United Response

United Response - 26 Tennyson Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 04 March 2016. The inspection was unannounced.

Tennyson Road provides accommodation for persons who require personal care for up to five people with a learning disability or autism. At the time of our inspection there were three people living at the service.

The provider had a registered manager in place as required by the conditions of their registration with the Care Quality Commission (CQC). 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.

Care plans needed improvement. They contained information on people's preferred routines, likes, dislikes and medical histories but this was minimal. They had not always been updated to identify how care and support should be provided when people's care needs had changed. This meant that people were at risk of not receiving the care and support they needed. You can see what action we told the provider to take at the back of the full version of this report.

People did not always benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited so could not be used to develop individual ways of stimulating and occupying people. The programme of activities was morning and early afternoon based on one staff member being rotored on in the afternoon and evenings. It was not clear how people had been involved in choosing their activities. Staff supported people in their own time if anyone had vocalised they wanted to go cinema in the afternoon or evenings.
Staff had a good understanding of the Mental Capacity Act 2005 (MCA); however this was not always demonstrated when best interest decisions had been made for people who were deemed to lack capacity. We made a recommendation to refer to the Mental Capacity Act 2005 and its codes of practice. Staff demonstrated a good understanding of the Deprivation of Liberty Safeguards (DoLS) and how to put this into practice.

There was no evidence which demonstrated that people knew how to make a complaint. There was no evidence that the provider had developed a robust system for dealing with complaints that had been received. We made a recommendation that the provider reviews their complaints system to ensure it is effective and accessible for identifying, receiving, recording, handling and responding to complaints.

People received care and support from staff who knew them well. Staff showed concern for people's wellbeing in a caring and meaningful way and responded promptly to requests for assistance. Throughout our visit we saw people were treated in a kind and caring way and staff were friendly, polite and respectful.

People were protected from harm and potential abuse. Staff we spoke with knew what to do if they were concerned about the well-being of any of the people using the service. Risk assessments were in place to support people to be as independent as possible.

Staff were supported to carry out their role through supervisions, team meetings and training. People received individualised care from staff who had the skills, knowledge and understanding needed.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began work. The checks included obtaining references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People had access to food and drink throughout the day and were encouraged to eat healthily and to maintain a balanced diet.

Medicines were managed safely and administered by appropriately trained staff. People received their medicines as prescribed and in their preferred manner. People were supported to access health care services and to maintain good health.

The registered manager had systems in place to regularly monitor the quality of the service. Where internal audits had identified shortfalls, the registered manager had put in place an action plan to address these areas. The registered manager had notified the Care Quality Commission (CQC) about significant events which had occurred in the service.

We found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

Identified risks associated with people's care were assessed and plans developed to mitigate them.

Staff had a good understanding of safeguarding. Staff knew what to look for and how to report any incidents.

Recruitment processes ensured staff were safe to work with people and the provider had ensured appropriate staffing levels were in place to meet people's needs.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training as required to ensure that they were able to meet people's needs effectively.

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

People had sufficient to eat and drink and were encouraged to eat a healthy diet.

Consent to care and treatment had not always been sought in line with the Mental Capacity Act 2005 (MCA).

Deprivation of Liberty Safeguards (DoLS) were in place.

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 people.

Staff acknowledged, maintained and promoted people's privacy.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

The regular programme of activities for people to participate in was in the mornings and early afternoons around staffing numbers and shift times. It was not clear how people had been involved in choosing their activities.

We looked at three care plans and found that some guidance had not always been updated to reflect peoples preferences on their care, treatment and support.

Records about complaints were not kept and no analysis of complaints made took place to identify trends. The complaints procedure was not displayed and was not produced in a format suitable to peoples' needs.

Is the service well-led?

Good

The service was well-led.

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 was an open culture at the service and staff told us they would not hesitate to raise any concerns.

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

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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 04 March 2016. The inspection was unannounced. One inspector undertook this 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 tell the Care Quality Commission about by law. We used all this information to decide which areas to focus on during the inspection. We contacted external health and social care
professionals that were engaged with people's care and received feedback from one professional.

We spoke with three people who lived at the service. Staff members helped the inspector to understand each person's communication abilities which enabled engagement with people who lived at the service. We observed how staff interacted with people who used the service. We spoke with two support staff and a senior support worker. The registered manager was not available during our visit.

We viewed three people's care records, which included their daily notes, care plans and medication administration records (MAR). We looked at a range of staff records including the personnel records of four staff members. We looked at the individual supervision records, appraisals and training certificates within these files. We looked at the provider's policies and procedures and other records relating to the management of the service, such as staff rotas between 28 December 2015 to 17 April 2016, health and

safety audits, medicine management audits, infection control audits, emergency contingency plans and minutes of staff meetings.

