Endurance Care Ltd

The Anchorage

Inspection report

78 Wootton Road
Gaywood
Kings Lynn
Norfolk
PE30 4BS

Tel: 07772057000

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 29 January 2018. This was an unannounced inspection, which meant the staff and provider did not know we would be visiting.

This service is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Anchorage is a care home providing accommodation, personal care and support for up to six adults who have a learning disability, sensory impairment or mental health conditions. There were five people living at the home at the time of our inspection.

The Anchorage has been registered with the Care Quality Commission (CQC) since October 2010. Since this time, a new provider Endurance Care Limited, had taken over the management of The Anchorage. This change occurred on 26 October 2017. The new provider had retained the previous staff team and registered manager. This was the first comprehensive inspection since the provider registered with CQC, as such; they had not yet received a CQC rating. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led.

We were told on the day of our visit the registered manager was no longer employed. However following our visit the provider notified us the registered manager would be resuming their responsibilities at the 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. The area operations manager met with us and provided us with the information we needed.

We found that the systems in place to reduce risks associated with the environment were not always suitable for purpose or properly maintained and this exposed people to the risk of harm. We found that one radiator covering was not fixed to the wall as intended and there were exposed pipes in the shower room, which could result in a person being injured. The bathroom and toilet facilities were not clean or properly maintained. People told us and staff confirmed they were unpleasant to use.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced.

The service was not always well led; although the registered manager had completed regular monitoring checks these were not considered to be robust. The area operations manager took immediate action to improve people's safety and quality of care delivery. We have received assurances since the inspection and continue to be in regular contact with the provider to ensure standards improve imminently.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Staff understood their responsibilities in safeguarding people from abuse and knew how to report any concerns they had.

Care records contained guidance and information to staff on how to support people safely and mitigate risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. People received their medicines safely and as prescribed.

People were supported by sufficient numbers of staff to meet their needs. Robust recruitment procedures were followed to ensure only suitable staff were employed.

People's needs had been assessed before they moved into the home to ensure staff could provide the support they required. Staff received training considered as mandatory by the provider. All staff attended an induction when they started work and had access to ongoing training. Specific training was provided if people developed needs that required it. The provider supported staff to achieve further qualifications relevant to their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to make choices about the food they ate and were supported to maintain a healthy diet. Staff ensured that individual support guidelines around diet and nutrition were followed.

People were supported to maintain good health and to obtain treatment when they needed it. Staff were observant of any changes in people's healthcare needs and responded promptly if they became unwell. Each person had a health action plan which detailed their health needs and the support they needed.

People had been encouraged to choose the décor and were able to personalise their bedrooms. Equipment and adaptations were in place to meet people's mobility needs.

Staff were kind, caring and compassionate. People had positive relationships with the staff who supported them and there was a homely, caring atmosphere in the home. Staff treated people with respect and maintained their dignity. They respected people's individual rights and promoted their independence. People were supported to make choices about their care and to maintain relationships with their friends and families.

People received care that was personalised to their individual needs. Care plans reflected people's needs, preferences and ambitions. People's needs were kept under review and their care plans updated if their needs changed.

People had opportunities to take part in activities that reflected their interests and preferences. People were supported to access the local community and had developed relationships within their community.

There were appropriate procedures for managing complaints. Records demonstrated complaints had been

listened to and acted upon.

People, relatives and staff benefited from good leadership. Staff said since the new provider had been in place, the management team supported them well and valued them for the work they did. They told us their suggestions for improvements were encouraged. There was a strong team ethos and staff said they received good support from their colleagues.

People who lived at the home, their relatives and other stakeholders had opportunities to give their views and the provider responded positively to feedback. People's care records were kept up to date and stored accessibly yet securely. The provider had notified CQC and other relevant incidents of notifiable events when necessary.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Some areas of the home were not cleaned to a suitable standard. People were not always protected from the risk of infection.

Safety incidences were not always analysed and responded to effectively. This meant the risk of further incidents were not always reduced, which could put people at risk.

There was enough staff deployed to meet people's needs and keep them safe. People were protected by the provider's recruitment procedures.

