Ashking House Limited

Ashking House

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

The inspection took place on 30 May 2018 and was announced. At our last inspection on 18 and 19 February 2015, we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Ashking House 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.

Ashking House provides accommodation and personal care for up to seven people in one two-storey building. At the time of our inspection there were seven people living at the home, all of whom had a learning disability. The home is managed and run by Allied Care Limited, a large organisation who owns services throughout the UK.

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." Registering the Right Support CQC policy.

There was a manager in post who had recently started running the service. They had applied to be registered. 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.

There were systems and processes in place to protect people from the risk of harm. There were enough staff on duty to meet people's needs.

Checks were carried out during the recruitment process to ensure only suitable staff were employed.

There were arrangements in place for the safe management of people's medicines and regular checks were undertaken.

The service was clean and had effective systems to protect people by the prevention and control of infection.

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.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were supported by staff who were suitably trained, supervised and appraised.

Staff were caring and treated people with dignity and respect. Care plans addressed each person's individual needs, including what was important to them, and how they wanted to be supported.

People were involved in undertaking activities of their choice. People were cared for in a way that took account of their diversity, values and human rights.

Where appropriate, people's end of life wishes were discussed and recorded.

People living at the home, their relatives and stakeholders told us that the management team was approachable and supportive. People and their relatives were supported to raise concerns and make suggestions about where improvements could be made.

The provider had effective systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed.

The registered manager kept themselves informed of developments within the social care sector and cascaded important information to the rest of the staff team. This helped ensure that staff were informed and felt valued.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Safe.	**Good**
Is the service effective? The service remains Effective.	**Good**
Is the service caring? The service remains Caring.	**Good**
Is the service responsive? The service remains Responsive.	**Good**
Is the service well-led? The service remains Well-led.	**Good**

Ashking House

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 comprehensive inspection took place on 30 May 2018 and was announced. We gave the provider 24 hours' notice because the service is small and we needed to make sure someone was available to assist us with the inspection. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider had 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.

During our visit, we spent some time observing staff delivering care and support to people, to help us understand people's experiences of using the service. We also looked at records, including care plans for four people, four staff records and records relating to the management of the service. We spoke with four people who used the service, three relatives, the manager, the area manager, the chef and three care staff. We also spoke with two healthcare professionals who were visiting at the time of our inspection. Following our inspection, we received feedback from one social care professional who was involved with the service.

Good

Is the service safe?

Our findings

Staff we spoke with indicated that staffing levels were not always adequate to enable them to support people and meet their needs. Their comments included, "No, I don't think it's enough. Sometimes [person] keeps calling me and it takes time for me to go to her. We used to have four staff, now three", "We used to have another staff member. When it comes to quality of care we can't support people, especially when it comes to personal care", "We are short staffed and we are sometimes left with two staff. We expect [manager] to stay with us, but [they] are not doing that. Leaving two staff and not helping on the floor" and "Very stressful. We need to ask them to wait. It was four staff and now three and sometimes two when someone is sick."

Most people and relatives told us they were happy with the staffing levels. However, one relative stated, "I think they could do with an extra one. Sometimes there's only two on and most of them need two carers. One has to do the cooking. They work hard here."

We raised this with the manager, who told us that in the past, the service had been over-staffed and staff had become used to this. They explained that staffing levels were calculated according to people's needs and therefore, the number of staff had to be reduced from four to three per shift. This had caused some dissatisfaction among the staff team.

We viewed staffing rota for the last five weeks and this confirmed there were always the numbers of staff as indicated by the manager, on duty to provide care and support to people. There were also ancillary staff available, such as a chef and cleaning staff. One staff member told us, "Staffing is now more stable. We rarely need to use agency. Residents are more settled because we know them better." We observed that people did not have to wait when they needed assistance, and there was a calm and unrushed atmosphere. This indicated that the staffing levels were adequate on the day of our inspection.

People and relatives we spoke with indicated they felt safe living at Ashking House. One relative told us, "Everything's gone really well. I'm impressed with everything. We believe [family member] is safe" and another said, "Yes [it is safe]. There are people with [family member] all the time."

Recruitment practices helped ensure staff were suitable to support people. These included checks to ensure staff had relevant previous experience and qualifications. Checks were carried out before staff started working at the service. This included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check was completed.

