Porthaven Care Homes Limited

Haddon Hall Care Home

Inspection report

135 London Road
Buxton
Derbyshire
SK17 9NW

Tel: 01298600700
Website: www.porthaven.co.uk

Date of inspection visit:
16 March 2016

Date of publication:
15 July 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 16 March 2016. It was the first inspection of the service since initial registration under the HSCA 2008.

Haddon Hall Care Home provides accommodation, nursing and personal care for up to 75 older adults, including people living with dementia. At the time of our visit, there were 53 people living at the service, including 19 people receiving nursing care. There was a registered manager at this service. 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 felt safe and relatives felt people were safely supported. Staff usually responded promptly to provide people with the assistance they needed to support them safely. Arrangements for staff planning and deployment, helped to mitigate risks to people's safety from their increased numbers and needs and ensure people's safe supervision.

The provider's arrangements helped to protect people from harm and abuse. Staff understood their role and responsibilities to recognise and respond to any suspected or witnessed harm and abuse of a person receiving care. Staff were recruited and monitored in a way that promoted safe care and practice.

Known risks to people's safety associated with their health needs, medicines and their environment, were assessed before they received care and regularly reviewed. People's care was planned and delivered in a way took account of this. People received care in an environment that was clean and well maintained. This helped to ensure that people received safe care and treatment.

People and relatives were happy with the care provided and felt that people's health needs were being met. People's care plans were sufficient to inform people's care. Staff referred to and followed instructions from external health professionals for people's care when required.

Staff received the training they needed to perform their role and responsibilities for people's care and they were conversant with people's health needs and related care requirements. Staff training and development needs and opportunities were regularly reviewed and sought to help ensure a consistent and thoughtful approach to effective care.

Staff understood and followed the Mental Capacity Act 2005, to obtain people's consent or appropriate authorisation for their care.

People received effective nutrition and they were supported to do this by staff who understood and followed their dietary needs and preferences.

People received care from staff who were motivated in their role, respectful, kind and caring. Staff understood and promoted people's independence, involvement, rights and choices in their care and also the appropriate involvement of their relatives.

Care was not consistently personalised and staff did not always provide people's care in a timely manner. Staff did not always respond promptly when people needed assistance or to support their independence.

A range of aids, adaptations and adjustments helped to support people living with dementia or sensory and physical disabilities. Further improvements were planned to enhance people's access to information.

People were supported to engage with others and in home life. This was done in a way that helped to promote people's participation and inclusion in home life and the extended community.

People and relatives were asked for their views about the care provided and informed how to make a complaint or raise any concerns. These were listened to, taken seriously and acted on and used to make improvements for people's care when required.

The service was well managed and led and people, relatives and staff were confident in this. The provider's record keeping and governance arrangements helped to inform and ensure continuous service improvement and accountability for people's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safely supported and staff deployment arrangements helped to ensure this

Staff recruitment and operational arrangements for people's care, medicines and their environment helped to protect people from harm and abuse.

Is the service effective?

Good

The service was effective.

People's consent or appropriate authorisation was obtained for their care.

People's health and nutritional needs were met by staff in consultation with relevant external health and medical professionals when required.

Staff were trained to perform their role and responsibilities for people's care. Arrangements for staff training and care plan improvements helped to ensure consistent and effective approaches to people's care.

Is the service caring?

Good

The service was caring.

People received care from staff who were patient, respectful, kind and caring. People and their relatives were appropriately involved and informed in people's care provision.

Staff understood and promoted people's rights, choices and known wishes relating to their care. Ongoing service improvements helped to enhance people's inclusion and involvement in their care experience.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was often personalised but staff did not always respond promptly or provide peoples' care in a timely manner.

Environmental and equipment aids, adaptations and adjustments helped to ensure that people's diverse needs were met. Further improvements were planned to enhance this.

People's engagement with others, participation and inclusion in home life and the extended community was promoted.

People's views, comments and complaints were listened to, acted on and used to make service and care improvements.

Is the service well-led?

Good

The service was well led.