People were supported to take risks as safely as possible.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's needs had been assessed before they moved into the home to ensure their needs could be met. People's dietary and health care needs were assessed and met.

Staff had access to the support, supervision and training they needed to support people effectively.

People's care was provided in line with the Mental Capacity Act 2005 (MCA).

The physical environment of the home met people's needs and equipment and adaptations were in place where necessary.

Is the service caring?

Good

The service was caring.

People received compassionate care from staff who knew their needs well. People had positive relationships with the staff who supported them.

Staff treated people with respect and maintained their privacy, dignity and independence.

People were encouraged to make choices about their lives and to be involved in planning their care.

Is the service responsive?

Good

The service was responsive.

People received care that reflected their individual needs and preferences.

People had access to activities they enjoyed. People were involved in their local community.

People were confident that they would receive a positive response if they raised concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality of the service was reviewed by the registered manager and staff. Systems were in place to monitor the quality of the service and consult with people. However, these did not identify the shortfalls we found during our inspection. Moving forward it was evident; the new provider was keen on developing and implementing an improvement plan.

People were encouraged to give their views and the provider responded positively to feedback.

The Anchorage

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 January 2018 and was unannounced. This was a comprehensive inspection carried out by one inspector.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used this information to plan the inspection. We did not request a Provider Information Return (PIR) form. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider an opportunity to provide us with information that was relevant to our inspection.

During the inspection we met five people who lived at the home and five members of care staff, including the area operations manager. If people were unable to tell us directly about their experience, we observed the care they received and the interactions they had with staff.

We looked at two people's care records, including their assessments, care plans and risk assessments. We checked recruitment and training records and how medicines were managed. We also looked at health and safety checks, quality monitoring checks and the results of the provider's latest satisfaction surveys.

Requires Improvement

Is the service safe?

Our findings

Staff had not maintained appropriate standards of hygiene which protected people from the risk of infection. Staff attended infection control training during their induction and had access to regular refresher training. There was an Infection Prevention and Control policy in place, which staff had signed to confirm they had read and understood.

There was a cleaning schedule in place which should have ensured that all areas of the home were cleaned regularly. However, we found this had not been effectively monitored or audited. We have covered this in the key question, is the service well-led? Consequently, the systems in place to reduce risks associated with the environment were not always properly maintained and this exposed people to the risk of harm.

The bathroom, shower and toilet facilities were not clean or properly maintained. This resulted in toilet areas being heavily stained and areas of the washing facilities being dirty. We observed toilet brushes heavily stained and were rusty. The shower curtain had mould growing and was also heavily stained. The bin in the bathroom was being used to put soiled continence pads without any clinical waste bags being used. This did not protect the risk of cross contamination. Female staff were not provided with a sanitary waste bin, staff confirmed this meant general waste bins were being used to dispose of soiled items. People told us the facilities were not pleasant to use. Without exception all of the staff and the area operations manager confirmed they would not use the washing facilities themselves due to them being inadequate.

We fed this back to the area operations manager at the time of our visit. Following the inspection we were sent evidence that new robust cleaning schedules had been implemented with immediate effect and that a staff sanitary waste bin had been ordered. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced. Records showed that eight falls had occurred between September 2017 to January 2018. These records had not been completed appropriately, some of these records were completed on a staff handover document, and others were on accident forms. Information recorded was brief and did not always demonstrate that people had been checked for injuries. There was no system in place for monitoring falls or any other accident to ensure potential themes or patterns in relation to accidents and incidents were identified. The area operations manager told us they would arrange an immediate staff meeting to ensure staff understood the importance of robust reporting. Following the inspection the area operations manager confirmed this had happened and that they had implemented a new system to analyse accidents and incidents. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

We found one radiator cover being stored in the corridor and exposed pipework in the ground floor shower room which could have increased the risk of injury to people. We found two people were at risk of falls and that multiple falls had occurred in the ground floor shower room. We fed-back our concerns to the staff on duty who immediately removed the radiator cover. We fed-back our concerns regarding the exposed

pipework to the area operations manager at the time of our visit. Since then we have received sufficient evidence that the exposed pipework has been made safe.

