CareQuality Commission

Dolphin Homes Limited

Beachview

Inspection report

28 Alleyne Way
Middleton-on-Sea
West Sussex
PO22 6JZ

Tel: 01243582896
Website: www.dolphinhomes.co.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 7 November 2016 and was unannounced.

Beachview is a residential care home that provides support for up to 10 people with a physical and/or learning disability and diagnosis of autism. At the time of our inspection there were six people living at the service. They had a range of complex care needs associated with autism and communication.

Beachview is a detached house that has also been adapted to cater for people with a physical disability and has wheelchair access throughout. All bedrooms are for single occupancy. All rooms have en-suite wet room facilities and, in addition, there are two communal bathrooms with bathing facilities. There is a large communal living and dining area and a separate sensory room. A lift provides easy access between floors.

The service did not have a registered manager in post at the time of our visit. 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. Beachview has not had a registered manager in post since August 2016. The area manager was managing the service day to day.

The area manager had identified the need to improve the standard and personalisation of care planning within the service. For example, whilst we found that people received appropriate care, this was not always reflected in the care plans, which contained unclear information and guidance to staff. The management team had plans to develop the care plans and to transfer the care plans to a new electronic system from January 2017 to ensure they were comprehensive and up to date.

The provider had failed to notify the Commission of Deprivation of Liberty Safeguards (DoLS) authorisations in accordance with the registration regulations.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People told us they felt safe at the home.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Accidents and incidents were accurately recorded and were assessed to identify patterns and triggers. Records were detailed and referred to actions taken following accidents and incidents. Reference was made to behaviours, observations and other issues that may have led to an accident or incident.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of

medicines. Medicines were managed safely.

Staffing numbers were adequate to meet the needs of people living at the home. The provider used a dependency tool to determine staff allocation. This information was reviewed following incidents where new behaviours were observed which might increase or change people's dependency level.

Safe staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The staff had a good understanding of their responsibilities in relation to MCA and DoLS. Staff sought people's consent about arrangements for their care.

Staff were skilled in working with people who lived with autism. Training included autism awareness, communication and supporting challenging behaviours. Due to a lack of consistent management, we saw that some staff had only received one support and supervision in the last 12 months. However, the staff told us they felt they supported each other well and found the provider approachable and supportive.

Food was produced using fresh ingredients, to a high standard and offered good choice. People could choose to eat in the dining room or other areas of the home. Drinks were provided at regular intervals and on request.

People had access to healthcare professionals when required. This included GPs, dentists, opticians and psychiatrists.

Staff were caring, knew people well, and treated people in a dignified and respectful way. Staff acknowledged people's privacy and had developed positive working relationships with people.

People were supported to attend a range of activities based on their individual needs and wishes. Relatives told us they could visit when they wanted and that there were good communication links with the home.

Staff listened and acted on what people said and there were opportunities for people to contribute to how the service was organised. People knew how to raise any concerns.

The views of people, relatives, health and social care professionals were sought as part of the quality assurance process.

Quality assurance systems were in place to regularly review and improve the quality of the service that was provided.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These were subject to a regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed in accordance with best-practice guidelines.

Is the service effective?

Good

The service was effective.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which, they followed to ensure people's consent was lawfully obtained and their rights protected.

Staff were trained in topics which were relevant to the specific needs of the people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took

time to speak and listen to them.

People were supported to maintain their privacy.

Staff knew how to communicate with people in an accessible way, according to their individual needs, so they could understand their choices and decisions.

People were consulted about their care and had opportunities to maintain and develop their independence.

Is the service responsive?

Good

The service was responsive.

The area manager had identified the need to improve the standard and personalisation of care planning within the service.

There were structured and meaningful activities for people to take part in.

People were able to express concerns and feedback was encouraged.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been no registered manager in post since August 2016.

The provider had failed to notify the Commission of Deprivation of Liberty authorisations in accordance with registration requirements.

The culture of the staff in the home was positive and they worked well as a team.

The provider sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

There were a number of systems for checking and auditing the safety and quality of the service.

