Dolphin Homes Limited

Sea Breeze

Inspection report

50 Salterns Lane
Hayling Island
Hampshire
PO11 9PJ

Tel: 02392467349
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?	Good

Summary of findings

Overall summary

This inspection took place on 24 July 2018 and was unannounced.

Sea Breeze is a 'care home'. People in care homes receive accommodation and 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. At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

Sea Breeze accommodates up to eight people with a learning and or physical disability in one adapted building. There were eight people living at the home on the day of the inspection. The care service has been developed and designed in line with the values that underpin the Registering the Right Support CQC policy 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 place. 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.

People continued to receive safe care as they were supported by staff who knew how to protect them from harm. Staff were aware of people's individual risks and plans were in place to minimise these while maintaining the person's independence. Staffing was arranged based on people's individual needs and what activities were happening in the home. Staffing remained flexible to suit the people living at the home.

People were treated well which had a positive impact on their well-being. People we spoke with told us that all staff spoke kindly to them and our observations confirmed people felt happy and comfortable in their home.

Safe medicines management was followed and people received their medicines as prescribed. Staff protected people from the risk of infection and followed procedures to prevent and control the spread of infections.

Staff completed regular refresher training to ensure their knowledge and skills stayed in line with good practice guidance.

Staff supported people to eat and drink sufficient amounts to meet their needs. Staff liaised with other health and social care professionals and ensured people received effective, coordinated care in regards to any health needs.

Staff were aware of people's communication methods and how they expressed themselves. This enabled

them to support people to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff respected people's individual differences and supported them with any religious or cultural needs. Staff supported people to maintain relationships with families. People's privacy and dignity was respected and promoted.

Staff applied the principles of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. An appropriate, well maintained environment was provided that met people's needs.

People received personalised care that meet their needs. Assessments were undertaken to identify people's support needs and these were regularly reviewed. Detailed care records were developed informing staff of the level of support people required and how they wanted it to be delivered. People participated in a range of activities.

A complaints process ensured any concerns raised were listened to and investigated.

Where possible people were involved in the planning and review of their care and support. People were supported to continue with their hobbies and interests which promoted their independence and confidence. Information was provided to people should they wish to raise a complaint.

Systems were in place to monitor and assess the quality and safety of the care provided. Where areas for improvement were identified, systems were in place to ensure lessons were learnt and used to improve the service delivery. There were opportunities for people and relatives to feedback their views about their care and this was used to improve the service. Staff were supported to carry out their roles and responsibilities effectively, so that people received care and support in-line with their needs and wishes.

The registered manager adhered to the requirements of their Care Quality Commission registration, including submitting notifications about key events that occurred.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Sea Breeze

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.

This inspection took place on 24 July 2018 and was unannounced. The inspection was undertaken by two inspectors.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the 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.

During the inspection we spoke with three staff, including the registered manager and a relative. People using the service were unable to speak with us, therefore we observed interactions between staff and people using the service. We reviewed four people's care records, medicines plus staff records such as supervisions. We reviewed medicines management arrangements and records relating to the management of the service, including policies and procedures. We also looked at matters related to infection control and prevention and documentation pertaining to the safety and suitability of premises.

Good

Is the service safe?

Our findings

The service continued to provide safe care. People who lived in Sea Breeze were not able to fully express themselves verbally. However, we observed people appeared to be happy, relaxed and comfortable with the staff who were supporting them. Staff agreed that people were safe. One relative said; "Yes definitely they are safe living there."

People were protected from abuse because staff completed training and knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff were confident the manager would take action, but also knew where to access the contact details for the local authority safeguarding team should they have to make an alert in the registered manager's absence.

The service maintained and developed risk management plans in order to protect people from identified risks. We reviewed the risk assessments and found these identified the risk, what the impact would be on the person and how staff could support them to minimise the risk. We also found risk management plans were regularly reviewed with people where appropriate. Risk management plans looked at all aspects of people's lives and included, for example, finances, eating, hygiene, medicines and the environment. Records relating to risk management plans were kept securely, and only people with authorisation had access to them.

We asked staff if they thought there were enough staff members on duty to provide safe and effective care. One staff member told us, "Definitely. We have enough time to spend with them (people)". Our observations on the day confirmed this. We reviewed the staff rotas and found the numbers of staff on duty reflected what staff told us. The registered manager explained staffing levels were flexible in order to meet people's changing needs.