The service was last inspected on 28 November 2013 when no concerns were identified.

Good

Is the service safe?

Our findings

People told us they were happy and content, they were supported by staff they could trust and who made them feel safe. One person told us, "The staff are lovely." Another person told us, "They listen to me; they are good 'uns."

People were protected from abuse because staff were trained and understood the actions required to keep people safe. Staff had completed the provider's required safeguarding training and had access to guidance to help them identify abuse and respond appropriately if it occurred. Staff were able to explain their role and responsibility to protect people. The provider's training schedule and staff files confirmed that staff safeguarding training was up to date. Staff were aware of the provider's policies to protect people, and were able to describe the procedure to raise concerns internally and externally when required. Posters in the service reminded staff of their responsibility to protect people from abuse.

The senior support staff had reviewed people's risk assessments and behaviour management plans and implemented changes to ensure people were safe and the risk of a future recurrence was reduced. Risks specific to each person had been identified, assessed, and actions taken to protect them. Risks to people had been assessed in relation to accessing the community, cooking and medication.

People's care plans noted what support people needed to keep safe. For example, they provided information about support each person required in relation to safety awareness and completing activities such as going out independently. These risk assessments detailed the required staffing ratio at different times and for specific activities to ensure the safety of people, staff and others.

Staff were able to demonstrate their knowledge of individual risk assessments and how they were expected to support people. For example; one person, when upset, would shout at others. The risk assessment detailed what the triggers for this behaviour could be, who was at risk, how to support the person safely and what known diversions should be used to help de-escalate the behaviour. We observed staff support this person safely and in accordance with their risk assessments and care plans.

Risks affecting people's health and welfare were understood and managed safely by staff. If people displayed behaviours which may challenge, these were monitored and where required referred to health professionals. Guidance and advice provided was followed by staff. This ensured risks to people associated with their behaviours were managed safely. One person had a positive behaviour support plan which gave clear details about how the person presented when they were relaxed, agitated and displaying behaviours which challenged. Each section detailed how staff should respond.

During our inspection we observed sensitive interventions by staff that recognised triggers for behaviours which may challenge, ensuring that people's dignity and human rights were protected.

People could access their money at any time and were supported by staff to ensure they were not subject to financial abuse. During the inspection we observed staff supported people to manage their finances and

protected them from the risk of financial abuse by adhering to the provider's recording processes.

Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electric safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment such as emergency lighting, extinguishers and alarms, were tested regularly by the provider's maintenance engineer to ensure they were in good working order. One person's bedroom door which was a fire door was being propped open by the person, we informed the senior support worker on duty that this was a risk. The senior support worker immediately contacted their contractor to arrange a safety door release to be fitted. This meant the person could have their bedroom door open but, if there was a fire, the door would be released and the person would be protected.

Daily staffing needs were analysed by the registered manager by calculating the number of people living in the service to how many hours each person was funded for by the local authority. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. However, the way staff were deployed restricted when people could go out and if they were to go out, it would need to be together as a group. Each day there were two staff working in the morning and one staff member working in the afternoon and evening, with one sleep in staff member each night. Staff told us there was always enough staff to respond immediately when people required support, which we observed in practice. One person required medical assistance during the afternoon, when there was one staff member on duty. The registered manager came in and supported the person to see their doctor. We were informed that if more staff were needed due to unforeseen circumstances, such as staff illness, they were provided from another service. The senior support worker told us, they used the same staff which ensured the consistency of care. Rotas confirmed there were always enough staff to meet people's needs safely.

Staff have undergone pre- employment checks as part of the provider's recruitment process, which were documented in their records. They included the provision of suitable references, 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. This meant people were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