Other risks arising from the premises or equipment were managed to promote safety, including staff maintaining appropriate standards of fire safety. Regular in-house checks were made on the fire alarm system, which was also professionally serviced each year. There was a fire risk assessment in place for the home and a personalised emergency evacuation plan had been developed for each person. Fire drills were held on a regular basis and the outcomes recorded.

Safety certificates for the home's gas and electrical supplies were up to date as was evidence of portable appliance testing. Equipment used in the delivery of care, such as toilet supportive aids, were checked regularly. The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. A missing person profile had been created for each person which would be shared with the police in the event of a person going missing.

People said that they felt safe with the support they were receiving. We asked people if they felt safe and they indicated positively, both verbally and through gestures. We observed that they appeared very happy and at ease in the presence of staff. People actively sought out the staff to tell them about the activities they had completed. When people became upset they actively sought out staff support to either talk with them or have a hug. This showed people were relaxed in the company of the staff.

Staff told us and records showed they had received appropriate training with regards to safeguarding and protecting people. All staff attended safeguarding training in their induction and regular refresher training. Staff told us safeguarding was discussed in team meetings and that the provider had reminded all staff about their role in keeping people safe. They knew how to raise any concerns they had outside the home if necessary, for example with the local authority safeguarding team.

Risk assessments were in place to reduce the likelihood of injury or harm to people. These included accessing the community, road safety, manual handling, eating and drinking and management of medicines. They were completed in a way that allowed people as much freedom as possible, and promoted people's independence. Staff understood any risks involved in people's care and followed the guidance in their care plans to ensure people were safe. Some people were at risk due to their individual needs, for example one person had diabetes and another person was at risk of choking due to swallowing difficulties. Staff had taken appropriate action to protect people from these risks. Staff supported the person who had diabetes to manage this condition through medicines and regular monitoring. The person at risk of choking was protected because staff followed guidance from a healthcare professional to minimise this risk.

There were enough staff deployed to keep people safe and meet their needs. The rota was planned to ensure there were sufficient staff with appropriate skills and experience on each shift. People were protected by the provider's recruitment procedures. Prospective staff were required to submit an application form detailing their qualifications and experience and to attend a face-to-face interview. The provider obtained references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

Medicines were managed and administered safely. There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and all care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of

how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

Good

Is the service effective?

Our findings

People received care from staff who had the knowledge to meet their needs. One person told us, "The staff are properly trained. They do a grand job." Another person told us, "The staff are my family. They know how to support me."

People's needs had been assessed before they moved into the home to ensure staff could provide the care they needed. Staff had the skills and knowledge they needed to meet people's needs effectively.

Staff told us they had access to the training and support they needed to carry out their roles. They said training was provided to enable them to fully understand and respond to people's needs. Staff reported that their practice was observed by managers on a regular basis and that they met regularly with a manager for one-to-one supervision. One member of staff told us, "We are well trained. It is always available." Another member of staff said, "I really enjoy the training and induction is really thorough." Each member of staff also had an annual appraisal with their manager, which provided an opportunity to receive feedback about their performance and discuss their training needs.

All new staff attended an induction and completed the Care Certificate if they had not already done so. The Care Certificate is a set of nationally agreed standards that health and social care workers should demonstrate in their daily working lives. Staff were given the opportunity to evaluate the training they attended which gave the provider feedback about whether it had equipped staff adequately for their roles. Staff were encouraged to work towards relevant qualifications in health and social care. The provider supported staff to achieve these qualifications by arranging an assessor who observed staff and provided them with feedback and advice about their practice.

The area operations manager maintained a spread-sheet record of staff training in courses they considered mandatory to provide effective care and recorded when staff had completed these. These courses included infection control, moving and handling, fire safety, first aid, health and safety, promoting dignity, equal opportunities and food hygiene. A computer system held details of what courses had been completed by staff and notified the management team when updates were required.

Staff communicated effectively with one another and worked well as a team. All the staff we spoke with emphasised the strength of the team as a unit and the positive impact this had on the care people received. Staff received supervisions with the registered manager at least three to four supervisions per year and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. Two staff said they discussed work, training, people who used the service, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings.