Records confirmed the provider had undertaken robust employment checks to ensure the suitability of staff employed. Staff records contained two references, work history, an application form and a Disclosure and Barring Services (DBS) check. A DBS is a criminal records check employers undertake to make safer recruitment decisions.

People were protected against the risk of unsafe medicines management. The service demonstrated good practice in medicines management. Staff received ongoing medicines training and confirmed they felt competent in medicines administration. We reviewed the medicines charts and found all stocks and balances were in order and medicines were stored and disposed of correctly. Medicine administration records (MARs) were completed with no errors or omissions. People at risk of experiencing pain who could not express it verbally were frequently assessed; care plans gave information how pain manifested itself in each person.

We noted the monitoring of therapeutic drugs was undertaken to ensure concentrations of the drug for the person were safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes. We also noted there was clear guidance for staff concerning the management of people taking all other types of medicines, such as those

used to prevent seizures. These included when taking the medicines was indicated and the signs and symptoms of potential side effects.

Where a percutaneous endoscopic gastrostomy (PEG) was in place, we noted staff were knowledgeable about the management of these; all relevant staff had been trained in this area. PEGs involve placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be infused, when taking in food and drink orally was limited or no longer possible.

Two people received their medicines covertly, that is without their consent or knowledge. We noted mental capacity assessments had been carried out in these cases and best interests' meetings held, with relevant parties present. We noted both the person's GP and pharmacist had been consulted during this process.

We looked at audits undertaken by the provider. They were conducted both weekly and monthly. They looked at aspects of medicines management, such as ordering and disposal. We noted previous areas of concern, such as overstocking of medicines, had been identified and dealt with promptly. This meant that the service learnt and made adjustments to their practice.

We looked at four care plans and each one contained a section entitled 'Equality and Diversity'. This outlined the barriers to a fulfilling life that the person might face because of their disability. For example, a person may feel a loss of control or choice if they were marginalised or ignored. The care plan contained practical measures to combat this, such as including people in the recruitment of new staff where possible.

People's finances were kept safe. All but one of the people living at the home's finances were managed by their parents. The provider had developed a system of requesting money when required. Money delivered to the home by parents was 'signed in' by two staff members and 'signed out' when needed. Receipts for all purchases were obtained and a running tally of each person's spending and balances were kept and regularly audited.

The premises were not purpose built but did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEPs) in place, which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood. There was also up to date documentation related to the safety and suitability of the premises, these included: call bell maintenance and hoist and wheelchair servicing and maintenance.

The home was clean. We did not detect significant malodours during our visit. There were preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves.

Staff received regular training and updates in the area of infection prevention and control and Control of Substances Hazardous to Health (COSHH), where appropriate.

There were risk assessments in place regarding areas where infection prevention was paramount, such as the management of sharps and laundry. There was also an annual Infection Control Statement, dated September 2017 which had identified areas for improvement, such as the need for a revised cleaning schedule, which had been completed.

Good

Is the service effective?

Our findings

The service continued to provide people with effective care and support. Staff were competent in their roles and had a very good knowledge of the individuals they supported which meant they could effectively meet their needs.

People were supported by staff who had received training to meet their needs effectively. The provider had ensured staff undertook training the provider had deemed as 'mandatory'. New staff completed the Care Certificate that covered Equality and Diversity and Human Rights training. Staff completed an induction which also introduced them to the provider's ethos, policies and procedures. Staff were supported and received regular supervision and team meetings were held. This kept them up to date with current good practice models and guidance for caring for people with a learning disability.

Staff and the manager knew people well. They spoke warmly of the people they cared for and were readily able to explain people's care needs and individual personalities. Throughout our visit we saw people's needs were met. Staff provided the care and support people required. People indicated to us they liked living at the home by the manner they moved around and interacted with staff.

Staff demonstrated they knew how people communicated and encouraged choice whenever possible in their everyday lives. The provider made use of technology in order to deliver care and improve the lives of people living at the home. Those able to use them had access to electronic devices, such as tablets and speech boards for communication, education or entertainment purposes. For example, pictorial images were displayed on the activities board to help ensure it was in a suitable format for everyone.