The service was well managed and led. Record keeping and governance arrangements helped to inform continuous service improvement and accountability for people's care.

Staff understood and followed their roles and responsibilities. They were motivated, informed and supported to provide people's care and make improvements when required.

Haddon Hall Care Home

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.

We visited the home on 16 March 2016. Our visit was unannounced and the inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before this inspection we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law. For example, a notification of a persons' death. We also spoke with local authority care commissioners and Healthwatch, Derbyshire who are an independent organisation that represents people who use health and social care services.

Before this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. The completed PIR was return to us.

During our inspection we spoke with 12 people who lived at the home and eight people's relatives or friends. We spoke with a total of 12 staff. This included the registered and deputy nurse managers, two care team leaders, six care staff, an activities co-ordinator and a cook. We also spoke with two visiting health professionals and the provider's external senior manager. We observed how staff provided people's care and support in communal areas and we looked at eight people's care records and other records relating to how the home was managed. For example, medicines records, staff rotas, training records and checks of quality and safety.

As many people were living with varying levels of dementia at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Good

Is the service safe?

Our findings

Staffing levels were safe and mostly sufficient to provide people with the care and support they needed. People, relatives and staff felt that staffing levels were mostly, but not always sufficient to provide people with the care and support they needed.

People were accommodated in one of three dedicated care units over three floors. Staff, who were providing care to people accommodated on the first floor of the home, felt that staffing levels there were not consistently sufficient to ensure people received timely or safe care. People accommodated there had more complex health care needs because they were living with dementia and required nursing care. Staff explained that some of those people required at least two staff to provide their care. For example because they were unable to move independently. This meant that when staff needed to assist those people in private areas, such as their own rooms or bathrooms; other people were left unsupervised in the communal lounge.

During the morning we observed a significant time period when there were no staff present in the first floor lounge, where five people were sitting. One person, whose care records showed they were at risk of falls, attempted to leave the room unaided. They were very unsteady on their feet and stumbled, grabbing hold of the door frame for support. The activities co-ordinator passing by was not able to support the person to walk further unaided. They sought assistance from care staff and helped the person into a wheelchair to move them safely. This meant that people were placed at risk of unsafe care from insufficient staffing levels or deployment arrangements.

We discussed our findings with the registered manager, who told us about their action to address this. We saw they had introduced a staffing tool to inform staffing planning and deployment arrangements in a way that considered the number and needs of people accommodated at the service. Revised rotas were planned to commence from this, which showed the introduction of flexible shift patterns to provide additional staff at key times. Staff recruitment was in progress to support future admission planning. This helped to mitigate the risk of people receiving unsafe care from insufficient staffing arrangements.

Otherwise we saw that staff supported people safely and promptly when they provided care. For example, when they supported people to take their medicines, to eat and drink or to mobilise safely. We received many positive comments from people and their relatives in relation to staffing arrangements and people's general safety at the service. For example, one person we asked about this said, "Yes, I am very confident, it's 24 hour care; there is always someone around in the vicinity if I need anything." A relative told us, "Yes, I think it is very safe here; it's a secure, lovely environment and plenty of staff around who seem to know what they are doing and are on top of everything." This showed staff usually supported people safely and mostly responded promptly when people needed assistance.

People generally felt safe at the service and knew what to do if they were unhappy or had concerns about their safety and that of others. One person said, "Yes, I feel safe here; if I didn't I would tell (staff) about it. Another person said, "There is always someone to hand if I need help." People's relatives and other visitors

were also confident that people were safe at the service. They and staff were informed about how to recognise and respond to the witnessed or suspected abuse of any person at the service. Staff fully understood their responsibilities, including the relevant reporting procedures to be followed in any event.

People's care plan records showed that potential or known risks to their safety from their environment and health needs were identified before they received care. Care plans also showed how those risks were being managed and they were regularly reviewed. For example, risks from pressure sores or from poor nutrition. This helped to make sure that people received safe care and treatment.

