Sense

SENSE - Community Services (East)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 May 2016 and was announced.

SENSE Community services (EAST) is a domiciliary care service that is registered to provide personal care to people living in their own homes. Their office is based on the outskirts of Peterborough city. The service provided included that for people with acquired deafblind sensory impairments and people with a physical disability. At the time of our inspection there were eight people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had appointed a new manager but they had not yet taken up their position.

The provider's human resources department and the registered manager ensured that the staff who were appropriately qualified were recruited in a safe way. Checks were in place to confirm this.

People's assessed care needs were met at the times they had wanted by suitably trained and competent staff.

Staff had been trained and were skilled in imparting their knowledge about keeping people safe. Staff were aware of those organisations and managers that they could report any concerns to if this was ever required.

Medicines management and administration was undertaken in a safe way. This was by staff whose competency to do this safely was regularly assessed.

The registered manager was aware of the process to be followed should any person have a need to be lawfully deprived of their liberty. They and staff were knowledgeable about the situations where an assessment of people's mental capacity was required. The service was working within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards codes of practice. Lawful powers of Attorney were in place where people's representatives' made decisions for them.

Staff knew people as well as the person's family member. People were supported by staff to build their independence. People received care that was respectful, dignified and compassionate based upon the finer points of those items and events that were important to the person.

Appropriate risk management strategies and records were in place for emergency events such as subjects including falls and medicines administered in the event of an emergency.

People were provided with a wide range of opportunities and occasions to be involved in their care needs

assessment. People maintained close links with those people and communities that were important to them.

People's nutritional care needs were identified and met in a safe way to maintain people's health and wellbeing. People were supported by, and access to, a range of health care professionals including a speech and language therapist, GP and community nurses.

People were supported with their independence to live in their own home as long as they wanted to.

Staff maintained a high standard of care though a robust and regular training and supervision programme.

People were provided with information in an appropriate format according to their needs as to how to make and raise suggestion and improvements to their care.

A range of effective audit and quality assurance procedures were in place. The provider had processes in place, which had been used, to ensure that the CQC was notified about events that they are required, by law, to do so.

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.

Staff knew how to recognise any signs of harm to people and how to report this.

Processes and staff training helped ensure that people's medicines were managed and administered in a safe way.

Staff were only employed after a robust recruitment process and checks on their suitability to work with people using the service.

Is the service effective?

Good

The service was effective.

People were supported to make decisions about their care and people were supported what they wanted to do or what was in their best interests.

People were supported by staff who had the right skills and knowledge about each person they cared for.

People's health and nutritional needs were met by staff who knew when people were well and when health care professional support was required.

Is the service caring?

Good

The service was caring.

People's care was provided with dignity, respect and compassion by staff who knew the meaningful aspects of how to make a difference to the person's life.

Staff showed concern for people's wellbeing and listened to what people said and communicated.

People maintained relationships with their families and other people that were important to them.

Is the service responsive?

Good

The service was responsive.

People's individualised care needs were met by staff who knew what people's strengths were.

Social stimulation was provided to people to support them with a range of hobbies, interests and pastimes.

People were supported to access the provider's suggestions and complaints process if this was ever required. The registered manager developed those aspects of people's care which worked well.

Is the service well-led?

Good

The service was well-led.

Staff were supported to embrace an open and honest culture and transparency in everything they did.

There was an effective audit programme in place which empowered staff and people to get the best out of their care.

People were supported to access and maintain strong links with the local community.

SENSE - Community Services (East)

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 12 May 2016 and was announced. This was because the registered manager and staff could be out. We wanted to make sure they were in. The inspection was completed by one inspector.

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 improvements they plan to make. We looked at this and information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with three relatives by telephone this was because not everyone who used the service was able to speak with us. We also spoke with the registered manager and three care staff.

We looked at four people's care records, managers' and staff meeting minutes. We looked at medicine administration training records and records in relation to the management of the service such as checks regarding people's home's environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaint procedures, quality assurance and audit records.

Good

Is the service safe?