Arrangements were in place for the management of people's medicines. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines cabinet (within a locked room). This assured us that medicines were available at the point of need and stored securely.

Medicines were administered by staff who had been trained in medicines administration and there were regular medicines audits. People received their medicines as prescribed, including controlled drugs. However, we looked at all the MAR charts and found two gaps in the recording of medicines administered. We discussed this with the staff member in charge of medicines on the day of the inspection and the manager who were able to provide us with evidence that the two medicines had been administered and this was a recording error. We witnessed the manager having a telephone conversation with the staff member who had not signed the record inviting them to a meeting to discuss the error.

Running balances were kept for medicines that were not dispensed in blister packs. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example, one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the person.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. We saw PRN protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. This also included information such as risk assessments with certain medicines that had a sedating effect.

Staff said they received training in safeguarding adults and training records confirmed this. The service had a safeguarding policy and procedure and a whistleblowing policy in place and staff had access to these. The provider had raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They had also notified the CQC, as required, of allegations of abuse and serious incidents. The manager worked with the local authority's safeguarding team to carry out the necessary investigations. Management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. Records we viewed confirmed this.

Where there were risks to people's safety and wellbeing, these had been assessed. Environmental risk assessments were in place and included food safety, clinical waste, water and electricity, medication and communal areas such as bathrooms and toilets. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. Risks identified included moving and handling (rising from a chair, walking, falls and transfers), profiling beds, hoisting, choking and behaviours that challenge. Each risk was analysed and included guidelines for staff to understand how to support the person effectively. For example, for a person at risk of choking, we saw, "Soft moist food to be cut up into small pieces" and "[Person] to remain upright for 30 minutes post meal." There was also information about different food textures and recommendations to ensure safety.

There were measures in place for another person who was at risk of falling and scalding when taking a shower. These included, "Water temperatures to be taken before shower and weekly checked done" and "All staff to ensure [Person] is with staff at all times in the shower room."

There were protocols in place to respond to any medical emergencies or significant changes in a person's wellbeing. Emergency contact numbers were accessible. Senior staff were available to help and support the staff and people using the service in case of an emergency.

Incidents and accidents were recorded and analysed by the registered manager and included an action plan to address any issues or trends identified. We saw evidence that incidents and accidents were responded to appropriately and care plans and risk assessments were updated accordingly. Lessons were learnt and appropriate action was taken to prevent reoccurrence. For example, when a person had fallen, they had

been referred to physiotherapy to have their mobility assessed during transfers. We saw that staff had updated the person's risk assessment accordingly.

The provider had a health and safety policy in place, and this was made accessible to staff and people living at the service. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. We saw evidence that all areas were regularly checked and any requirements were actioned appropriately. There were regular safety checks of equipment which included kitchen equipment and moving and handling equipment such as hoists and slings. People were protected from the risk of infection and staff used appropriate protective equipment. All areas of the home were odour-free, clean and tidy and free of any hazards and all cleaning products were safely locked away.

The service had taken steps to protect people in the event of a fire, and we saw that a general fire risk assessment was in place. We saw evidence that checks of all fire safety equipment were carried out regularly. These included the fire alarm system and fire extinguishers. The provider carried out regular fire drills and fire alarm tests and staff were aware of the fire procedure. People's records contained personal emergency evacuation plans (PEEPS). These included appropriate action to be taken in the event of a fire according to people's abilities and needs.

Good

Is the service effective?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that where possible, people had been involved in discussions about their care and support. Assessments included background information which helped staff understand each person and their individual needs. Relatives thought that the staff team provided a service that met people's individual needs. A healthcare professional felt that the home managed people's needs well.

People were supported by staff who had appropriate skills and experience. All staff undertook training the provider considered mandatory such as health and safety, safeguarding, fire safety and infection control. They also undertook training specific to the needs of the people who used the service which included Mental Capacity Act 2005 (MCA), positive behaviour support, epilepsy, privacy and dignity and challenging behaviour. All staff employed at the service had achieved a recognised qualification in Health and Social Care, and had achieved or were undertaking the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Training records confirmed that staff had completed the training identified by the provider to deliver care and support to the expected standard.