Care Quality Commission

Beachview

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 07 November 2016 and was unannounced. One inspector undertook the inspection.

Before the inspection, the provider completed 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events, which the provider is required to send to us by law. We used all this information to decide which areas to focus on during the inspection.

On the day of our inspection, we met with four people living at the service. Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We did however, observe people as they engaged with their day-to-day tasks and activities. We looked around the premises at the communal areas of the home, activity areas and six people's bedrooms.

We spoke with two care staff, deputy manager and area manager. We spent time observing people in the communal living areas.

We looked at the care plans and associated records for two people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was last inspected on 1 May 2014 when no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I am happy living here, I like it here. I do feel safe." Another person told us, "I feel safe."

The service had policies and procedures regarding the safeguarding of people, which included definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, racial, financial and verbal. Without exception staff told us they would keep the person safe, observe the person, give them 1:1 if needed, talk to their manager and if needed report their concerns to the Care Quality Commission and/or the local authority safeguarding team.

Staff said they felt comfortable referring any concerns they had to the area manager if needed. The area manager had a flow chart on their office wall explaining the process which would be followed if a concern were raised.

Before people moved to the service an assessment was completed. This looked at the person's support needs and any potential risks to their health, safety or welfare. Where risks were identified, these had been assessed and actions were in place to mitigate them. Staff were aware of how to manage the risks associated with people's care needs and how to support them safely. Risk assessments were in place and reviewed monthly. Where someone was identified as being, at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. For example, people living with epilepsy had specific care plans and risk assessments on how their seizures should be managed by staff.

A person told us, "I have epilepsy. The staff know how to keep me safe. I feel safe." The person told us they had a motion sensor mat in their bedroom, adding, "It's on at night in case I have a seizure. This alerts staff and then they support me."

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate people's medicines had been given as prescribed. Medicines were locked away as appropriate. All staff were trained to administer medicines. The area manager or deputy manager completed an observation of staff to ensure they were competent in the administration of medicines. We checked a sample of the medicines and stock levels and found these matched the records kept.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicant's conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working

with people who use care and support services. Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were supported by sufficient staff whose suitability for their role had been assessed by the provider.

Staffing numbers were adequate to meet the needs of people living at the home. The provider used a dependency tool to determine staff allocation. This information was reviewed following incidents where new behaviours were observed which might increase or change people's dependency level. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. There were two care staff and one senior carer or deputy manager on duty from 7am to 7pm. In addition to this, between Monday to Friday, the area manager worked from 9am to 5pm, offering support and guidance when needed. At night, there were two waking members of staff from 7pm to 7am. The service had a 24 hour on call system in case additional staff were needed. Rotas we reviewed confirmed there were sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. For example, for the gas heating, electrical wiring, fire safety equipment and alarms, Legionella testing and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment which included guidance for staff in how to support people to evacuate the premises in an emergency.

Good

Is the service effective?

Our findings

People said they discussed their care needs with staff members who had been assigned to support them.

Not all staff had received supervision sessions in line with the provider's policy, which stated staff should receive supervision every six to eight weeks. Two staff files showed that the staff had only received two supervisions in the last year. However, staff told us they felt supported by the team and area manager. We spoke with the area manager about their plans for supervisions. They told us that part of their plan was to review the provider's policy and update it to reflect staff should receive four supervisions per year. The area manager showed us their audit tool, which demonstrated that supervisions were not being carried out as regularly as they should. The action plan was in place to ensure staff supervision was arranged and the area manager had completed this.

Staff received training and appraisal of their work so they had the skills and knowledge to look after people effectively. This included specialised training in autism awareness, communication and supporting challenging behaviours.

Newly appointed staff received an induction training programme to prepare them for work at the service. A member of staff told us this was comprehensive and covered the aims, objectives and purpose of the service. It included an induction checklist to confirm staff were instructed in areas such as lone working, the care of people and staff conduct. Staff confirmed they completed the induction and that the induction involved observation and assessment of their competency. Staff enrolled for the Care Certificate, which is a nationally recognised qualification from Skills for Care. This Certificate covers 15 standards of health and social care and are work based awards that are achieved through assessment and training.