Our findings

Staff had a good understanding of how to ensure people were protected from the risk of harm occurring. The registered manager had developed staff's skills and their understanding of how to protect people from harm. One member of staff told us, "If a person is quieter than normal or withdrawn I would ask their family member and check if anything was wrong. If I had any concerns I would report them to the [registered] manager or if there was anything serious, to the police." One relative said, "I absolutely, most definitely trust the staff with my [family member] and that they are safe." People and their family members were supported to access information about being safe when the person started to use the service. In addition, people with other communication skills were provided with systems which enabled them to report their concerns if ever this should occur. This showed us that the safety of people was given the relevant consideration it deserved to help prevent any risk of people experiencing harm.

All relatives told us that they felt their family members were safe with the staff who provided a consistently safe standard of care. One relative said, "When [family member] is hoisted into, or out of, their wheelchair the staff make sure that my [family member] is safely fastened in and that they tell them exactly when each stage of the move is happening."

We found that there was a process in place to identify and ensure risks to people were regularly reviewed. This was to provide people's care in the safest way practicable such as ensuring that people's homes were a safe place for care to be provided in such as ensuring bathroom floors were kept dry. We saw that risk assessments were in place as part of people's safe moving and handling practice. Other risk assessments included those for travel in the community, choking and the use of medicines for people whilst in the community or at home. Not all of people's risk assessments were detailed and these omitted how to support people safely such as with the security of people's wheelchairs in vehicles. However, relatives told us that they had instructed the staff exactly how the wheelchair needed to be secured and that there had never been any incidents. The registered manager told us that they would add this further detail to the people's care plan straight away.

Relatives told us and staff confirmed that care visits were on time and for the specified period. One relative told us, "We have had the same staff for a long time and one has been caring for [family member] since we started using SENSE services." The registered manager showed us how they planed staff rotas and the availability of staff who had the right qualifications to meet people's needs. We found and relatives confirmed that there was generally enough staff. One relative said, "If staff can't be available the [registered] manager or the deputy always lets us know in good time. It's never a problem. I wish that staff could stay longer [than care is commissioned for]." The person told us that where their family member's needs had changed that requests for additional time or staff were always considered. Staff told us that there had been improvements in their planned rosters in the past 12 months and the scheduling of care visits enabled them to arrive on time. One said, "I have been caring for one person for four years and this really helps keep them safe." This was because the staff knew the safest way to provide aspects of the person's care. Another staff member told us, "If ever we are off sick either alternate care sessions with people are arranged or another member of staff would see if they could cover the shift. However, we only do this if it is safe. It isn't just about

a numbers of staff. You have to know the person."

Systems were in place to monitor and record any incidents such as potential neglect. The registered manager ensured that any lessons learned were passed on to staff. Where it was not deemed appropriate by the registered manager for staff to continue with the person's care then this was actioned. One relative told us, "My [family member] took a dislike [for no apparent reason] to a staff member and they asked for, and were provided with, an alternative member of staff and they are very happy now."

One relative said, "If ever an incident occurred the staff know exactly what to do especially if [family member] has a [medical condition]." We found that protocols were in place and that staff were able to tell us about the requirements to support people with their medicines when they were in the community. For example, with their health conditions which required medicines to be administered straight away. Staff's competency to administer people's medicines was regularly assessed after they had been trained. This was to ensure they maintained a good understanding of safe medicines administration. We found that the responsibility for medicines administration was clearly identified. For example, where relatives were responsible and the level of support each person required. Relatives told us that their family member's medicines were stored in a safe place and administered when required. One said, "The only medicines that staff administer is for my [family member's health condition]. We do everything else."

One care staff told us, "I was trained and then given mentoring before being observed administering [people's] medicines." Training records confirmed to us that staff who administered medicines were up to date with their training. The registered manager showed us how their monitoring system alerted them to any staff whose medicines administration refresher training was due. We found that people's medicines were managed and administered in a safe way. Examples included the checking of medicines expiry date as well as audits to ensure that safe standards of administration were adhered to.

Good

Is the service effective?