People were cared for by staff who were suitably supervised and appraised. The manager acknowledged that some supervisions were late and they were organising a schedule to ensure that all staff received regular supervision. staff we spoke with told us that they had received supervision and records we viewed confirmed this. They said that this had provided an opportunity for them to address any issues and to receive feedback on good practice and areas requiring improvement. The area manager added that their doors were always open and staff could come and speak with them anytime.

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 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. We found that the provider understood the principles of the MCA and had followed its requirements. The manager had identified people for whom restrictions had to be put in place and had taken appropriate action to make sure that where the restrictions amounted to a deprivation of liberty, they had made the necessary applications for DoLS authorisations in people's best interests. This included people who were at risk if they went outside by themselves.

Staff employed at the service had received training in MCA and DoLS. Staff we spoke with demonstrated a

good understanding of the MCA and DoLS. They were able to provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interest if they lacked capacity. We saw information about the MCA in an easy-read format in a file, however the manager was unsure if people who used the service had been made aware of this by the previous manager. They added that they would ensure the document would be discussed in the next residents' meeting and would display it in various areas of the home.

The staff recognised the importance of food, nutrition and a healthy diet for people's wellbeing and as an important aspect of their daily life. People told us they enjoyed the food they ate and were given choice. Their comments included, "I can have apple juice any time I like", "Always delicious. Fish and chips on Fridays" and "If [staff member] wants a drink, I make her a tea. They say, [Person's name], you're doing a fine job."

People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plan. Nutritional care plans contained guidelines for staff to ensure they understood and met people's individual needs. For example, "[Person] is able to eat and drink independently and may need reminding not to put too much in [their] mouth" and "[Person] is encouraged to eat a low sugar and low carbohydrate diet to help control [their condition]." Where able, people were encouraged and supported to make a drink or a snack in the kitchen. The kitchen had an area adapted for people who used a wheelchair, which included a low work surface.

The chef displayed a good knowledge of people's nutritional needs and preferences. There was a 'snack menu' devised for a person who had dietary needs, and alternative cultural choices were available. Menus were created following meetings with people. People who wished for different food were catered for. This ensured people's preferences including their diverse and cultural dietary needs were met. The manager told us, "We have meals from different countries once a week." The menus we viewed confirmed this. There were posters displayed in the kitchen with information about healthy food, such as fruit and vegetables, and important information such as 'Dysphagia warning signs'. Dysphagia is the medical term for swallowing difficulties. All food was correctly stored and fridge temperatures checked every day.

People received the support they needed to stay healthy. One relative told us, "The care is of high standard and that's the most important thing." Records showed that people's health needs were monitored and any concerns were recorded and followed up. There was evidence that people were referred to the relevant healthcare professionals when needed to ensure they received appropriate treatment. On the day of our inspection, nurses were visiting a person using the service. They told us, "We don't visit very often. This is a good thing as it shows there is no issue about pressure sores." When asked the reason for their visit, they stated, "They just needed advice about someone's skin. But there is nothing to worry about. It just goes to show how careful they are at checking and calling us." Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This helped to ensure that the service was meeting people's health needs effectively.

The environment was designed to meet people's needs. Specialised equipment such as hoists and accessible baths and showers were available. Corridors were bright and spacious and displayed artwork created by people who used the service. People's bedrooms were decorated in colours chosen by them. Each bedroom was personalised and reflected people's choices and interests. Communal areas displayed photographs of events that had taken place at the home and outings. There was a sensory room on the ground floor which contained a variety of activity materials, and which people could access to play music or relax. The garden was well maintained and accessible to people who used the service. There were tables,

chairs and benches around and an area for people who wished to smoke.

Good

Is the service caring?

Our findings

People and relatives told us, and we saw people were treated with kindness, compassion and dignity. One person told us, "the staff are good to us" and "yes, they respect my privacy." Relatives' comments included, "Yes they do [respect person's privacy]. They give him a lot of choices as well", "[Staff member] is lovely. [Family member] and [staff member] get on really well together", "When [Family member] is not been well they are very attentive", "Very impressed. We chose it out of a number of homes because of the care and attention there", "Yes, they do their best. They cover her up when they shower [Family member]" and "I think they've got good staff at the moment." A healthcare professional confirmed this and said, "It's lovely. They're very caring with the clients" and another stated, "We can see the staff have a great rapport with people. Laughing and joking."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. It was clear from all the staff we spoke with that respect, dignity and personal choice were values they all shared and which they were proud of. We saw a range of thank you cards and letters from friends and relatives. Some comments we saw included, "Big thank you for all you've done", "I know [family member] is happy and enjoying interacting with you. I can rest assured [they] are well looked after and happy with you."

