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Chippings

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?	Good

Summary of findings

Overall summary

This was an unannounced inspection which took place on 12 December 2016.

Chippings is a residential care home that provides accommodation and support for a maximum of six adults with a learning disability and or autism. At the time of this inspection there were six people living at the home. People had varied communication needs and abilities. Some people were able to express themselves verbally using one or two words; others used body language and gestures to communicate their needs. Everyone who lived at the home required support from staff for all aspects of their life including emotional and physical support.

During our inspection the registered manager was present. 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.

Quality assurance audits and checks were completed that helped ensure quality standards were maintained and legislation complied with. Quality assurance processes included obtaining and acting on the views of people in order that their views could be used to drive improvements at the home. Survey findings were not being reported on at the frequency stated in the provider's policy. We have made a recommendation about this in the main body of our report.

People's legal rights to consent were upheld. Capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. The home followed the requirements of the Mental Capacity Act 2005 and was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Information about people who had a legal right to make decisions on behalf of people was not in place. We have made a recommendation about this in the main body of our report.

Staff were available for people when they needed support in the home and when they wanted to participate in activities outside of the home. Robust recruitment procedures were followed to ensure staff were safe to work with people.

People appeared very happy and at ease in the presence of staff. Staff were aware of their responsibilities in relation to protecting people from harm and abuse.

Medicines were managed safely and staff training in this area included observations of their practice to ensure medicines were given appropriately and with consideration for the person concerned.

Checks on the environment and equipment had been completed to ensure it was safe for people to use.

People were supported to take control of their lives in a safe way. Risks were identified and managed that

supported this. Systems were in place for responding to incidents and accidents that happened within the home in order that actions were taken to reduce, where possible reoccurrence.

Staff told us that they had enough time to support people in a safe and timely way. Staff were skilled and experienced to care and support people to have a good quality of life. Training was provided during induction and then on an on-going basis. Staff received a high degree of support that enabled them to carry out their roles and responsibilities.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People were routinely involved in the review of their care packages. People were supported to access healthcare services and to maintain good health. People had enough to eat and drink throughout the day.

Positive, caring relationships had been developed with people. Staff knew what people could do for themselves and areas where support was needed. Staff appeared dedicated and committed.

People received personalised care that was responsive to their needs. Activities were offered and people were supported to increase their independent living skills. People were also supported to maintain contact with people who were important to them.

Staff understood the importance of supporting people to raise concerns. Information of what to do in the event of needing to make a complaint was available to people.

People spoke highly of the registered manager. Staff were motivated and told us that management of the home was good. The registered manager was aware of the attitudes, values and behaviours of 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?

Good

The service was safe.

Staffing levels met people's needs safely. Robust recruitment procedures were followed to ensure staff were safe to work with people.

Systems were in place that ensured that people received their medicines safely.

Potential risks were identified and managed so that people could make choices and take control of their lives.

Staff knew how to recognise and report abuse correctly.

Is the service effective?

Good

The service was effective.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life.

People's right to consent where upheld. The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005. Obtaining information about people who could legally act on people's behalf will offer further protection to people.

People were supported to eat balanced diets that promoted good health.

People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and positive, caring relationships had been developed. Staff knew the needs of people and treated them with dignity and respect.

People exercised choice in day to day activities. Systems were in

place to involve people in making decisions about their care and treatment and people were supported to use these.

Is the service responsive?

Good

The service was responsive.

People received individualised care that was tailored to their needs.

Staff supported people to develop their independent living skills, relationships that were important to them and to lead fulfilling lives.

People were listened to and their comments acted upon.

Is the service well-led?

Good

The service was well led.

People's views were sought and used to drive improvements at the service. Quality assurance systems were in place that helped to ensure good standards were maintained. Obtaining people's views at the frequency detailed in the provider's policy will assist in driving further improvements.

The registered manager was committed to providing a good service that benefited everyone. Staff were motivated and there was an open and inclusive culture that empowered people.

Chippings

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 checked 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.

One inspector who had knowledge and experience of supporting people with learning disabilities carried out this unannounced inspection which took place on 12 December 2016.