People's medicines were safely managed and staff responsible were trained and informed help ensure this. However, we observed there was a significant delay in some people receiving their morning medicines. The nurse explained that because people were living with varying levels of dementia, they needed time to understand what was happening. They also told us that people's medicines that needed to be given a specific time, such as before breakfast or any pain relief medicines had been given at the appropriate time. They also advised they had noted the times of any delays to make sure that people were given their medicines at the correct time intervals. This helped to ensure the efficacy of the medicines being given and people's safety.

Staff gave people their medicines safely and in a way that met with nationally recognised practice. Some people's medicines administration records (MARs) showed they were prescribed medicines such as for pain relief, to be given at the time they needed it, rather than at regular intervals. People's care plans for this, known as medicines protocols and related MARs showed the required instructions for their consistent and safe administration, which staff followed. We noted that a copy of people's related medicines protocols were not always kept alongside the MAR, which may increase the risk of medicines error. We discussed this with management who agreed to the action required to any risk to people from this. Medicines stocks were monitored to ensure their receipt and safe administration. This helped to make sure that people received their medicines in a safe and consistent way and showed that people's medicines were safely accounted for.

Nationally recognised recruitment procedures were followed to check that staff, were fit to work at the service and provide people's care before they commenced their employment. Checks of the professional registration status of nurses employed at the service and their fitness to practice were also carried out before they started working there and periodically thereafter. This meant that staff were recruited and monitored in a way that helped to ensure safe care and practice.

Throughout our inspection, we saw that staff wore personal protective clothing (PPE) when required, such as disposable gloves and aprons. For example, when they handled waste or dirty linen. The home was visibly well maintained and we observed a high standard of environmental cleanliness that was regularly monitored by the provider through their management checks. Records showed that safety checks and required servicing and maintenance of equipment in the home were regularly undertaken to ensure their safe use. For example, checks and maintenance of hoist equipment and hot and cold water systems. Emergency plans were in place for staff to follow in the event of a foreseen emergency in the home; such as in the event of a fire alarm. Staff were aware of and received related training and instruction for this. This helped to ensure that people received safe care.

Good

Is the service effective?

Our findings

People said they were happy with the care and support they received. One person told us, "I am very happy with my care so far." Another told us, "I have a bath when I need one and staff help me in whatever way I need." A visiting health professional who regularly visited people at the service told us they found staff to be, 'Always professional; they act and tell us when there are changes in people's health conditions."

People's relatives felt that staff understood their health and care needs. They said that staff responded appropriately to refer people to relevant external health or medical professionals when required. For example, following changes in people's health needs or conditions. One relative said, "Yes, they understand his health needs, I have no concerns about that." Another told us that, staff acted on and followed any advice or instructions from external or medical professionals.
People's care plans reflected this and showed that people were supported to access external health professionals and that staff followed their instructions for people's care when required. This included for the purposes of specialist and routine health screening. For example, following any changes in a person's health condition or for routine eye or foot care.

Care plans showed people's health conditions and how they affected them. Although some people's care plans relating to their dementia care were standardised. This meant they did not always show how people's experience of living with dementia affected them personally, or specify related care interventions that were specifically known to be helpful to them. However, we saw that nationally recognised assessment tools had been introduced to help staff understand people's dementia, how it affected them personally and their related care needs. Staff were also collating this information from this in people's daily care records. The nurse told us this helped to support the development of planned care that was more tailored to people's individual needs and experience of living with dementia. Care staff we spoke with knew people well and told us they took time to understand people's care needs relating to their dementia. This helped to inform and ensure the efficacy of people's care.

Staff received a formal introduction to their role, which met with recognised national standards for this. The Care Certificate was also introduced for new care staff to complete. This identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care. Following induction, all non-professional staff were supported to undertake and progress a national vocational qualification relevant to their role.

Staff told us they mostly received the training and supervision they needed to perform their role and responsibilities for people's care and the staff training record showed this. Staff felt that the provider's arrangements for their individual supervision and training for moving and handling and positive restrictive behaviour support had not been wholly sufficient to ensure consistent practice. The registered manager told us that action had been planned to address this, management records showed. This helped to make sure that people received consistent and effective care.

