement that the overall rating from our last inspection is displayed within the home. We found the provider had displayed their rating.

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 worked in an open and transparent way and relatives we spoke with explained how accommodating they had found the registered manager to be and how they were always prompt to contact them if there were any concerns or issues.

We found the provider had been compliant with their 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.