People's medicines were managed safely in accordance with current legislation and guidance. This was because medicines had been administered by staff that had completed appropriate training and had their competency assessed annually by the registered manager. Staff told us about people's different medicines and why they were prescribed, together with any potential side effects. People's preferred method of taking their medicines, and any risks associated with their medicines, had been documented. We looked through everyone's medication administration records (MAR). They included a picture of each person, any known allergies and any special administration instructions. The MAR forms were appropriately completed and records confirmed that people received their medicines as prescribed. Where people took medicines 'As required' there was guidance for staff about their use. These are medicines which people take only when needed. Medicines were stored safely and securely.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 demonstrated they had a good understanding of the MCA; however this was not always demonstrated when making best interest decisions for people who were deemed to lack capacity. For example, staff confirmed that people were enabled to give consent to most decisions concerning their day to day support by using communication techniques individual to the person. Mental capacity assessments had not always been completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing. Best interest decisions did not always include the appropriate professionals, advocates and relatives. For example we saw for two people no mental capacity assessment had been completed and the best interest's decision had been made solely by the registered manager and senior staff regarding their clothes being locked in a wardrobe. Staff told us they were locked away because one person would try on all their clothes during the day and another person would access their clothes inappropriately. The staff were unable to explain what they meant by this. We could not see that consideration had been given to whether the restriction was proportionate and the consequences of not having the restriction in place were not highlighted in their care plans or risk assessments. We could not see that consideration had been given to ensuring the restriction in place was not any more restrictive than was absolutely necessary. We saw in other instances where people had had capacity assessments completed and best interest decisions being made in regard to health and finances.
We recommend the provider refer to the Mental Capacity Act 2005 and its codes of practice.

Staff demonstrated a good understanding of (DoLS) and put this into practice. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw a DoLS authorisation form had been completed for three people Restrictions had been imposed on them at night and when accessing the community between 10pm and 7am as they were considered to be at risk. All three people required to be supported in the community on a one to one basis and were unable to leave the service without support.

Staff had completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. Staff told us their induction programme gave them the skills and confidence to carry out their role effectively.
The registered manager had linked the induction process to the new Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are expected to achieve nationally.

New staff completed monthly support meetings with the registered manager during their induction programme which was separate to their support and supervisions. These ensured they had received the appropriate training and preparation for working with people in the service. Records showed that the provider's mandatory training for staff was up to date and included topics such as safeguarding people from abuse, medication, moving and handling, health and safety, fire safety, food hygiene and infection control. Training was refreshed regularly to enable staff to retain and update the skills and knowledge required to support people effectively.

Where necessary the provider had enabled further staff training to meet the specific needs of the people they supported, including autism, learning disabilities, person centred planning, communication and managing challenging behaviour.

Staff received effective supervision, appraisal, training and support to carry out their roles and responsibilities. Most staff had received an annual appraisal and the registered manager had scheduled the remainder to be completed during 2016. All staff had received monthly support and supervisions. Supervisions provided staff with the opportunity to communicate any problems and suggest ways in which the service could improve. Staff told us that the registered manager and provider encouraged staff to speak with them and were willing to listen to their views. In addition to this, staff participated in an informal monthly meeting to discuss their wellbeing.

People told us that staff always spoke with them to gain their consent before providing any care or support. We observed staff communicating with people using the methods detailed in their care plans. Staff were unhurried when talking with people and gave them time to consider their decisions.

Records demonstrated that relatives were invited to and attended care reviews and the registered manager had ensured they had a chance to consider all significant decisions, even if they could not attend meetings in person.

People were supported to have enough to eat and drink and were provided with a balanced, healthy diet. People were encouraged and supported to prepare their own meals, snacks and drinks in accordance with their eating and drinking plans. If staff identified concerns for people's well-being they were referred to the dietician and speech and language therapist.

Staff were aware of people's health needs, and recognised when they were unwell. Staff understood the impact of health appointments on people's anxieties, and worked with health professionals to address people's health needs without causing them distress.

People were supported to maintain good health through regular check-ups with their GP, optician and dentist. People's records contained essential information about them which may be required in the event of an emergency. These were referred to as 'hospital passports.' Information included people's means of communication, medicines, known allergies and the support they required. Each person also had a health plan which documented their health appointments and reviews, and advice and guidance from health professionals. At the time of our inspection the registered manager was in the process of updating these records. This ensured health professionals would have the required information in order to be able to support people in line with their needs and preferences.

Good

Is the service caring?

Our findings

People told us the staff were always friendly and treated them with kindness. During the inspection staff responded to people with patience and understanding, and followed people's preferred communication and behaviour care plans. One person told us, "The staff are nice to me." Another person said, "They [staff] make me laugh, they joke with me." There was a supportive atmosphere at the service, where people and staff shared a mutual respect and understanding.

During the inspection we observed staff readily provided support to people. Staff were attentive and responded promptly to people's needs. We observed people becoming worried and anxious who were immediately supported by staff offering reassurance and compassion. Staff understood triggers that could potentially upset and distress people and took action to prevent these situations from occurring and supported people's well-being. For example, one person became anxious due to a television programme they were watching. We observed staff comfort the person and provide reassurance. The person appeared satisfied with this. Staff then encouraged the person to engage in an activity they enjoyed to reduce their anxiety further.

