Harbour Care (UK) Limited

Anchor House

Inspection report

1 Evering Avenue
Parkstone
Poole
Dorset
BH12 4JF

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30 August 2016

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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

Anchor House is a care home in a suburban, residential area for up to seven people with learning and physical disabilities. Individual bedrooms are situated on the ground and first floors, which are connected by a staircase and a passenger lift. Some bedrooms have ensuite shower room facilities. There is a lounge, kitchen, wet room and bathroom on the ground floor. The paved garden to the rear of the property and the front door are wheelchair accessible. There is some on-site parking, with an on-off drive so that people can access vehicles directly outside the front door.

At our last inspection in October 2015 we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued warning notices in relation to person-centred care, safe care and treatment including the management of medicines, and governance and record keeping, requiring the provider to meet the regulations by 29 January 2016. We also required the provider to take action to meet the regulations in relation to consent, the cleanliness of the premises, and notifying the Care Quality Commission (CQC) of significant incidents. We rated the service 'inadequate' in relation to whether the home was safe, responsive and well led. We rated it as 'requires improvement' in relation to being effective and caring. The overall rating for the service was 'inadequate' and we placed the home in special measures.

Following that inspection, the provider sent us an action plan, which stated the action they would take to meet the warning notices by 29 January 2016 and the other required improvements by 2 April 2016.

This comprehensive inspection took place on 26 and 30 August 2016. The first day was unannounced. There were six people living there when we visited. We found improvements had been made to meet all the relevant regulations.

There was a registered manager, who had registered with CQC since the last inspection. A registered manager is a person who has registered with 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.

People received the care and support they needed from staff who understood their needs. Care plans were regularly reviewed, up to date and personalised to the individual. They contained thorough and clear instructions for staff. People's individual risks were identified and assessed, and were managed through people's care plans. Where necessary, health professionals were consulted for advice in devising care plans, for example, in relation to specific moving and handling or nutritional needs.

Where there was concern that people might not be able to give valid consent to aspects of their care, their mental capacity to do so was assessed. If people were found to lack mental capacity in relation to decisions about those areas of care, staff made best interests decisions on their behalf in consultation with their family members and health professionals.

People's health was monitored and they were supported to see healthcare professionals when needed, including for dental and optical care.

People had access to meaningful activities at home and in the wider community. Staff regularly supported them to go out.

Peoples' medicines were managed and administered safely. Medicines were stored securely and medicines records were complete. People had medicines when they needed them.

The premises and equipment were kept in good order. Equipment such as hoists and beds was inspected and serviced regularly. The house was visibly clean and a programme of redecoration was under way. People and their relatives had been consulted about this and their preferences had been heeded.

Accidents and incidents were recorded and were reviewed by the registered manager for action necessary to keep people safe. The provider monitored them for any trends that might suggest further changes in practice were necessary.

Staff understood their responsibilities in relation to protecting people from abuse. They were regularly reminded of these through staff meetings and supervision.

Staff morale had improved considerably since the last inspection. There were enough staff on duty to meet people's care needs. Staff were well supported through training and supervision to be able to perform their roles safely and effectively. The staff we spoke with expressed confidence in the registered manager's leadership.

Quality assurance systems were in operation to maintain and improve the quality of service provided. People and their relatives were consulted regarding their care and how the service was run. There was a programme of audits within the service and from the provider's management team. Any shortcomings or areas for improvement were addressed.

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.

Medicines were managed and administered safely.

The premises were visibly clean.

The premises and equipment were well maintained.

Is the service effective?

Good

The service was effective.

Staff were supported through regular training and supervision.

People's rights were protected because staff followed the principles of the Mental Capacity Act 2005.

Where possible, people were supported to make choices about what they ate and drank.

Is the service caring?

Good

The service was caring.

The home had a welcoming and relaxed atmosphere.

People were treated with dignity and respect by staff who knew them and understood their needs.

Is the service responsive?

Good

The service was responsive.

People's care plans were detailed and up to date, containing clear information about the care and support they needed.

People received care and support as specified in their care plans.

Complaints information was available for people in an easy read format.

Is the service well-led?

Good

The service was well led.

The registered manager and staff had worked since our last inspection to create an open, positive culture.

Quality assurance systems operated effectively. Action was taken if shortcomings were found.

Accurate and complete records were maintained.

Anchor 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 inspection was undertaken by one inspector on 26 and 30 August 2016. The first day was unannounced. We met everyone living at the home and spoke with one person. Because everyone else was not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk to us. We also spoke with the registered manager, her manager and three members of staff. We reviewed two people's care and support records and medicines administration records, three staff files, staff supervision and training records and other records relating to how the service was managed. These included maintenance records and quality assurance records. Following the inspection we spoke with three relatives of people who lived at the service.

Before our inspection we reviewed the information we held about the service. This included notifications from the service about significant incidents and feedback from commissioners of services. We had also received a Provider Information Return (PIR) from the service. 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.

Good

Is the service safe?

Our findings

A person and relatives we spoke with told us they felt people were supported safely at Anchor House.

At our inspection in October 2015 we found that people did not always receive their medicines safely. There were discrepancies between the amounts of medicines in stock and what was recorded as being in stock. Medicines audits were not conducted regularly. Medicines administration records contained gaps where staff should have signed to record medicines and in some instances medicines had not been given as prescribed. Staff competency in handling medicines had not been assessed as it should have been. People were at risk of not receiving pain relief when they needed it. We issued a warning notice in relation to safe care and treatment, including the safe handling and recording of medicines, which required the provider to meet the relevant regulation by 29 January 2016.