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. We reviewed the completed PIR and we checked information that we held about the service and the service provider. This included statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spent time with all six people who lived at the home. Due to their levels of communication we were unable to have detailed or lengthy conversations with them. In order to ascertain if people were happy with the support they received we spent time observing the care and support they received. This included how staff interacted with people and people's body language when they were going about their daily routines.

We spoke with the registered manager, the deputy manager and two care staff. In addition, we also spoke with two relatives of people who lived at the home on the telephone. We also reviewed information that we received from an external professional and with their consent have included their comments in the report.

We viewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for two people, and other records relating to the management of the home. These included staff training and support records and one person's employment records. We also looked at quality assurance records, staff meeting minutes, questionnaires, policies and procedures and incident reports.

Chippings was last inspected on 21 January 2015 when no concerns were identified.

Good

Is the service safe?

Our findings

Due to the nature of people's disabilities we were not able to confirm with them directly that they felt safe. However, people appeared very happy and at ease in the presence of staff. Relatives told us that they had no concerns about the safety of their family members. One relative said, "I am very happy X (family member) is there." A second relative said, "I definitely feel X (family member) is safe, Chippings fits the bill."

People were supported by staff who understood safeguarding and protection from abuse. Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to protecting people from harm and abuse. They were able to describe the different types of abuse, what might indicate that abuse was taking place and the reporting procedures that should be followed. One member of staff explained, "I would report to my line manager straight away. We can go further to area manager as well. Can go to CQC and social services. It's important to make sure abuse is reported. I must speak on behalf of the residents."

The registered manager was also aware of his responsibilities to safeguard people from harm. A copy of Surrey County Council safeguarding procedures and contact details was on display in the office for staff to refer to if needed. Records confirmed that the registered manager discussed safeguarding during staff meetings to ensure staff had a full understanding of protecting people from harm and abuse. Information was shared with the local authority when concerns were identified about people's safety.

People were supported to take control of their lives in a safe way. Risks were identified and managed that supported this. Risk assessments and care plans were in place that considered any potential risks and strategies were in place to minimize the risk. Staff were able to describe the ways they supported people with any behaviour that challenged. These included distraction techniques, observation from a distance and allowing outbursts of anger in a safe and controlled environment to protect others. For example, one member of staff explained that one person could become anxious if in crowds. Strategies to support the person included singing their favourite songs and the use of positive language. Records confirmed that staff were consistent in their approach and support. As a result the person's safety and those who they lived with was not compromised.

Incidents and accidents were reviewed on an individual basis in order that actions were taken to reduce risks to people. For example, when a medicine error occurred the persons GP was contacted for advice to ensure the person was safe. In addition, a meeting was held with the member of staff who was involved and a reflective exercise completed, a critical incident form completed, their competency reassessed and further training provided. On another occasion, when there was an incident of aggression between two people who lived at the home, behavioural assessments were reviewed and plans implemented to mitigate future risks. Advice was sought from a behavioural specialist and the registered manager reported to the local safeguarding team and CQC.

Staff understood the procedures that should be followed in the event of an incident or accident. They were able to explain first aid procedures, fire safety processes and accident reporting. Personal Emergency

Evacuation Plans (PEEP) were in place that gave instructions to staff on how to safely support people to leave the building if there was a fire. As a result, people would receive safe support in emergency situations. Checks on the environment and equipment had been completed to ensure it was safe for people. These included fire safety equipment and drills.

Staff were available to support people safely. Staff told us that they had enough time to support people in a safe and timely way. The registered manager told us that staffing levels were based on people's needs. Their dependency levels were assessed and agreed with the relevant local authority that funded people's placements and staffing allocated according to their individual needs.

Four staff were allocated on shift during weekdays and three staff of a weekend. In addition to this the registered manager was employed on a full time basis. Of a night one member of staff was on duty with access to an on call system that could be called upon in the event of an emergency.

When we arrived at the home we were informed that one member of staff was on leave and that another had rang in sick that morning. We were informed that a member of staff from another of the provider's homes was coming to cover. They arrived shortly afterwards. Records confirmed that when there were not four staff on duty the registered manager supported people with their care needs. Records also confirmed that at times additional staff were arranged to meet people's needs. For example, medical appointments and activities.