Staff displayed a gentle and patient approach throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. They were attentive to people's needs throughout the day and responded promptly. For example, when a person using the service verbalised "Tea, tea", a staff member acknowledged their request and immediately went out of the room. They returned a short time later with a beaker of tea and said, "Here is your tea, [Person's name]."

We observed some people being moved by staff in their wheelchairs. We noticed that staff communicated appropriately with people, ensuring they were happy to be pushed before moving them. They also encouraged people to remain as independent as they could be, for example encouraging one person to mobilise in their wheelchair by themselves. People were supported to maintain their bedrooms if they were able. For example, one person liked polishing their bedroom and staff encouraged them to continue with this activity.

Staff ensured they respected people's dignity. For example, during mealtime, people were assisted by staff who did not rush them. They communicated with people appropriately and respectfully. They ensured they wiped people's mouths discreetly with disposable cloths. We saw that when a person dropped some tea on their protective apron, staff promptly wiped this and provided the person with a clean apron.

Staff demonstrated a good level of engagement with people. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day. Staff consulted people about what kind of music they wanted to play. One person went to choose a CD with a member of staff and clearly enjoyed listening to this.

People's religious and cultural needs were respected, and care plans included details of this. The kitchen staff told us that different cultural diets were catered for. The menus we viewed confirmed this.

Good

Is the service responsive?

Our findings

People told us they knew how to complain and added they did not have any concerns. One person told us, "I've never complained. Definitely not. Always happy yes." Relatives agreed and said, "I haven't complained. I've brought up concerns. When I have done that within 24 hours (area manager) has answered. Happy with response yes" and "I haven't got any complaints."

The service had a complaints procedure in place and this was available to people who used the service and relatives. A record was kept of all the complaints received. Each record included the date, nature of the complaint. However, we saw that one complaint received in March 2018 did not include actions taken and what was in place to prevent reoccurrence. We discussed this with the area manager who told us they had discussed the concerns with the relatives over the telephone, and actions had been agreed verbally. However, no records were maintained to show how the provider dealt with the complaint in line with their complaints procedure. We discussed the concerns with the relative who had complained, and saw that they were satisfied with the response they received. The manager and area manager told us they would ensure that all actions are recorded and kept with the original complaint in future.

People and relatives we spoke with were happy with the activities organised at the home. One person told us, "I go to Lakeside. We all go there and pick up food for a party and Christmas stuff. You can get the James Bond DVDs there." Relatives comments included, "They have aromatherapy come in and they do have people in and out for different things", "Sundays, a family friend picks him up and takes him to church", "They've got a bus. If the minibus is alright and if there's enough staff and a driver. We've asked for 2 members of staff to take him swimming. It's better than it was but not as much as we want", "[Family member] likes going out. They went to Southend the week before last. It depends what mood he's in. I think he's content to be there and talk to other residents" and "They have entertainment and they take [Family member] shopping and to the pub."

Staff told us they ensured there were opportunities to provide activities outside the home environment and within the community whenever possible. People were consulted about what they liked to do and any outings they wished to take part in. We saw evidence of these discussions in the minutes of meetings and people's care plans. For example, one person had expressed their enjoyment of certain television programmes and going shopping. Staff also added that they celebrated religious events throughout the year.

An external therapist visited people weekly and were visiting people on the day of our inspection. We saw that people seemed to enjoy the one to one interactions and responded positively to these. The therapist told us, "Staff are very attentive here, and quick to respond to people's moods. They give me information I need to know. They check with people before I go to them. Whenever I notice something wrong, I pass it on and it is addressed."

Care plans were comprehensive and contained detailed information about the care needs for each person and how to meet these. Each person's care plan was based on their needs, abilities, likes, dislikes and

preferences and included personal care, communication, mobility and dexterity, medicines, medical history, daily living and social activities. They also included a snapshot of each person's condition, their likes and dislikes such as preferred activities and food. The snapshots also included 'What those who know me like about me'. For example, '[Person] is very helpful', '[Person] is a sociable person' and '[Person] loves animals and dogs'.