Our findings

All relatives commented that they usually had the same care staff. One said, "Having the same staff is really crucial as this significantly improves the way my [family member's needs are met." Prior to using the service people's care and support needs were assessed and matched against staff's experience and training. This was to help ensure that the right staff with the right skills were available to meet these needs effectively.

The registered manager was provided with sector specific guidance and kept up-to-date with this. This was from organisations including those associated with people who had various, sensory impairments. We found and staff confirmed that there was a process in place that helped ensure that staff's planned training and supervision was completed. All staff told us that they had regular supervision, training and support from the registered, or deputy, manager. As well as e-learning for the provider's mandatory training including moving and handling, infection control and prevention and food hygiene, staff were provided with specialist training by a qualified in house trainer. This was for subjects such as tracheal suction, British sign language, diabetes awareness, and the administration of medicines to manage people who lived with epilepsy.

All staff had received training in subjects including, health and safety, the Mental Capacity Act 2005 (MCA) and first aid. The registered manager's training records showed that all staff training was up-to-date or planned. Relatives told us that they felt that staff were very skilled in the way they provided care for family members. One relative said, "I think they [staff] know my [family member] better than me as they spend so much time with [family member]." Another relative said, "They [staff] know what they are doing as they get lots of training and [family member] seems to have blossomed with their independence [as a result of staff skills in enabling people]."

The registered manager explained to us the systems that were in place to support staff in their role. For example, following staff's initial induction training they were supported with shadow shifts [working with a more experienced member of staff] until they were confident to do their job independently. One member of staff told us, "My induction lasted five days but that was just the start. I was then given opportunities to shadow experienced staff, get to know people, before I was allowed to care for people on my own. For some people there is always two staff so I am always learning something." Another care staff told us, "I am always supported with requests for training as long it is for people I care for it is never refused."

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. 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 must be made through the Court of Protection [CoP] for people living in the community. We checked whether the service was working within the principles of the MCA.

We found that the registered manager and all staff had an understanding of the MCA and Deprivation of

Liberty Safeguards (DoLS) codes of practice. For example, assuming in the first instance that people could make their own choices. One relative said, "They [staff] let my [family member choose [what they want]. It's their choice. The staff always involve them in conversations." The registered manager showed us how they had, as a result of people lacking capacity, contacted the local authority. This was to ensure that people were only deprived of their liberty when this was lawful. Best interest's decisions had been identified and these were implemented in the least restrictive way.

We saw that other advanced decisions, such as lasting power of attorney for health and wellbeing, had been authorised by the CoP. This was to ensure that the person had decisions made on their behalf, which were always in their best interests. A member of staff told us that the MCA was, "Always assuming people had capacity and respecting their decisions. If they make unsafe [unwise] decisions it's their choice, but we encourage them as far as possible to do things safely." Another staff member said, "I always offer a choice such as shower gel, soap, options of clothes to wear and foods to eat." Daily care records also confirmed to us how staff had offered people choices and how much the person had appreciated this either by 'smiling and laughing' or general body language and happiness.

Care plans recorded, and relatives confirmed to us, the appropriate eating arrangements that were in place such as those for a soft food or low sugar content diet. Care plans recorded in detail how people needed to be supported to eat and drink sufficient quantities. This was even if the person made unwise decisions on what they ate or didn't eat and also where people had their nutritional support in a way other than orally. For example, through a tube into their stomach. One relative told us, "Whenever my [family member goes out, the staff know that they can have sips of liquid and they do this at home as well." Another relative said, "[Family member] isn't a great drinker but they [staff] offer this little and often." Where people were at a nutritional risk measures were in place which included fortified food and fluid supplements to assist them in maintaining a healthy weight.

Care staff told us, and we found, that they supported people to access health care professionals including a GP, dietician and community nurses. One relative told us, "If ever my [family member] needs emergency care I am absolutely confident that staff would call 999." Care staff told us that they were trained for these situations and that if people did not respond quickly after the administration of medicines then they would immediately contact the emergency services. We saw that various referrals had been made to speech and language, and occupational, therapists. This was for changes to the equipment people had been provided such as new wheelchairs. Whenever this had occurred this had helped improved or maintain people's independence. This showed us that people's healthcare needs were responded to.