Safe recruitment processes were followed to help ensure staff were safe to support people. Staff recruitment records contained information that demonstrated that the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. They also included application forms, at least two forms of identification and information about training they had received.

Due to the nature of people's disabilities we were not able to confirm with them directly that they were happy with the support they received to manage their medicines. However, we observed that staff supported people in a sensitive way and made sure doors were such to promote privacy. Where people had been identified at being at risk of choking their medicines had been prescribed in liquid form so that they could take them safely. Staff responsible for administering medicines were trained and competency assessments were in place that included observations of their practice.

Appropriate arrangements were in place in relation to the recording, storage and administration of medicine. A monitored dosage system was used to help ensure people received the correct amount of medicine at the right time. Protocols were in place for PRN (as and when required) medicines that supported their safe administration. A relative told us that their family member had a high pain threshold but that staff understood this. They told us that staff were vigilant and ensured their family member was offered pain relief when required. There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. The recording and storage of medicines and training of staff was in line with the provider's medicines policy.

Good

Is the service effective?

Our findings

Due to the nature of people's disabilities we were not able to confirm with them directly that they had consented to the care they received. However, we observed that staff checked with them that they were happy with the support being provided on a regular basis and then waited for a response before acting on their wishes.

Capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. 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). DoLS applications had been made for everyone who lived at the home. They required constant supervision, could not go out in the community by themselves and the entrance to the home was locked at all times due to their individual needs and safety. Two applications had been authorised at the time of our inspection.

The registered manager and staff demonstrated understanding of when best interest meetings should be held to ensure that decisions were made that protected people's rights whilst keeping them safe. Mental capacity and DoLS training was included in the training programme that staff were required to participate in with all staff having completed this. One member of staff explained, "It's all about deciding if a person has capacity to make decisions. This needs to be continually reviewed and capacity can change. Should involve professionals, the person, staff and family. You have to give information to the person in ways they understand so it's individualised and in their best interests. Look at the risks, the pros and cons and record." As part of this process mental capacity assessments had been completed and best interest meetings held and recorded. We saw that best interest meetings and decision making processes were clearly recorded and featured in all aspects of peoples care planning and support. For example, staff had recorded that health care professionals had decided that blood tests would not be in a person's best interest. When changes in the person's behaviour occurred staff arranged another best interest meeting with healthcare professionals to ensure the original decision was still the right one.

We did note that one person had an audio device in their room that could be listened to in the office. The registered manager told us that this was to alert staff if the person had a seizure. The person had not had a seizure since 2005 and the registered person told us that the person's epilepsy was stable. Consideration and assessment of the person's ability to consent to this had not been completed. The registered manager said that they would seek advice about the continued use of the equipment to ensure their rights to privacy were assessed and acted upon.

Information was not in place that confirmed if relatives had a Lasting Power of Attorney (LPA) for property and financial affairs or for making health and welfare decisions. A LPA is issued by the Office of the Public

Guardian to ensure people had the legal right to act on behalf of individuals. Although there was no evidence that relatives had made decisions without the legal right to the registered manager was unable to confirm if anyone had an LPA.

It is recommended that the registered person follows best practice guidance in relation to the MCA and decision making.

Staff received support to understand their roles and responsibilities through regular training, supervision and an annual appraisal. Formal supervision consisted of individual one to one sessions which took place every other month and group staff meetings. All staff that we spoke with said that they were fully supported. For example, one member of staff said, "We get regular training, regular supervision an once a year an appraisal."

Staff were skilled and experienced to care and support people to have a good quality of life. One relative said, "Staff do seem to know what they are doing." A second relative said, "They (staff) know X (family member) so well and meet his needs." Staff had completed an induction programme at the start of their employment that followed nationally recognised standards. Staff confirmed that during their induction they had read people's care records, shadowed other staff and spent time with people before working independently. They also said that they had regular meetings with the registered manager during their induction who reviewed their progress and offered support. Training was provided during induction and then on an on-going basis.