People told us they enjoyed the food provided and were able to make choices about what they ate. We observed staff planning the next few days menu with people. They used a recipe book and supported people to choose from the book, people were supported to plan what ingredients were needed and then

were supported to the shop to purchase items. People told us they were supported to eat food they enjoyed and were encouraged to maintain a healthy diet.

People's nutritional needs had been assessed before they moved into the home and any support they required was outlined in their care plans. For example, for a person who was diabetic, there were detailed guidance for staff on how to support and encourage the person to eat healthy, for example by always checking sugar contents in food items and making sure sugar free options were available. Healthcare professionals such as speech and language therapists had been consulted when people developed needs related to eating and drinking. Any guidelines put in place by healthcare professionals had been incorporated in people's care plans and was followed by staff.

Staff sat down to support people when they were eating and drinking and made it a social occasion. They supported people to eat at their own pace. A member of staff smiled at the person they were supporting, making sure they had eye contact while they were helping them. Staff made sure people were safe when they were eating and drinking. A person was eating their meal independently, a staff member made sure they did not eat too much food each time, so they could swallow safely.

People were supported to stay healthy and to obtain treatment if they needed it. Records indicated staff were observant of any changes in people's healthcare needs and responded promptly if they became unwell. We observed multiple professionals contacting the service and talking to people about their upcoming appointments. For people who did not want to take the telephone calls they indicated they were happy with staff to take the call and then share with them what the professional was contacting them about. Record demonstrated that people's healthcare needs were monitored by staff and that relevant healthcare professionals were consulted about people's care where necessary.

Staff had developed a heath action plan for each person which recorded their medical history, any health needs they had and any treatment they received. Each person had a hospital passport, which provided important information for medical staff in the event of a hospital admission.

People told us the home provided suitable, comfortable accommodation. The home provided bright communal and private rooms. A well maintained garden was available for people to use. People had been encouraged to choose the décor and furnishings for their bedrooms and were able to personalise their bedrooms as they wished. Equipment and adaptations were in place where necessary to meet people's mobility needs including shower chairs and toilet hand rails. There was evidence that these were checked and serviced regularly.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff followed appropriate procedures to ensure that people's rights under the MCA were protected. Capacity assessments had been carried out where necessary to determine whether people needed support when decisions that affected them were being made. Staff presented information to people in ways they best understood, which helped their decision-making. People's care plans outlined how they indicated consent to their support and how they communicated their choices. Where people lacked the capacity to make a particular decision, staff had consulted all relevant people, such as relatives and healthcare professionals, to ensure the decision was made in the person's best interests. The management team

checked that mental capacity assessments had been carried out where necessary and that all relevant people had been involved in making any best interests decisions.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people were subject to restrictions for their own safety, applications for DoLS authorisations had been submitted to the local authority. We saw evidence that people had been supported by independent mental capacity advocates regarding DoLS applications. Staff understood that restrictions should only be imposed upon people where authorised to keep them safe and people were supported in line with the conditions of any DoLS authorisations.

Good

Is the service caring?

Our findings

People received good care from staff who knew them well. They had developed positive relationships over time as they were supported by the same staff on a regular basis. One person said, "The staff are lovely." Another person told us, "The staff are here every day. I know who is coming on shift. They always make sure I am ok and take time to talk to me."

We observed staff working and speaking with the people present at the time of the inspection. They spoke in a respectful tone, did not rush their speech and gave people time to respond. Staff had good rapport with people and demonstrated they knew all about their likes and dislikes when speaking with them.

Staff we spoke with demonstrated a caring approach to people and expressed that they wanted to provide care that met people's needs to improve their quality of life. Staff told us they had sufficient time to listen to people and spend time with them. Staff we spoke with knew about people's care needs and were able to explain people's preferences and daily routines.

One staff said, "It's really important to know the person you are supporting. Otherwise that is when people get anxious and feel scared. For one person we support, routine is really important." Another staff member said, "The care plans tell you everything you need. They are written with the person, with their choices included. One person on occasions will want to stay in bed until after lunch. Trying to persuade them otherwise can really impact their mental health. So we respect their choice but after lunch we try our best to encourage the person to freshen up, wash their hair, get into fresh clothes and go out. They go through cycles. We monitor and observe the person so we know when the cycle starts." We saw that staff responded to people in a proactive way that enabled them to predict people's mood and behaviours and reduce the likelihood of any behaviour that may challenge the service.