Good

Is the service caring?

Our findings

Our conversations with relatives as well as the registered manager and care staff showed us that staff were very considerate of each person's care. All relatives spoke very positively about how compassionate the staff were. One said, "They [staff] are just wonderful with them [family member]. I hear [family member] laughing in the bathroom with them [staff] and when they come out my [family member] is smiling lots. I know that they have enjoyed the experience and that the care has been exactly as requested." Another relative saying, "We have been fortunate enough to have some wonderful [care] staff with whom [family member] has become very fond of. The care has always been of the highest standard." A third relative told us, "It [the care] is very, very good and I have no hesitation whatsoever when staff go out with [family member as I trust them totally." During a recent illness for [family member] they [staff] gave support which was about as caring as it gets. I couldn't have managed without them."

Staff gave us examples of how they communicated with each person they cared for. This was through a variety of assistive technology, communication cards, sign language and pictures as well as body language and facial expressions. This helped promote respectful and compassionate care. One staff member told us, "If they [person] are asleep I just let them as I know they need this. This was because staff knew if the person had experienced a health condition and that this was the most caring thing to do. On other occasions they are so happy to see me they can't wait to go out to [hobby]." One relative told us how staff helped their family member eat in a dignified way and how much their family member enjoyed the staff and their company.

We found that staff respected people's privacy and dignity using various means. For example, letting people wash their own face and other areas. One staff told us, "We can't leave [name] for their safety but as far as possible we let them have privacy either with a towel and not watching their every move." A relative told us, "[Family member] likes the girls [staff] as they are [their] age and they share similar life experiences." Another relative told us, "Staff always offer a choice. [Family member] is very particular about what they wash with and I know just what difference this makes by being respected."

Where people had a visual or hearing impairment staff made sure that the person knew that staff had arrived. People's care plans clearly identified the guidance on how each individual person liked to be spoken with such as slowly or clearly as well as the use of the person's preferred method of communication.

Staff described to us what people could independently do for themselves as well as how to provide other aspects of their care. We saw people's care plans were detailed and provided staff with relevant guidance on those aspects of people's lives that were important to the person. For example, taking part in cooking, going ice skating, horse riding or swimming. Relatives told us that these were things that their family member really looked forward to. One said, "They [family member] are always awake when the girls [staff] come to take them [hobby]." One care staff said, "I really do love caring for people with an impairment. We had training with a blindfold and ear defenders and this really helped me understand what it could be like to live with sensory loss. It makes it easier for me to help them in the right way." Another staff member told us that as a result of their 'guiding' [training on how to guide people who had a visual impairment] they knew how

to really make that important difference to people's lives.

It was obvious to us, by our conversations with staff about how passionate they were about having meaningful interactions with people. Examples of this included the depth of descriptions they gave us about the people they cared for and the difference this had made to the person's life. Staff spoke to us about what people had achieved and what their aspirations were. Examples of this included going out to a café, going to a night club or other sensory stimulation venues where people shared similar interests. The provider's PIR included comments about people's care such as, "staff having the right communication skills is vitally important to individuals [people] to enable staff to pass on information and be able to explain what is happening. Communication is directed at the person letting them know what they are going to be doing." From speaking with relatives we found this to be an accurate statement.

Other involvement people had in their care planning included a face to face visit with people's advocates or relatives when the person started to use the service. Examples of this included staff's day to day conversations and communications with people and their family members. This also included more formal reviews of the person's care needs. On these occasions staff took the opportunity to give people the explanations they needed in a format that enabled the person to be involved as much as possible such as in large print.

We saw and relatives told us that as far as possible people were supported in a way which meant the risk of social isolation was minimised. For example, with visits to various clubs such as those to meet old school friends, going for a meal or a coffee as well as a wide variety of sporting activities at various locations.

People were provided with information and organisation which could advocate for people who relied upon others to speak up for them. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. This also included lawful lasting power of attorney advanced decisions made that were in people's best interests. This was to make decisions people could not always make for themselves.