Management continuously sought training and development opportunities for staff through links with specialist external health practitioners, care charities and support agencies. For example, in relation to end of life care or Parkinson's and Alzhiemer's disease or diabetes. A number of staff lead roles were being developed from this through their additional training. This helped to ensure that nationally recognised care practice standards were being followed in relation to people's health needs.

Staff and relatives were supported to undertake a virtual sensory dementia experience, known as the 'virtual dementia tour.' This aims to sensitise carers through simulation, to the issues of dementia and some of the physical symptoms associated with ageing. It also aims to provide an experienced understanding of what it might feel like to live with altered physical or sensory abilities. Staff and relatives we spoke with said this helped them to understand how people's experience of living with dementia could affect them and helped to inform what may be helpful or unhelpful for people's related care. The registered manager was also working with a national care channel concerned with the care of older people; to involve staff and consenting residents at the service, to make a training DVD about the prevention of urinary infections in care homes. This inclusive approach promoted awareness and understanding and helped to enhance people's care experience by their inclusion.

People were provided with personal care in line with legislation and guidance in relation to consent. 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 deprive do their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

People said that staff asked them for their consent before they provided care. Both they and relatives said that staff took time to talk with people and explain what they were doing. One person said, "Staff explain what they are going to do and always ask if it is alright beforehand."

Staff had received training and they were aware of the principles of the MCA. Many people were not always able to consent to their care or make important decisions about their care and treatment because of their health conditions. People's care plans showed an appropriate assessment of their mental capacity and a record of any decisions about people's care and treatment when this was made in their best interests. They also showed appropriate consultation with their relatives and relevant health professionals where required.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). For example, when people were not able to independently choose whether or not to live at the home. Records showed that DoLS were either formally authorised by or requested from the relevant local authority. This showed that people were protected from the risks of receiving care without appropriate consent or authorisation.

People's nutritional needs were being met and they received a balanced diet. We received a lot of positive comments from people and relatives about the meals provided. One person said, "Can't fault what I've had so far; really tasty and well cooked." Another person told us, "A good choice of ample food and drink and food is always warm when it needs to be."

We observed that lunchtime meals looked appetising and they were well presented. Portion sizes were tailored to meet people's requirements and there was very little food wastage. Food menus showed that a choice of food and drinks were routinely offered throughout the day. Lunchtime was a relaxed occasion and

flexibly organised to suit people's preferred location. Most people ate in the main dining room and staff served meals to other people in their own rooms as they chose. Tables were attractively set with linen cloths, crockery and glassware. Staff interacted well with people and spent time to help make sure everything was right with their meal.

Staff provided people with the assistance and support they needed to eat and drink. When required, staff helped people to eat at their own pace and provided them with gentle encouragement when needed. Staff knew people's dietary needs and preferences and followed instructions from relevant health professionals concerned with people's nutrition. For example, the type and consistency of foods to be provided, where risks were identified to people's safety from choking, due to swallowing difficulties.

Good

Is the service caring?

Our findings

We found staff were respectful, kind and caring and that they promoted people's rights in their care. We received many positive comments from people and relatives about staff's caring approach. One person said, "Staff are so kind and caring and always friendly." A relative told us, "Genuine and positive staff here have made us feel very welcome." Another person said, "All of the staff here, whatever they are doing, they are always kind, friendly and professional; they go over the top to do what they can for you."

People said that staff treated them with respect and ensured their dignity and privacy at all times. They gave us some examples, which we observed as routine practice during our inspection. This included knocking and waiting to before entering people's rooms and checking with people how they wanted to be supported. One person's relative said, "I would say that they very much treat people with respect."

People and relatives said they felt at ease in the home and welcome in the home. Relatives were appropriately involved in people's care and people were regularly consulted, supported and informed to make choices about the care provided. One person said, "I get up when I like and go to bed when I like; I chose what I am doing; how it will be done." Another person told us, "Staff are very good; they don't impose; they listen and they encourage."