Staff were trained in areas that included first aid, fire safety, food hygiene, infection control and moving and handling. They had also completed training courses that were relevant to the needs of people who lived at Chippings. These included epilepsy, communication, equality and diversity, person centred care, fluids and nutrition and non-physical interventions. As part of the training and support provided staff completed 'Reflection on Learning' forms after training event. The registered manager used these to monitor if the training had been effective and staff knowledge had increased. The forms asked what staff had learnt, what changes they would make to their practice and what staff would discuss in supervision.

People had enough to eat and drink throughout the day to help them stay healthy. People who were unable to communicate verbally were supported to make choices by staff that were knowledgeable about their preferences. For example, a member of staff said of one person who lived at the home, "X can crawl in here (kitchen) and that's an indication they are hungry." Staff knew in detail peoples non-verbal forms of communication. They were able to explain how this ensured people were involved in meal choices and their preferences respected. One member of staff said, "Lunchtimes we show people items and they will indicate either using gestures or sounds. Some people can help themselves."

Staff knew people's individual preferences without the need to refer to their records. For example, a member of staff said of one person who lived at the home, "X loves milkshakes, spicy food and salad." People's likes and dislikes as well as information on whether they had specific dietary or nutritional needs were recorded. This enabled staff to provide people with food they liked and for those who could not tell them verbally what they wanted, with food they were known to enjoy.

Risks associated with choking and swallowing were managed effectively. For one person with specific needs in this area staff provided support and ensured their food was cut up into small bite sized pieces and fluid charts were completed in order to monitor they had sufficient to remain healthy. The registered manager had obtained the assistance of professionals such as a speech and language therapist when necessary. Advice was available for staff and we observed that this was followed when they supported people to eat

and drink.

During our inspection we observed that people had lunch at times of their choosing. Some people chose to eat in the dining area and others in their rooms. People's facial gestures and body language indicated that they enjoyed their meals. Staff assisted people when required and offered encouragement and support.

People were supported to access healthcare services and to maintain good health. One relative said, "They take X (family member) for regular check-ups with the GP and opticians. They are quick to get them seen by a doctor if they have any concerns." Referrals, appointments and assessments were made with GP's, dentists, opticians, epilepsy specialists, speech and language therapists and psychiatrists. Records showed people were supported to attend annual healthcare reviews and specialist appointments where required, for example epilepsy. People had hospital passports which provided hospital staff with important information about their health if they were admitted to hospital. A Disability Distress Assessment Tool (DisDAT) was also in place for each person which helped staff identify if the person might be in pain or discomfort and require medical attention. This tool was designed to help identify distress in people who have severe limited communication.

Good

Is the service caring?

Our findings

Relatives praised the staff that supported their family members. One said, "I am more than happy with the staff. They give a lot of privacy and always knock on X (family members) door even though they cannot respond. They are very good at showing respect." A second relative said, "There is a lovely atmosphere at the home and staff have a good rapport with the people who live there."

Positive, caring relationships had been developed with people. We saw frequent, positive engagement with them. Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. The atmosphere was calm and relaxed. We observed people smiling and choosing to spend time with staff who gave people time and attention. Staff appeared dedicated and committed. We observed that people were treated with kindness and compassion in their day to day care. When staff came on shift they greeted people in a friendly way.

The registered manager monitored staff practices informally on a daily basis and formally discussed this in supervision and staff meetings.

People were supported to express their views about their care and support as much as they were able. Areas of the home had recently been redecorated and people had been shown colours in order that they could choose how they would like their home painted. Relatives told us that they were kept informed about their family member's welfare. One relative explained, "They (staff) are very good at phoning us and keeping us informed. They offer reassurances.

People were routinely involved in the review of their care packages. Each person was allocated a key worker who met with them on a regular basis to ensure people's goals were being met. Relatives said that keyworkers understood and supported their family members. One relative said, "X (keyworker) is fantastic. He helps X (family member) to buy clothes; purchase toiletries and makes sure dresses smartly. They have a great relationship."

Regular residents meetings were also held in order that people could be involved in making decisions. Although people who lived at the home had varied communication needs the minutes demonstrated that staff also considered non-verbal communication. For example, during the November meeting people received an apology about the disruption to the home whilst new fire doors were being fitted. Staff recorded that one person smiled in response, another covered their ears to indicate the works were noisy and a third person said "That's fine." Staff then reassured the person who had indicated the works were noisy and advised them it would be completed within a week.