Good

Is the service responsive?

Our findings

People's care needs were assessed using a combination of methods. These included the local authority's and provider's assessment process. This was to identify those aspects of people's lives that were important to the person. Methods used to help identify what worked best for the person included the use of people's various communication skills to enable them to take part in the assessment process. These included sign language and objects of reference people could point or indicate with other means about what the person wanted to say. This was to help ensure people's preferences were clearly identified such as the decisions people could make for themselves and how these were communicated.

People were supported to meet with friends as well as going out to take part in social activities such as going to a night club, ice skating and trampolining. Other examples included, the time of day they preferred this as well as the foods and drinks that people really enjoyed. We found that the provider had accurately assessed people's needs. Where people's needs changed such as a change in the person's posture and the identification and provision of suitable mobility equipment this was acted upon.

In care records we saw that these were reviewed in response to people's changed needs. For example, when two staff were required on a regular and consistent basis where the person's previous care arrangements had changed. For example, where people needed additional support to maintain and improve their independence. Other strategies were in place to ensure people were not exposed to undue risk such as noise or bright lights such as the avoidance of occasions this could occur. This helped ensure that the triggers for people's health conditions were avoided.

People received care from staff who really knew what was important to the person. For example, how the person liked to eat, what social hobbies and interests they liked to do and how they wanted to do them such as with staff or doing things independently. One relative told us, "[Family member] has made great strides in their independence. It's early days but the difference already is noticeable. They [staff] support [family member] to do the things [family member] likes. When they go out [hobby] the staff enjoy it as much as [family member] does. It makes such a difference." People were supported to take part in past times that any person was previously able to do such as going to a night club, going shopping or out for a meal with friends. Relatives told us and the registered manager confirmed the social interests that people could access. These included taking part in a karaoke and attending other social meetings.

People's care plans were detailed and gave staff guidance on how best to make a difference to people's lives. This included knowledge of people's favourite activities which included ice skating, hand massages and manicures. Staff told us that they found the care plans contained the level of detail based upon how the person wanted to live their lives and the support mechanisms required to do this successfully. For example, going out in their car with staff. Where a combination of family member's or relative's support was in place, arrangements existed to help ensure that the person's care needs were met or exceeded.

The registered manager saw the potential in people and staff supported each person to achieve their full potential. This was through a combination of accessing educational and social programmes. We found that

staffing to support people was based upon a consistent approach with the same regular staff supporting people wherever this was possible. This helped ensure that people got the best out of the care they received. One relative said, "I have to say that staff and [family member] are very well matched. Especially staff being of a similar age really helps [family member] to talk about similar interests." Another relative explained to us, "There is a lot of support facilities in place for my [family member]. It is absolutely perfect."

People had various opportunities to provide feedback on those aspects of their care they benefited most from as well as where fine tuning was required. Examples of this included the time people preferred their support and where changes to this had been implemented. For example, one relative told us that the registered manager and deputy manager kept in touch on a regular basis. They or staff said, "I have had to make some minor changes to [family member's] care but in the past 12 months everything has just been exactly how we want it. It [the care] has made such a difference. I couldn't have done it on my own as I just don't have the time that staff do." Another relative told us, "One good thing is they [deputy manager] always rings back if I have anything bothering me. It is all ticking along quite nicely."

The provider had a complaints process and procedures in place but this had not been required to be used. We saw that various means were provided to support people to comment on their care. These included communication passports, assistive technology and speech augmentation devices. The service had an up-to-date complaints policies and procedures in the form of a service user guide. This included details on how to contact the registered manager as well as other organisations such as the Local Government Ombudsman. One relative said, "I have had no complaints but we do have contact with the office [staff] and all the responses have been positive, such as changes to staff based purely on my [family member's] preferences and no other reason."

Good

Is the service well-led?

Our findings

People, their relatives and staff were involved in improving and developing the service. We found that people benefitted from their involvement in the service. This included the means they used such as their preferred communication skills such as objects of reference or picture cards. This was as well as staff's knowledge about exactly it was that the person was communicating.