Staff had the knowledge and skills to undertake their role and regularly refreshed this through completion of training courses. From training records, we saw staff were up to date with the provider's mandatory training and had also completed additional courses in relation to people's specific needs. This included learning disabilities, autism, and supporting people who displayed behaviour which might challenge others. The provider and registered manager had systems in place to support staff with completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received regular supervision and an annual appraisal. These systems gave them the opportunity to reflect on their performance and to obtain advice and guidance about how to further improve their practice and support people using the service.

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.

Staff adhered to the principles of the Mental Capacity Act 2005 (MCA). People's consent was obtained prior to providing care. We looked at care plans in the light of issues of consent and capacity. People had received mental capacity assessments where this was appropriate and had sought the consent of people with capacity before acting. We noted this was done in the process of care planning and review. Where a person did not possess mental capacity, we noted up to date mental capacity assessments were in place, in areas such as medicines management and support. There was also evidence of best interests meetings with relevant parties present. It was clear the provider's focus was on facilitating people to make some choices for themselves whenever possible, independent of whether they were deemed not to possess capacity.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS authorisation for those they had assessed as requiring assistance in the community in order to maintain their safety. They were aware of when these authorisations lapsed and arranged for people to be reassessed.

We noted DoLS applications had been made for all people living at the home but, on the day of our visit, only one had been formally assessed and authorised. We looked at documentation related to this; we noted it was 'decision specific'; that is the reason for the restriction of the person's liberty was clearly stated and did not apply to aspects of the person's life unrelated to this.

One member of staff said, "I can see the difference we make in service user's routines on a daily basis and we have a proven track of improving various aspects of their life; including access to community, communication or learning new skills". Another told us, "I have really been enjoying supporting our service users in all aspects of their lives including doctor and dental appointments, accessing the community and within the home, for example cooking, cleaning, personal care."

People were supported to eat a nutritious diet and were encouraged to drink enough to keep them hydrated. People identified at risk of future health problems through weight loss or choking had been referred to appropriate health care professionals. For example, speech and language therapists. The advice was clearly recorded and staff supported people with suitable food choices.

People were encouraged to remain healthy, for example people were supported to go swimming. People's health was monitored to help ensure they were seen by appropriate healthcare professionals so their ongoing health and wellbeing was assured. People's care records detailed that a variety of external healthcare professionals were involved in their care.

Records showed that relatives were kept up to date with any changes in a person's health and the outcome of healthcare appointments. Relatives confirmed this.

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. The manager and staff were aware of equality and diversity issues. We could see that people were receiving care and support which reflected their diverse needs in respect of the seven protected characteristics of the Equalities Act 2010 that applied to people living there which included age, disability, gender, marital status, race, religion and sexual orientation. This information was appropriately documented in people's care plans where needed. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

The service was well maintained and decorated. There was a lounge and kitchen for people to use as and

when they wish. We observed people navigating around the home independently and easily locating their bedroom and the communal areas. Each person's bedroom was personalised and provided ensuite bathroom facilities. There were resources and sensory stimulation for people to use at their leisure.

Good

Is the service caring?

Our findings

Staff continued to provide a caring service. People appeared relaxed and comfortable with the staff working with them. There was a busy, but happy atmosphere in the service. Many people had lived at the service for a number of years and had built strong relationships with the staff who worked with them. One relative said; "The staff are brilliant, excellent and we couldn't ask for better."

We observed care and support given to people throughout the day. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff and no incidents of infantilising or discourteous staff actions. Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people really well; for example, staff knew people's daily routines without referring to documentation. Those at risk were monitored closely but discreetly where necessary; for example, those at risk of self-injury.

We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans and risk assessments were discussed and agreed with people or their representatives. Records of contact with family members were kept and there were regular, formal reviews of care to which relatives were invited.

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. It was evident staff saw people as individuals.

We observed staff responding promptly to people's requests for assistance and regularly approaching people to check whether they were happy and comfortable and whether there was any assistance they required. Staff were aware of what made people happy and we observed people smiling when interacting with staff. Staff were aware of what may upset people and provided emotional support when required.

People were actively encouraged and supported to contribute towards decisions about their care. Within the individual support plans, there was a pictorial easy read plan that we observed people having been involved in completing with staff support.