The area manager maintained a spread sheet record of staff training in courses considered mandatory to provide effective care and recorded when staff had completed these. This allowed the area manager to monitor this training and to check when it needed to be updated. These courses included infection control, moving and handling, fire safety, first aid, health and safety, promoting dignity, equal opportunities and food hygiene.

The area manager supported staff to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff told us the training they received was of a good standard and that the area manager encouraged staff to attend training courses. Staff were supported to achieve further qualifications to enhance their skills and knowledge.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consideration and consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams.

We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests. Records showed that staff had received training on MCA and DoLS. When we spoke with staff, they were able to explain their understanding of this topic. Staff were knowledgeable and were able to apply the requirements of the legislation in practice ensuring peoples day-to-day care and support were appropriate and that their needs were met.

The service provided specialist care for adults living with autism and additional learning disabilities or other complex needs. We checked to see that the environment had been designed to promote people's wellbeing and ensure their safety. People's individual needs were met by the adaptation, design and decoration of the service. There was a purpose built lift that enabled people to move from one floor to the other. There was wheelchair access throughout, which meant people could move freely around the shared areas. There was a separate sensory room available for people. The service was well maintained, decorated and furnished in a style appropriate for the young people who used the service.

Each person had their own bedroom, which was individually personalised as they had brought in personal belongings that were important to them. Staff had helped people to personalise their rooms and make them more homely.

Food was produced using fresh ingredients, to a high standard and offered good choice. People could choose to eat in the dining room or other areas of the home. Drinks were provided at regular intervals and on request. A main meal was cooked at lunchtime taking into account people's preferences, but people had the choice of an alternative. A good variety of food and healthy snacks was available including fruit. People were encouraged to assist with cooking as part of their weekly activities.

We looked at people's care plans in relation to their dietary needs and they included detailed information about people's dietary needs and the level of support they needed to ensure that they received a balanced diet. People's weight was monitored where they were either assessed as at risk of not receiving adequate nutrition or at risk of becoming overweight due to their medical conditions. This was monitored and professional advice obtained if required. Annual reviews that took place with local authorities, demonstrated staff always sought advice and guidance when needed.

People's care records showed that their day to day health needs were being met. People had good access to healthcare services such as dentist, optician and GPs. People's care plans provided evidence of effective joint working with community healthcare professionals. We saw that staff were proactive in seeking input advocacy services, (advocates help people to make decisions that are right for them and in line with their personal preferences and choices) dieticians and other professionals as needed.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People were cared for in a person-centred way and one member of staff told us, "It's important to ensure each person here are supported as individuals". Another staff member told us, "This is their home; we have to respect their space and ensure that their choices are supported". Some people living at the service had limited verbal communication skills, but they were included in meetings to review their care.

Using a touch screen tablet a person was able to communicate with us, and told us, "The staff are very caring. They are lovely. I get on with all the staff. I am very happy."

A member of staff told us how they understood one person, "You can tell [person] likes and dislikes through particular words and sounds used". People were able to indicate their preferences through verbal signs or by physical gestures. One person had a tablet with a communication app that enabled the person to type in what they wanted to say and for the tablet to translate this and read it aloud . Another person carried around a pad and pen and was able to write their views and any questions.

From our observations, it was clear that staff knew people's likes and dislikes extremely well.

People's privacy and dignity were respected and promoted. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice.

A member of staff said when they supported people with their personal care, "We always make sure the doors are closed, and curtains are pulled shut if needed". Another staff member told us that it was important to ensure people had the privacy they needed and that they had their own space.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support as much as they were able. Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed to help give people a normal life.

People were encouraged to be as independent as possible; we observed staff encouraged people to make their own drinks and snacks throughout our visit. Staff were tentative and tactful, offering reassurance and praise during these tasks.