Staff were asked for their views at staff meetings as well as when they visited the provider's office. This gave staff the opportunity to comment on what worked well and where changes were needed such as what each person's achievements had been since the previous meeting. People's and relatives' views were sought using a feedback form as well as telephone calls to review the person's care. The registered manager could also identify any trends from people's daily sessional care records. If any concerns were identified then this was recorded centrally on the provider's records system for events such as the frequency of people's behaviours and appropriate action that would then be taken. For example a review of the person's medicines.

The registered manager told us that the biggest challenge in ensuring that the right standards of care were maintained and improved was through having staff with the right skills. They said, "With people having complex communication skills it is essential that staff have these skills." They added that as a result of having the right staff, the benefits to people were, "Making a dramatic difference every time we help people. Preventing isolation and ensuring access to the community. Accessing local deaf blind associations and youth club events as people really like the opportunity to be with and share experiences with their peers." Relatives we spoke with confirmed to us that this was the case. One care staff told us that they had specialist training which supported people to improve their independent living skills. They said, "This has been very useful knowing the support people need. It is essential to support people to be independent."

All staff we spoke with confirmed that the support they received from the registered manager enabled them to do their jobs well. For example with regular supervision that was planned and an annual appraisal of staff's performance in their role. Less formal methods of support were also available for staff. One member of care staff told us, "They [registered and deputy manager] are always on the end of the phone if I need them. I can call them at any time no matter what the issue may be. They support me and they do it well. I can't just ask for any training but if there is a specific need such as additional qualifications in sign language or epilepsy then this is always supported. I hadn't had moving and handling training but when a person I care for needed this I was provided with the training. I have been in the sector sometime now and the training from SENSE is the best I've had."

One relative told us, "I had a call from the [deputy] manager in the office. They asked me how things were going for my [family member] and me as it is early days for us both. Everything seems to be going well as [family member] has been smiling more or indicating to me how happy they are after being out [in the community]." Information from people's daily sessional [care] records was used to identify what worked well. For example, the person exhibiting very positive behaviours and smiling a lot. The registered manager told us, "We visit people with the service's deputy manager and working alongside staff and people's

parents and relatives until the person and staff were satisfied with the quality of care provided and that it met the person's needs and aspirations."

We saw that people's views about their care had been sought. Responses to the questions asked were either that the person was satisfied or very satisfied with all aspects of their care. For example, if the service met their needs. One relative had commented very recently what the service did well and wrote "The support staff are lovely. They go to great lengths to ensure [family member] is happy. Another comment included that "the service was 'always' managed in a way that respected their [person's] hobbies and interests as well as maintaining relationships and friendships".

Spot checks regarding the quality of staff's work were completed by the deputy and registered, manager and senior care staff. This was to help ensure that the care staff were working to the right standards as well as exhibiting the provider's values of putting people first and foremost. One member of care staff told us, "We get our performance assessed for medicines administration, moving and handling practice as well as how well we engage with people who often communicate in other ways other than just verbally. If there is anything that needs improving we are given constructive feedback and how best to improve."

The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the registered manager had notified us about these events where required.

Staff team meetings were held regularly, when the provider expected staff to attend these meetings or be sent these by e-mail; this was when they were encouraged to discuss general themes such how independent each person was and any identified training needs. For example, one member of care staff told us, "As long as I apply in time for training the manager supports me."

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said, "Most people I care for are vulnerable and if ever I had any concerns whatsoever I would report these to [registered manager] and that they would act fairly." All relatives told us that they only ever had positive things to say about the service and its staff and management.

The registered manager had access to various means to identify good and best practice. This was through a range of forums including provider's meetings where information for national organisations such as Social Care Institute for Excellence. Information on the provider's web site identified that the provider was an organisation which specialised with deaf blindness. Their values were to support people in "a world in which all deafblind children and adults can be full and active members of society". This was demonstrated in all aspects of our inspection and the service that was provided.

Support to the registered manager was also provided. This was from a representative of the provider as well as a process known as "I" statements and demonstrated how each member of staff would "listen to others", "be open and honest" and "celebrating people's successes" no matter how small these were.