Each section of the care plan was divided in three areas such as 'What is happening now', 'What are your hopes/what would you like to achieve' and 'Our plan to support you to achieve your hopes'. Each section was detailed and included information gathered from the pre-admission assessment and reviews carried out with the person and others who knew them well. Throughout the care plan, crucial information was typed in darker font to ensure it was seen immediately. For example, '[Person] must be checked every 20 minutes during the night'. Care plans included a separate document entitled 'My plan' document. This was in a pictorial format and included, 'What do I want in my life', 'What are my hobbies' and 'What do I like to do on my birthdays'.

Staff took time to understand and meet people's individual needs. For example, one person who used the service liked a fictional character and we were shown a photo of the person dressed as this character. Staff told us that the manager had taken them to a particular themed event in London for a birthday surprise and had supported the person to dress up as the character. We saw that the person's room was personalised and included painted murals of the character on two walls. We saw that the person appeared happy to share this with us.

Where appropriate, staff discussed end of life care with people and their family. However, staff told us they were mindful that most people and relatives did not wish to take part in these discussions. The manager told us they were aware that this was an important subject and would ensure that appropriate discussions took place as needed.

Good

Is the service well-led?

Our findings

People and relatives we spoke with were complimentary about the staff and the manager. They said they were approachable and provided a culture of openness. Relatives' comments included, "The manager is approachable, so far. Everything she has said, she has done", Everything they were talking about at the annual review was so good. I think they are well looked after and staff are doing a good job", "They're constantly looking to update the property", "[Manager] is lovely", "The manager makes sure [family member] is looked after. They do their best. It's not perfect" and "[Manager] is nice. I have got faith in them. Long may it continue."

The manager had started working at the service in January 2018 and had applied to be registered with the Care Quality Commission (CQC). They had a background in physiotherapy and held a qualification in health and social care. They were supported by an experienced area manager who had worked for the provider for 18 years. The manager kept themselves abreast of developments within the social care sector by attending provider forums, conferences and seminars organised by the local authority, as well as reading publications and consulting relevant websites.

The area manager made regular visits to the service and worked closely with the manager. They undertook bi-monthly quality visits of the service. These included checks of the building, the environment, issues regarding people who used the service and staff and documentation. The manager told us that they felt well supported by the area manager and communication between them was good. There were contingency plans in place in case of an emergency or any events that may impact on the smooth running of the service. For example, pandemic flu, flooding or major incidents. This helped ensure that staff were confident about taking appropriate action.

Most of the staff we spoke with told us they were happy with the management team. Their comments included, "There's been a lot of changes with managers. At the moment, we're alright with the support from management", "I like working here", "Manager is new. They need to learn more. They need to know the clients. It's all paperwork", "I really enjoy it. No bad side" and "I am happy."

The provider had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks, health and safety checks and care records. Audits were evaluated and where necessary, action plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were regular. Where areas for improvements had been identified, we saw that action had been taken and signed off. However, we saw that actions on some areas for improvements were still ongoing and had not been signed off. We discussed this with the area manager who told us they would ensure this was checked and signed off without delay.

Staff told us they had regular meetings and records confirmed this. The items discussed included care plans, audits, environment updates, ideas for improvements and communication. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any

lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. There were also senior staff meetings, and meetings for people who used the service and their relatives. Some of the subjects discussed included complaints and concerns, improvements planned and ideas, mealtimes and activities. This indicated that people, relatives and staff were involved in the development of the home and felt valued.

People and their relatives were encouraged and supported to feedback about the service through quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. We saw that the results indicated that they were happy with the service and the care provided.

The provider carried out yearly satisfaction surveys of staff and external professionals to gather their feedback about the service and identify any areas for improvement. The October 2017 staff surveys indicated that staff had expressed their dissatisfaction with staff turnover and staffing levels. Questionnaires were analysed by the registered manager and actions were taken where concerns were raised. We saw that concerns were discussed in staff meetings. The manager and area manager told us they were aware that some staff were unhappy and were supporting them during individual supervision and staff meetings.

People using the service were given 'service user guides' in an easy read format. These included information about the provider, photographs of their bedroom and other areas of the home, information about CQC and how to make a complaint, and terms and conditions.