Staff supported people to explore their preferences and supported their individual needs. This included in regards to their religion, culture and developing and maintaining relationships. One person was going home with their parent on the day of the inspection and staying overnight, the relative told us "[Name] loves to come home but also gets excited when we come back, that's good."

We observed people's privacy and dignity being respected within the home. Staff knocked on doors, and said who they were before entering.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. A member of staff said "Each person has communication support to help them understand things for them." Staff used sign language and translated people's replies for us when we were talking with them. There were pictures available to help people make choices and people used electronic devices to play with and communicate.

Good

Is the service responsive?

Our findings

The service continued to be responsive.

People were able to make choices and staff respected their decisions. On the day of our inspection we saw people chose how they spent time during the day and the activities they engaged with. Staff explained that it was important for people to have choice and control over their lifestyle.

We examined three people's care plans and daily records. They were legible, up to date and securely stored. People's choices and preferences were documented. We noted personal and social histories were very detailed; it was possible to 'see the person' in care plans. The staff we spoke with were knowledgeable about the people they were caring for.

The daily records we looked at were person centred; an insight into people's daily lives could be obtained by reading them.

The care plans we looked at contained relevant and up to date information. For example, we noted one person needed insulin to control their diabetes. We noted evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health. The person had blood glucose levels taken and recorded appropriately. There was guidance in the care plan to aid staff in the management of possible emergencies. For example, the care plan described the symptoms and management of hypoglycaemia and hyperglycaemia. The staff we spoke with understood their responsibilities in this area.

Another person presented with behaviours that could challenge others from time to time. We noted a behavioural assessment and care plan was in place which outlined potential triggers to behaviours and recommended 'de-escalation' techniques to reduce the risk to other people and staff. The training information we were given showed staff had received training to assist people safely.

Where a person was deaf and visually impaired, the care plan contained information for staff to help them manage this, including ensuring staff were aware of the person's 'objects of reference' around them. For example, an apron was given to them to feel to indicate it was time for their meal.

Staff supported people to engage in a wide range of activities and to try new things. We saw people had a busy weekly programme of activities which included regular scheduled activities as well as ad-hoc sessions where people chose what they wanted to do during those times. We saw the activities included those relating to daily living skills, such as making drinks, as well as leisure activities and sessions to support their health such as swimming.

We noted the complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman (LGO). The staff

we spoke with were clear about their responsibilities in the management of complaints.

We discussed end of life care with the registered manager. Due to the young age of people at the home, no one was receiving end of life care, however the registered manager told us that their action plan included discussion with the families.

Good

Is the service well-led?

Our findings

The service remained well-led. We asked staff if they thought the home was well-led. One staff member told us, "I think it's a great place to work and they (people) make it worthwhile". A relative said; "The manager always makes themselves available when we need anything."

People lived in a service whereby the provider's caring values were embedded into the leadership, culture and staff practice. As a consequence of this, people looked happy, content and well cared for.

Staff told us the senior staff were approachable and always available to offer support and guidance. They were open, transparent and person-centred. They were committed to the company and the service they managed, the staff, but most of all the people. Effective recruitment was an essential part of maintaining the culture of the service. People benefited from a manager and team leader who kept their practice up-to-date with regular training and worked with external agencies in an open and transparent way, fostering positive relationships.

Staff were motivated and hardworking. They shared the philosophy of the management team. Shift handovers, supervision, appraisals and meetings were seen as an opportunity to look at and improve current practice. Staff spoke positively about the provider.

Staff spoke of their fondness for the people they cared for and stated they were happy working for the company, but mostly with the people they supported. Senior managers monitored the culture, quality and safety of the service by visiting to meet with people and staff to make sure they were happy. The registered manager had held meetings with the relatives and said they were always available.

People lived in a service which was continuously and positively adapting to changes in practice and legislation. For example, the registered manager was aware of, and was looking at how the Accessible Information Standard would benefit the service and the people who lived in it. This was to ensure the service fully met people's information and communication needs.

The provider's governance framework helped monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving. For example, systems and process were in place to check accidents and incidents, environmental, care planning and nutrition audits. These helped to promptly highlight when improvements were required and action was taken accordingly.