The staff approach and values of the service was focused on people's strengths and abilities. People were treated as individuals and had outcome focused care plans in which, they and people important to them, were involved in completing and reviewing on a regular basis. They included information about people's areas of strength, interests and choices. We saw that people's goals had been agreed with them and their choices respected. This was recorded in a format that could be easily understood by people using the service. People were supported in making decisions by care managers and relatives, who acted as advocates when important decisions were required.

Staff knew people's individual communication skills, abilities and preferences. For example, one person used sound to communicate. Staff understood what each sound meant and what the person was trying to communicate. Staff told us this was based on working with the person over a period of years. People and their relatives were also able to comment about the care and the support they received through regular reviews, informal discussions, meetings and feedback questionnaires sent out by the provider.

We saw that people's privacy and dignity continued to be actively supported, with people having access to their own personal bedrooms as well as communal areas. We also saw care staff knocking and waiting for

permission before going into bedrooms, toilets and bathrooms.

People were also supported to maintain their independence, as far as possible, and were encouraged to participate in the cleaning and tidying of their bedrooms and the communal areas and participate in meal preparations. Care plans identified that people should be encouraged to do as much as possible for themselves, in relation to their personal care.

Staff we spoke with understood about confidentiality. They told us they would never discuss anything about a person with others and when they have handovers or meetings, they do so in a private area so they would not be overheard. Files were kept in locked cabinets in the office, which was accessible to staff only.

Good

Is the service responsive?

Our findings

People told us they were involved in their care and support. They said they had been involved in planning their care so the support provided could meet their needs. One person told us, "I know what is in my care plans. I helped write them." Another person said, "The staff know me well. They meet my needs. This makes me happy. If something changes they involve me."

People's needs were fully assessed prior to admission so that a comprehensive care and support plan could be developed to meet their diverse needs. The area operational manager told us that as part of the pre-admission process, people and their relatives were involved to ensure that staff had a good insight into people's personal history, their background, their individual preferences, interests and future aspirations. From this information, a personalised plan of care and support could be put together ensuring the person was at the centre of their care.

Care plans detailed how staff should support people's individual needs. Care plans contained good detail for staff to follow; such as the action they should take to support people, whether in the home or out in the community. Care plans were reviewed on a regular basis, involving people in this review. Daily records were also recorded against each care area, detailing matters such as people's moods, personal care received, their dietary intake and what activities they had participated in.

People and their relatives were continuously involved in the assessment and planning of their care through regular review meetings. Throughout our inspection we observed that staff supported people in accordance with their care plans.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. One person had been involved in local Church for many years and sang as part of the choir. Records confirmed that person was supported to attend the Church on a weekly basis and at other such events, the Church offered.

People living at the service continued to be supported to participate in a range of activities, including attending day centres. 'Residents' meeting records confirmed discussions took place with people regarding activities they wished to organise, holidays and places they wished to visit. People told us they felt there was access to a range of events and activities. People were supported to follow their interests and take part in social activities. One person said, "I go out on my own. I have been out today. I did some shopping." Another person confirmed they visited the library once a week to use the computer and did cookery lessons.

People we spoke with knew how to report any concerns. Although the complaints procedure was not on display in the service, records demonstrated that at each resident's monthly meeting people were encouraged to raise concerns. We found two formal complaints had been made in 2018 by people regarding the recent decorating that had occurred in the home. There were procedures in place to deal with complaints effectively, records were fully completed, investigated and responded to appropriately. The

management team shared the learning with the staff team with the aim to make improvements at the service.

Records showed that the management team had consulted with SOME people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive.

Requires Improvement

Is the service well-led?

Our findings

The area operations manager told us, at the time of the inspection the registered manager had left employment the week prior to our visit. However following our visit the provider notified us the registered manager would be resuming their responsibilities at the service.