Staff supported people to maintain contact with friends and relatives. This included helping people to send friends and relatives cards, to speak to them on the phone and to arrange home visits. Staff positively supported friendships that people had outside the service. As part of one person's routine, each Wednesday a member of staff would support them to call their relatives. The person had a care plan in place to support this, to ensure each staff member on duty enabled this to happen.

On the day of our visit staff communicated with people in an appropriate manner according to their understanding. They communicated with some people using Makaton and other people using short words and phrases. Makaton uses speech with signs and symbols to help people communicate. We heard one member of staff speaking in a steady and quiet voice to a person who could become anxious. The staff member asked the person short simple questions, in a soft voice, to direct this person to the activity in hand and help them to remain calm.

Each person had a communication care plan, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, and angry or in pain and how staff should respond.

Staff ensured they gave people as much freedom as it was safe to do so. One person, who was anxious, was observed walking around the service. The care plan stipulated that when the person became anxious it was important to give them space. We observed that staff kept a discreet eye on this person so that they could see them at all times, but did not always follow them, to make sure they had their own personal time. When the person was ready to talk, the staff offered them a drink and reassurance.

People were supported to be as independent as possible and to take responsibility for aspects of the household routine such as making drinks and preparing meals.

People's abilities to express their views and make decisions about their care varied. To ensure that all staff were aware of people's views and opinions, the were recorded in people's care plans, together with the things that were important to them.

When staff spoke about people they focused on the positive aspects of their character and described their enjoyment in supporting people to get the most out of their lives. People were involved in their care plan according to their understanding and abilities.

Good

Is the service responsive?

Our findings

Without exception, staff demonstrated thorough knowledge of people's needs. Each person had a current assessment of their needs and their preferences were documented. However, we found that care plans contained unclear and minimal information. The management team informed us that they were in the process of reviewing and updating all care plans. We have expanded on this in the 'well led' domain. it was clear from our observations that despite the minimal detail in the care plans, this had minimal impact on the delivery of care being provided.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. These assessments formed the basis of each person's care plan.

We saw that one person's care plan contained detailed information and clear directions about all aspects of their health, social and personal care needs to enable staff to care for them. Care plans included guidance about people's daily routines, communication, well-being and activities they enjoyed. Each person had a one page profile so staff could see at a glance what was important to the person and how best to support them.

Information about people's daily routines, likes, dislikes and preferences were contained in their care plans, which were written in a person-centred way. Detailed guidance was in place for staff to support people who presented behaviours that could result in harming themselves or other people. The specific behaviours that the person may exhibit were clearly listed, together with the appropriate response that staff should take and information about what could trigger the behaviour.

People's moods and behaviours were observed and recorded together with any lessons learnt from any incident that could inform future ways of positively supporting the person. People's well-being was discussed at staff meetings, reviewed by the area manager and health professionals were involved as appropriate.

Activities were not always organised or planned in advance. People decided what they wanted to do spontaneously on the day according to how they felt. People told us this is what they preferred. People enjoyed shopping for food at a local supermarket and were supported by staff to purchase food of their choice, and then prepare a meal.

We observed that people were encouraged to use the garden, as an area to relax in and talk with staff. There were garden seats and a trampoline that people told us they enjoyed using.

Information about what activities people liked to take part in was recorded in their care plans. During our visit to the service, people were occupied in household tasks, hoovering, making meals, art work and accessing the local area.

People were asked throughout the day if they wanted to go out in the community. People went out to the shops, for a drive and a meal.

Each person was supported by a keyworker who co-ordinated all aspects of their care. The purpose of the key worker role was to ensure people were supported with purchasing their toiletries, accessing activities, communicating with relatives and supporting people to review their care plans monthly.

People's concerns and complaints were encouraged, explored and responded to in good time. A member of staff said that they recorded complaints and compliments, which were kept in a folder dedicated for this purpose. Formal complaints were dealt with by the area manager who would contact the complainant and take any necessary action.

We observed one person voice some concerns to a staff member on shift, on the day of our visit. The staff member listened carefully to what this person had to say and outlined the action they would take. The person was satisfied with the response that they received.

Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the area manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was available in easy read and picture format.