People's care plans showed their agreement to their care, as they were able to provide this. Care plans showed the involvement and contact information of family or friends who were important to people. They also showed peoples' known wishes, choices and preferences for their care, which staff understood.

Throughout our inspection there was a relaxed atmosphere during which some people's relatives and friends visited at times to suit the person receiving care. We saw there was a private dining facility for people to eat with family and friends in small or larger groups as they chose.

We observed that staff were patient and caring in their approach and often took time with people. For example, we observed that care staff took time to walk with one person to the window and chatted with them about the view they often liked to take in there. Afterwards the care staff member guided the person back to their chair. They then gently reminded the person they were going to fetch them a cup of coffee and that they would not be long. This was important to the person as they sometimes became anxious if they did not understand what was happening around them.

Staff understood the provider's aims to ensure people's rights in care. For example, saw that staff encouraged and supported people to make choices about their care, such as where to spend their time, what to eat and drink and often by encouraging people to do as much as they were able. One care staff told us, "Staff work here because they want to; we think so much of the residents; it's their home and we respect that; we try to make it as much home from home as we can; we try to ensure people's rights and accommodate their wishes."

We saw that staff ensured people's dignity and privacy. For example, by closing bedroom and bathroom

doors when personal care was being provided or by making sure that people's clothing was properly adjusted. The registered manager told us about their improvement plans to increase people's inclusion and involvement in their care through named staff key workers and a resident buddy system for people on their admission to the home. This showed that people's rights in their care were considered and promoted.

Requires Improvement

Is the service responsive?

Our findings

Staff did not always ensure a personalised approach to people's care or respond promptly to ensure people received care and assistance when they needed it. People and their relatives felt that care was often but not always personalised and that staff often but not always responded promptly when people needed assistance. This meant that staff did not always recognise or respond to ensure people's independence. For example, not providing the adapted utensils one person needed to enable them to eat and drink independently. Examples also included staff not consistently responding to or acting on people's known requests for their care arrangements. One relative said, "Carers are wonderful, but one of the problems is that they have to work to timetable, so don't always work to the pace of the condition they are dealing with; they work to time."

One person who was not able to move independently said they were sometimes left waiting too long for assistance to move to back to other areas, such as their lounge or their own room. For example, after lunch or a social activity. The person said, "I think they know, but forget." We observed in two dining room areas after people had eaten their meals, that all of the staff disappeared for well over thirty minutes, leaving people unattended and waiting for staff to support them to move. Some began to complain openly to each other about this, until staff eventually returned.

Another person told us they were dissatisfied that they had often waited too long for their medicines required at night before they went to bed. However, they also said this had been recently resolved from changes to the related arrangements, which were agreed when they raised this. On the first floor of the home we observed that the nurse on duty did not finish giving people their morning medicines until 12 mid-day, from a start time of 8.30 am. The nurse advised that it was important not to rush people who were living with varying levels of dementia and often needed time to understand what was happening. This meant that some people were left waiting for too long for their medicines.

Otherwise, during our inspection we saw that staff usually acted promptly when people needed assistance. For example, when people needed support to go to the toilet, to have a drink or when they needed reassurance and emotional support. It was a sunny morning and one person commented on this and added that they fancied a drink of cold lemonade. A care staff promptly fetched this and made sure they were provided with a special straw to enable them to drink this independently. Staff knew how to communicate with people and we saw that they engaged and interacted well with them. This showed that staff knew people well and understood how their dementia sometimes affected their mood and emotional wellbeing. For example, we saw a number of occasions when people became anxious or upset. Staff acted promptly to reassure and support each person in a way that was meaningful to them and which helped.

We observed that environment adaptations helped to support people living with dementia or with sensory of physical disabilities. The operations director advised that environmental design at the service was completed in consultation with Stirling University. We observed this had been subtly achieved, with tasteful adaptations, which often helped to promote people's environmental engagement, orientation and recognition. For example, accessible memory boxes were built into the wall at the side of each person's

bedroom door. The boxes contained personal items that were meaningful to people, such as a favourite family or personal pastime photograph, an animal, favourite ornament or personal achievement award. We also saw a range of other adaptations such as bold coloured light switches, crockery and toilet seats, which helped people to recognise them by their contrast. In many rooms such as toilets, lights automatically switched on when people entered them. At lunchtime, a number of people were provided with aids and adaptations to support their comfort and independence. For example, adapted crockery and utensils, correct seating and table height when eating. Further improvements were planned to support people's communication needs. For example, the introduction of pictorial food menus to assist people.