The provider had systems to ensure that various aspects of the service delivery were being monitored. These included monthly audits carried out by the registered manager. These covered areas such as care plans, medicines, health and safety and infection control. We found some audits were effective and identified areas for improvement. For example, where care plans had needed reviewing and updating, they had been. Staff personal files had been audited and where particular training was going to expire, arrangements had been made for staff to attend refresher courses.

However, the audits completed had not identified any of the areas of concern found during our visit regarding the safety and maintenance of the premises and ensuring people were protected from the risk of harm. Consequently there had been a fundamental failure to manage areas of the service leading to people sometimes receiving poor quality and unsafe care. The provider had a lack of oversight into the continuous monitoring of quality and safety at the Anchorage to prevent the safety concerns we found. Although the area operational manager took immediate steps to safeguard people and improve aspects of the environment, these actions were in direct response to our feedback rather than proactive and continuous improvement.

We looked at the cleaning records for the service and found that staff had not completed the cleaning schedules as required. The registered manager had failed to check the cleaning schedules to ensure they were being completed. The registered manager failed to complete environment checks to ensure the home was safe and compliant to the infection control policy. The systems in place to ensure the cleanliness of the environment had not been effective in ensuring people received care in a hygienic and safe setting.

Safety incidents were not always appropriately reported, investigated or managed to prevent further incidents from occurring. For example, staff were not always recording incidents where people had fallen. We found the ones that had been recorded had not been analysed. This meant these incidents were not investigated or monitored by the provider to reduce the risk of further incidents from occurring. Lessons were not learnt in response to incidents.

We discussed our concerns with the area operations manager, who acknowledged improvements in the monitoring of safety and quality were required. The area manager provided evidence that she had taken steps to address some management failures in the home prior to our visit and had an action plan to improve the standards.

Following the inspection we were sent evidence that new robust cleaning schedules had been implemented with immediate effect. The area manager had also implemented a new managers monthly audit with immediate effect which incorporated all the Health and Social Care Act Regulations we inspect. This was a

much more thorough audit which included looking at safety accident and incidents, analysing the incidents for trends and checking the environment. At our next inspection, we will assess how changes to their quality assurances processes have been embedded to ensure improvements are made and sustained.

Staff said that since the new provider took over in October 2017, they received good support from the management team. They told us the provider and registered manager were approachable and valued them for the work they did.

The area operations manager said, "I am always available, even out-of-hours. The organisation is very supportive." Staff supported these comments and confirmed management were contactable and responded when staff needed support.

Staff communicated information about people's needs effectively. Staff beginning work had a handover from staff who had worked the previous shift. The handover kept staff up to date with any changes in people's needs or how their support was provided. Staff were expected to read the communication book at the beginning of each shift to make themselves aware of any updates or changes to people's care.

Staff met regularly as a group and used these meetings to review people's needs and to consider how the support they received could be improved. Staff told us the management team encouraged their suggestions to improve the service people received and valued their contributions. Staff also used team meetings to discuss the provider's values, such as promoting dignity in people's care and ensuring people were valued as individuals, and how these could be implemented in practice.

Staff had worked together to set team goals which included promoting inclusion and the provision of high quality personalised care. One staff member said, "We use the mum test that you gauge services by. Would we want our family to live here, would I want to live here?"

The provider used a variety of ways to keep staff knowledge up to date and to enable them to gain insight into the experience of the people they supported. For example at staff meetings they had used quizzes to test staff knowledge of MCA/DoLS, medicines management and safeguarding. Staff reported they found these sessions useful as they were relevant and practical. Staff had experienced different aspects of care to understand the experience of the people they cared for.

People, relatives and other stakeholders had opportunities to give their views about the service and these were listened to. The provider carried out an annual survey of people, relatives and other stakeholders such as professionals with an involvement in people's care. The results of the most recent annual survey all provided positive feedback about the service, including the care people received and the skills and attributes of the staff team.

Staff worked well in partnership with other agencies to ensure people received the care and support they needed. The staff team had established close links with the community learning disability team to support some people.

People's personal information was kept confidential. Staff maintained accurate records for each person about their needs and the care and support they received. The provider knew which events should be notified to CQC and had informed the Commission and other relevant agencies about notifiable events when necessary. The provider's quality monitoring audits included checking that CQC had been informed of any notifiable events.