Staff knew people's individual communication skills, abilities and preferences. One person who lived at the home had developed their own form of sign language. Staff understood this and communicated with the person using their preferred and individualised method. As a result staff and the person had a friendly conversation about the Christmas tree that had been put up in the home and the person planning to visit their family over the Christmas holiday period.

Staff understood the different ways in which people communicated and responded using their preferred communication method. One member of staff explained about the specific needs of an individual. They said, "X is non-verbal and communicate through objects of reference and hand over hand techniques. X loves watching X (name of a cartoon character) DVD's in their room. They prefer not to interact with others."

People had communication guidelines in place which helped ensure their individual wishes were acted upon. For example, one person's guidelines informed staff 'If X takes staff to his room and leads to stereo this means they want the music restarting at the beginning of the CD and staff should do this.'

Staff understood the importance of respecting people's privacy and dignity. When assisting people to have their medicines they did this behind closed doors to promote the individual persons privacy. Staff were seen asking others to leave the office when one person came there to have their medicine. One member of staff explained, "It's important we support people to have dressing gowns on when going from their bedrooms to bathrooms. Also knock on doors before entering."

People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. Good attention had been given to people's appearance and their personal hygiene needs had been supported. For example, people wore colour co-ordinated items of clothing and their hair was clean and styled.

Records confirmed that peoples bathing preferences were respected. This included if they preferred a bath or shower and the frequency.

Good

Is the service responsive?

Our findings

Due to the nature of people's disabilities we were not able to confirm with them that they received the care and support they required, as detailed in their care plans. However, during our inspection we observed that staff supported people promptly in response to people's body language and facial gestures. Relatives confirmed that they were happy with the support provided to their family members. One said, "X (family member) can be quiet challenging but they (staff) have persevered and X is a lot more settled." A second relative said, "X (family member) has autistic tendencies so has routines that are important. Staff understand this."

People received a responsive service that met their individual needs. Staff were in the process of supporting one person to move from a ground floor bedroom to a first floor room. This was because they had identified that noise from the laundry room affected their sleep. Time was being taken to facilitate the move as the person had set routines and staff understood the importance of these and working at a pace that was decided by the individual.

Another person had a communication board in their room that was used to inform them of appointments and activities planned for their week. They showed us this and we saw it reflected events planned for the day we were at the home.

An activity programme was in place that included walks in parks, shopping trips, swimming, bowling and activities at a centre ran by the provider. During the morning of our inspection three people went to a coffee morning at the activity centre. Another person chose to stay at home and listen to music in their room. A fifth person indicated to staff that they did not want to go out as they were not feeling too well.

People were supported with their relationships. Staff helped people to purchase birthday cards for family members and to arrange visits and contact. Relatives told us that the registered manager and staff actively involved them and supported them to maintain contact with their family members.

People were supported to maintain their independence based on their individual capabilities. One person was supported with their laundry. They were supported to carry their own linen basket to the bedrooms and to put their clean clothes away. Other people were supported to put powder in the washing machine. Another person was able with support from staff to run their own bath. Staff were able to explain how they supported people to maintain their independence. One member of staff explained, "X (person who lived at the home) will get their own cup and I put their hand on mine when I pour the kettle. It's all about supporting to do as much for themselves as possible."

Detailed and comprehensive, personalised support plans were in place that provided information for staff on how to deliver people's care. Records included information about people's social backgrounds and relationships important to them. They also included people's individual characteristics, likes and dislikes, places and activities they valued.

Staff knew what people could do for themselves and areas where support was needed. They knew, in detail, each person's individual needs, traits and personalities. They were able to talk about these without referring to people's care records. For example, a member of staff said of one person, "X has no family and completely considers staff and Chippings as their family and this is important to know. X likes lots of interaction, is very tactile. They like to give hugs and kisses but we encourage giving handshakes. They can become anxious if X (another person who lived at the home) is not around as they have known each other for a very long time so it's important to give lots of reassurance."