Staff told us they took pride in the caring values of the service. One staff member said, "I like spending time speaking to them, they have great personalities". Another staff member said, "I am passionate about working with the people here. I care about them". We observed these values demonstrated during our inspection and found staff to be committed, patient and caring towards people living at the service. Staff told us that it was important for all people living at the service to feel safe and secure with staff supporting them with their personal anxieties.

Staff spoke passionately about people's needs and the daily challenges they faced. Without exception staff were able to tell us about the personal histories and preferences of each individual at the service but this wasn't always reflective in peoples care plans.

People respected others living in the service, who they regarded as their friends. We observed one person greet another person on their return from an activity. The person helped them take their coat off and encouraged the person to sit with them, and they then gave each other a greeting hug. This was well received from the person returning from their activity.

People took pride in completing household tasks and had a daily rota for housekeeping. Staff praised people for completing daily tasks and provided constant encouragement while doing them. People had their own activity schedules which showed what they were doing, when and with whom. This ensured that people were informed about who would be supporting them during the day to reduce their anxieties. Staff gave people time to communicate their wishes and did not rush them. Although people were encouraged to take part in scheduled activities they were able to exercise their right of choice and to decide when they had had enough.

People experienced positive relationships with staff who worked as a team to develop people's trust and

confidence Staff told us that they had completed shadow shifts prior to their selection where their compatibility to people and their needs had been assessed. New members of staff told us they had been supported by other staff to develop their relationships with people.

People's rooms were personalised to reflect their tastes, preferences and interests. Photographs of families and activities were displayed in the service to remind people of events and others important to them. This ensured that relationships were maintained to promote people's wellbeing. Staff were aware of items of particular importance to people, which were available when people wanted them.

People were supported by thoughtful staff that treated them with dignity, privacy and respect. Staff told us, "I always think to myself, how would I like to be supported. I always knock on their doors; I wait for them to tell me I can enter. We don't talk about another person in front of others." Another staff member said, "We make sure we respect what they can do and provide support where identified as needed". Another staff member told us, "We always knock first, ensure the person answers before entering their room". A staff member gave an example of a person who needed support with their hair in the shower but once this was done the person would be left to finish their shower independently.

Requires Improvement

Is the service responsive?

Our findings

We found that care plans were not always accurate or contained the information required to provide sufficient guidance to staff to enable them to support people in a person centred way.

When changes in people's needs occurred, care plans were not always updated to reflect the person's preferences in how they would like to receive their care, treatment and support. For example we saw three examples of when people's care plans did not contain information about their identified calcium level needs, thyroid needs and how to manage and monitor a person's sore feet. Risks associated with these diagnoses were not clearly explained in the care plans or effectively managed. People were on medication for these conditions but the care plans did not stipulate what to look out for reference to deterioration and when to intervene and seek medical assistance.
All staff we spoke to had worked at the home for some time and had a good understanding of peoples support needs. Their knowledge was up to date regarding changes in needs for people using the service and was more detailed than that contained in the care plans.
People had care plans that were entitled as 'person centred' which contained information on their routines, likes and dislikes, personal care needs, communication styles, domestic support and social activities. However the information provided was vague and repetitive. In one person's care plan there were two peoples names recorded where the information had been cut and pasted from one person's care plan to another. A sheet at the front of people's folders indicated information within plans was being reviewed monthly. The monthly reviews did not indicate or document how the person was involved in their review and what their views were.
Goals for people were documented, however there was no plan in place to say how their goals was to be achieved and no updates to say if this had been achieved.
People had limited opportunity to take risks and develop independent living skills. More assessment and planning was needed to see what people could do for themselves and develop skills and design activities that would give people useful skills and experiences. Activities where people participated and developed their skills gradually were not structured so that people consistently practiced a new skill. People were able to participate in some activities in the kitchen but they were protected from taking risks to further develop their independence. People were reliant on individual staff that made the effort to encourage people to do a part themselves rather than as part of an on-going plan. People needed more support to manage their independence and have more control over their lifestyle. Activities were organised around people's preferences and with staff support that varied depending on the activity. For example, if people were going out into town or to the gym they needed more staff with them than if they were at home doing a craft activity.
The failure to ensure care and treatment is reflective of people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that knew them well. They were able to tell us about people's preferences. For example, staff knew what people liked to eat and when they liked to get up and go to bed. Staff told us about one person who liked a fixed routine, another person who liked the cinema and another person who enjoyed gardening. These activities corresponded with what staff had recorded in the persons daily notes.