People were supported to engage in a range of social and recreational activities within and outside the home and to practice their religious faith in the way they chose. There was a well-equipped activities room and dedicated staff who co-ordinated a weekly activities programme, which people could join as they chose. For example, reminiscence, board games and crafts. A range of 'clubs' had recently been introduced into the programme from people's feedback, to enable their engagement with others who held similar interests, such as music, literature and a garden project. The programme also included a range of sensory and one to one activities and exercise.

The registered manager told us about further arrangements to help ensure a more personalised approach to people's care in relation to their leisure and wellbeing. This was being promoted in consultation with people and their relatives and through trained staff champions. Minutes of meetings showed that recent improvements from this helped to increase people's access to places of interest in the local and extended community. This helped to ensure people's participation and engagement in home life in a way that was meaningful to them.

People's views, comments and concerns about the service were sought, listened to and acted on. A service customer satisfaction survey had been recently undertaken with people and their relatives or representatives. Survey results showed overall satisfaction with the care provided. This helped to ensure people's participation and inclusion in their positive care experience.

People and their relatives were appropriately informed and knew how to raise any concerns or make a complaint if they needed to. They also said that these were usually dealt with promptly by the registered manager or the administrator. For example, one person's relative told us, "When I made a complaint to the manager, she acted on it and instructed staff accordingly; sorted!" Records also showed that complaints were investigated and responded to and used to make improvements when required.

Good

Is the service well-led?

Our findings

There was effective management and leadership at the service. People, relatives and staff were confident about management and leadership in the home. People and their relatives, said that the registered manager or her administrator were visible and available to them. We received many positive comments from them about this. This included, "Very well managed and run, both managers are visible around the home;" "Yes, I think it is very well led; I am kept informed; the manager is very approachable, listens and acts if needed;" and "I am listened to; I go to the administrator if the manager is busy; there's no problem."

Staff said the registered manager was very approachable. One staff member said, "She's strict, but fair and honest." Another said, "She always busy, but she's brilliant; always here and we can ring her in the office if she's not on the floor."

Management arrangements helped to ensure accountability and continuous improvement for people's care. The registered manager told us that they carried out regular checks of the quality and safety of people's care. For example, checks relating to people's health status, medicines and safety needs. They also included checks of the environment, equipment and the arrangements for the prevention and control of infection and cleanliness in the home. Checks of accidents and clinical incidence relating to people's health status were routinely monitored and analysed by the registered manager. For example in relation to falls, infections, skin soreness, medicines errors or people's nutritional status. This helped to identify any trends or patterns and was used to inform any changes that may be needed to improve people's care.

The registered manager told us about some of the care and service improvements that were either made, planned or in progress from their recent management checks. This included improved medicines systems, staff deployment, training and care planning improvements and ongoing service development to enhance people's inclusion, participation and involvement in their care experience. The provider's external governance arrangements supported and monitored the care and services people received in consultation with the registered manager. This demonstrated effective management and continuous service improvement.

There were clear lines of management accountability for communication, monitoring, reporting in relation to people's care and service provision. Staff said they were regularly asked for their views about people's care and they understood this and their roles and responsibilities for this. For example, they understood how to raise concerns or communicate any changes in people's needs. This included reporting accidents, incidents and safeguarding concerns. The provider's procedures, which included a whistle blowing procedure, helped them to do this. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their rights and how to raise serious concerns about people's care if they needed to.

Records relating to the management and running of the service and people's care were accurately maintained and they were securely stored. The provider had sent us written notifications telling us about important events that had occurred in the service when required. For example, to tell us about Deprivation

of Liberty (DoLS) authorisations.