The complaints procedure for visitors and relatives included information about how to contact the local government ombudsman, if they were not satisfied with how the service responded to any complaint. The area manager made a record of any complaints, together with the action they had taken to resolve them.

Views of the people using this service were sought through an annual questionnaire, which a member of staff, an advocate or relative supported them to complete. Monthly 1:1 key worker meetings occurred which; is when a allocated staff member meets with the person each month to discuss their views on the care they received, activities they would like to do in the future and discuss any changes occurring in the service, for example, décor, staffing or new people moving in.

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to notify the Commission of authorisations under the Deprivation of Liberty Safeguards (DoLS). The provider had failed to act in line with their legal responsibilities. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is part of the registration condition for a service to have a registered manager. A registered manager had not been in post since August 2016 however, the provider had commenced the recruitment process to fill this position.

People told us, "The manager is helpful, she listens", and another person said, "The manager is lovely and friendly." A third person told us, "The area manager was nice, but we need a proper manager who is going to stay".

A staff member told us, "[area manager] is completely approachable. I'm comfortable around them. Another staff member told us, "I have learned a lot from the management here, they are very supportive".

Quality assurance systems were in place to regularly review the quality of the service that was provided. These audits were carried out by a nominated officer of the provider and the area manager. There was an audit schedule for aspects of care such as medicines, activities, care plans, finance checks, accident and incidents, health and safety and infection control. Records demonstrated that information from the audits was used to improve the service. Where issues were found, a clear action plan was implemented to make improvements. For example, certain policy and procedures that needed reviewing were identified. Each person had a current assessment of their needs and their preferences were documented. However, we found that care plans contained unclear and minimal information. The management team informed us that they were in the process of reviewing and updating all care plans. The quality audit tool the area manager used each month evidenced that had been an on-going area of development since July 2016. The area manager explained that from January 2017 they would be starting the process of transferring the care plans over to a computerised system, which would enable support staff to record daily care notes for people. The computerised system would include areas such as care plans, risk assessments, care notes, vital signs and contact details for health care professionals and relatives. The impact of this new system meant staff would be able to access people's care plans promptly and record on-going monitoring information in real time. This would ensure people's care records were accurate and accessible.

As a result of the new systems being implemented, we found that people's care records were in varying stages of completion. The area manager said it was their next goal to ensure the care records reflected the care that was actually being given to people and the target for completion was January 2017, when the care plans would then be transferred to the computerised system. We discussed this with the area manager and agreed this was an area requiring improvement.

Records demonstrated that people, their relatives and professionals were contacted to attend reviews and update plans where needed. Specific incidents were recorded collectively such as falls, medication errors

and finance errors so any trends could be identified and appropriate action taken.

There had been two staff meetings in 2016, one in July 2016 and one in November 2016. This ensured that staff had the opportunity to discuss any changes to the running of the service and to give feedback on the care that individual people received. Discussion points were mainly around shift changes, key worker allocation, legislation updates and policy and procedure updates.

Staff said they felt valued and listened to. Staff felt they received support from their colleagues and that there was an open, transparent atmosphere. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously.

Staff said they felt valued, that the area manager was approachable and they felt able to raise anything, which would be acted upon. We were told there was a stable staff group at the service, that staff knew people well and that people received a good and consistent service.

People, relatives and professionals were asked for feedback annually through a survey. The last survey was between May and October 2016. The results had not yet been analysed, however, we read through some of the comments, which all were very positive. The survey completed by people included their views on the manner of staff, whether they felt listened to and if they knew how to make a complaint.

Two staff explained their understanding of the vision and values of the service. They told us, the ethos of the service was to provide and ensure meaningful trusting relationships were built, that people were respected, all in a homely relaxed environment. Overall staff said their focus was to ensure the quality of care provided and that people and their relatives were happy. We observed these values demonstrated in practice by staff during the provision of care and support to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of authorisations under the Deprivation of Liberty Safeguards (DoLS) and registration requirements. Regulation 18 (1) (4A) (a) (b) (4B) (a) (b) (c)