People did not always benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited so could not be used to develop individual ways of stimulating and occupying people. The was no regular personalised programme of activities, but staff told us they did spend some time with people when not carrying out personal care tasks. At times during our inspection we saw that staff spent time chatting with people. There were some magazines and books around the service that people could take advantage of, but staff did not use these to engage with people.
On the day of our inspection an external guitar teacher visited the service and we saw that one person enjoyed this; they were learning to play the guitar. We observed another person supported to access the gym. However overall external activities were group orientated and it was not clear from records kept if people were involved in choosing this.
The service did not have a system in place for gaining people's views, other than the annual satisfaction surveys completed annually and reviews with a person's local funding authority annually. There was no information that was documented and reviewed regularly with reference to people's involvement in their care, suggestions for their home and the activities they wanted to do.
Although there were a number of activities taking place some people had chosen to stay in their rooms and we did not see any evidence that people's risk of social isolation was being monitored or effectively addressed. Staff told us, "They like spending time in their room", "We've tried to involve [person] in the day but they just like sitting in their bedroom watching their programmes".

There was a complaints procedure in place. The senior staff member stated that there had not been any complaints recently. Records confirmed the last documented complaint was in June 2008. The complaints procedure was not in a format that was suitable for the needs of the people using the home, however they were aware of whom they could speak to if they were not happy. Staff knew what to do if a complaint was received. During our visit we saw a person who made a complaint to a staff member. We asked the staff member if they intended to document this at any point and we were informed that the person always complained and it was never documented. We spoke with other staff on duty who confirmed the person was known to make regular complaints but they were not documented. This information was not kept within the complaints log and no analysis of this had taken place. The persons care plan did not reflect if this was a known behaviour or how to support reoccurring complaints. This meant that the complaint was not recorded appropriately.
We recommend that the provider reviews their complaints system to ensure it is effective and accessible for identifying, receiving, recording, handling and responding to complaints.

Good

Is the service well-led?

Our findings

People told us, "The manager is nice", "The manager is very good, she is helpful". A staff member said, "They [registered manager and area manager] are very good, we are really supported and shown where to find things." Another staff member told us, "[registered manager] is the best manager I have ever had. We also have a really good senior support worker".

Quality assurance systems were in place to regularly review the quality of the service that was provided. These audits were carried out by another employee of the provider such as a registered manager or area manager to provide a more objective view of the service. These audits were unannounced. There was an audit schedule for aspects of care such as staff training, medicines, activities, care plans, finance checks, accident and incidents, health and safety and infection control. Records we observed demonstrated that information from the audits were used to improve the home. Where issues were found a clear action plan was implemented to make improvements. For example training was not up to date in one month, the following months report indicated this had been addressed. One report indicated some care plans needed reviewing, the following months report indicated this had been addressed.

Records demonstrated people, their relatives and professionals were contacted to hold the reviews and updated 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.

Staff meetings were held monthly and ensured that staff had the opportunity to discuss any changes to the running of the home and to give feedback on the care that individual people received. For example, minutes of the staff meetings sampled indicated that staff supported people to attend a celebratory meal, the meal was arranged in the evening, but people they were supporting found the venue too noisy. It was agreed that the next meal arranged would be at a different venue of people's choice or the same venue but during the day when it was less busy. Records sampled showed staff had tried this with success.

Staff said they felt valued and listened to. Staff told us that they felt they received support from their colleagues and that there was an open, transparent culture.

Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously. Staff said they felt valued, that the registered 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 home, that staff knew people well and that people received a good and consistent service.

People and their relatives were asked for feedback annually through a satisfaction survey. The last survey was in 2015, and was completed by people. They included people's views on the manner of staff, whether people felt listened to and if they knew how to make a complaint. The senior staff member told us that people completed these with support from staff. The responses from the last survey were all positive. However it was not clear from the report how many people from this service had completed the survey as the report only produced a summary from all of the locations owned by the provider.

The survey completed by relatives included their views on the standard of the accommodation, if they were made to feel welcome and if staff had a good understanding of people's needs. The responses from the last survey were, overall, positive. However, it was not clear from the report how many relatives from this service had completed the survey as the report only produced a summary from all of the locations belonging to the provider.

The staff described the vision and values of the home. They told us, "We ensure people live as full a life as possible by respecting people's choices And giving them a happy, fulfilling life. We ensure we respect people as people, not as numbers or figures". Another staff member told us, "We empower people to have a voice and ensure people are included in their care". Another staff member told us, "We ensure people get what they need. The right care they deserve. We ensure we are happy positive staff". Overall staff said their focus was to ensure the quality of care provided, and to ensure 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate, did not meet their needs and did not reflect their preferences. People were not always involved in planning their care. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (d) (e) (f)