People were routinely listened to and their comments acted upon. Due to the nature of people's disabilities they would not be able to fully understand the provider's formal complaints processes. However, staff understood the importance of supporting people to raise concerns who could not verbalise if they were unhappy. One member of staff said, "Look for signs, facial gestures, if agitated this can mean someone is not happy. They could be in pain so offer medicine, or they might want a drink so offer this. It's important we think about them and act on their behalf."

Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

Pictorial information of what to do in the event of needing to make a complaint was displayed in the home. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. The service had not received any formal written complaints in over 12 months.

Good

Is the service well-led?

Our findings

There was a positive culture at Chippings that was open, inclusive and empowering. Everyone spoke highly of the registered manager. A relative said, "I find X (registered manager) very good. He takes on board our comments, really listens. He always deals with things straight away." A second relative said, "X (registered manager) is a brilliant manager. He has such a good relationship with everyone and as a result there is such a lovely atmosphere at the home."

Staff were motivated and told us that management of the home was good. They told us that they felt supported by the registered manager and that they received supervision, appraisal and training that helped them to fulfil their roles and responsibilities. One member of staff said, "We have a fantastic manager in X (name of the registered manager). He leads so well by example in a sense that there is nothing he would do. The residents are genuinely at the heart of everything he does. He looks at people's strengths and weaknesses and matches residents and staff together who complement each other." A second member of staff said, "Management is very good. X (registered manager) will always point you in the right direction."

An external social care professional wrote and informed us, 'The manager was nice and friendly and had a good understanding of X (person who lived at the home) needs.'

A range of quality assurance audits were completed by the registered manager and representatives of the provider. These helped to ensure quality standards were maintained and legislation complied with. These included audits of health and safety, infection control, the environment, care records, and staff training, support and levels. Action plans were put in place when needed and evidenced that prompt action was taken to address shortfalls. For example, the October audit identified that a first aid kit was required in a vehicle and this was addressed before the November audit.

Monthly staff meetings took place in order that information could be shared and the views of staff obtained. The registered manager said, "Its important staff get together and talk and they also help with team building. The minutes of meetings were detailed and informative. During the staff meetings information was shared about the findings from audits and changes in people's support needs. Feedback was also given from meetings that members of the management team had attended. In addition, the provider published a quarterly newsletter and operated a staff forum as other ways of involving and informing staff.

The provider operated a 'Parents Forum' where relatives of people who lived in homes run by the provider could meet, discuss the organisation and share their views. The last Forum took place during November where subjects discussed included new managers within the organisation, legislation, finance and home improvements.

Surveys were sent to people, their relatives and staff in order that their views could be used to drive improvements. The findings from all of the provider's services were collated into one report. The last report of findings was completed in 2015. This was not in line with the provider's quality assurance policy which said that surveys would be sent to people annually and a report published.

It is recommended that the registered person reviews the systems for obtaining the views of people so that they are obtained in line with the provider policy.

Prior to our inspection the registered manager completed and returned the PIR as we requested. The PIR was in the main accurate and reflected the evidence gained during our inspection. We discussed the contents of the PIR with the registered manager who informed us that specific examples of how the home met the KLOE's would be included in the next PIR as opposed to some of the generic statements.

There were clear whistle blowing procedures in place which the registered manager said were discussed with staff during induction, supervision and staff meetings. Staff confirmed this. Staff were able to explain what these were when asked. They understood how the whistleblowing procedures offered protection to people so that they could raise concerns anonymously.

The registered manager was aware of the attitudes, values and behaviours of staff. They monitored these by observing practice and during staff supervisions and staff meetings. Records confirmed that the provider's vision and values were discussed during induction with new staff and staff that we spoke with confirmed this.

The registered manager was aware of his responsibilities in line with Duty of Candour. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. A Duty of Candour policy had been introduced that staff could refer to if needed. The registered manager demonstrated an open and transparent demeanour throughout our inspection which reflected the principles underpinning Duty of Candour. The provider had a system in place where changes to policies or if new policies were implemented staff were required to read and sign that they had done so. However, when we checked this policy had not been included and staff said that they were not aware of its existence. The registered manager informed us this would be included on the next staff meeting agenda.