At this inspection, we found peoples' medicines were managed and administered safely. Medicines were stored securely. We checked the amount of a particular drug in stock, which tallied with the records for this medicine. Medicines administration records (MAR) contained information about people's allergies and were filed behind a laminated photograph of the person. They were complete, indicating that either people had received their prescribed medicines or there was an explanation for why medicines were not given on particular occasions. Most of the people living at Anchor House were not able to say they were in pain, but staff were familiar with how people communicated when they were in pain or feeling unwell and might need pain relief. This information was included in people's care plans, and there was clear information in care plans about medicines prescribed 'as required' so that staff knew when and how to administer these.

Action had been taken to help ensure that medicines were managed safely. The pharmacy had audited the service earlier in 2016 and issues identified by that audit had been acted upon. For example, the registered manager had nominated a second member of staff to take responsibility for ordering and signing in medicines in the absence of the designated medicines lead. There were also monthly medicines audits by the service, with any gaps or discrepancies identified investigated and followed up with the staff concerned. Staff were trained periodically in handling medicines and their competency was assessed regularly.

Some people had their medicines administered with certain drinks or food according to their preference, as opposed to the medicines being concealed because the people were unwilling to take them. By the end of the inspection the registered manager had obtained confirmation from a pharmacist that the medicines concerned were safe to administer in these particular ways and would not be affected by the food or drink. As the people concerned lacked the mental capacity to consent to taking medicines, best interests decisions regarding administering medicines had been taken in consultation with people's health professionals and families, in line with the requirements of the Mental Capacity Act 2005

At our inspection in October 2015 we found that people's care was not always safe, as their health needs were not always identified and acted upon. Risk assessments and care plans had not been regularly reviewed and kept up to date.

At this inspection, we found that risks to people's personal safety had been assessed and were addressed through people's care plans. These were kept under review. Risk assessments were in place for areas such as moving and handling, the use of bed rails and risks posed by particular health conditions such as epilepsy. People also had personal emergency evacuation plans ('PEEPS') so that staff and emergency services personnel would be able to support them to safety in event of fire. Copies of these were kept in a place that would be easily accessible to the fire and rescue service. A 'nurse call' alarm system was being installed during the inspection, to assist people or staff to call for help in an emergency.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. Accidents and incidents were recorded by staff and reviewed by the registered manager for any further action that was necessary. They were logged on the provider's computer system and analysed by the provider for trends that could identify the need for additional monitoring or changes that were needed at the service.

At our inspection in October 2015, we identified concerns regarding the cleanliness of the premises and the regular inspection, servicing and maintenance of equipment, notably lifting equipment and beds.

At this inspection, we found the house in a visibly clean condition. All areas smelt fresh and were kept in good order and free from clutter. People needed considerable support to keep the house clean or for staff to do this on their behalf. Cleaning rotas were in operation and the importance of keeping on top of cleaning had been emphasised at staff meetings. Housekeeping was monitored monthly. Staff told us their keyworker responsibilities included ensuring that people's rooms were clean and in order.

The premises and equipment were kept in good order. Lifting equipment, including the passenger lift and hoists, had been checked and serviced by a specialist contractor within the last six months. Beds had also been maintained by a contractor. Much of the house had been redecorated since the last inspection, with plans for the remainder to be attended to in the coming months. This included plans to renovate the downstairs wet room, which had some cracked tiles that would be difficult to keep clean. The risk posed by legionella, bacteria that can live in the water system and cause serious illness, had been assessed by a specialist contractor and measures were taken to control this, such as cleaning and descaling showers regularly. A gas safety certificate had been obtained within the past year. Fire alarms and equipment were regularly checked and were inspected and serviced periodically.

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and were aware of how to act on these to keep people safe. Telephone numbers for reporting concerns, both within the provider's organisation and to outside agencies concerned with safeguarding people, were readily available for staff. Staff were reminded of their responsibility to report concerns at staff meetings and during supervision. There were controls, including regular balance checks, on money held on people's behalf. We observed staff count the cash held for two people and saw that this was consistent with the amount recorded. A relative commented that they did not always receive the regular updates that had been promised in relation to their family member's bank account, but that they had previously not received these at all.

People were supported by sufficient, regular staff who knew them and had the right skills and knowledge to meet their individual needs. A number of staff had left and joined the service since our last inspection, and all staff vacancies had been recruited to. Staff worked 12 hour shifts, with 4.7 staff on duty during the day, and one waking and one sleeping member of staff at night. The staff we spoke with confirmed that staffing levels were sufficient for them to meet people's care needs and ensure their safety, although this could sometimes be challenging when the service was very busy, particularly on mornings when a number of

people were going out. Staff were busy on one of the mornings of the inspection, with people getting ready to leave the house and another person needing support following a seizure. However, they remained calm, attending promptly when people needed assistance and taking time with people to provide the support they needed, rather than hurrying them.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, proof of identity, proof of entitlement to work in the UK, records of interview, appropriate references and occupational health clearance. Criminal records checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with in a care setting. Where necessary, the registered manager had reviewed adverse findings from pre-employment checks, risk assessed these and obtained additional evidence of the staff member's good character and suitability for care work.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff. For example, a relative told us, "[Person] couldn't get better care" and described the staff as "an excellent team".

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.

At our last inspection in October 2015, we found that suitable arrangements were not operating to act in accordance with the Mental Capacity Act 2005. Where there was doubt about people's ability to consent to particular aspects of their care, their mental capacity had not always been assessed. Where people were assessed as lacking capacity to particular aspects of their care, best interests decisions had not always been undertaken as to the care that was the least restrictive possible and in the person's best interests.

At this inspection we found that people's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. Throughout our visit, we observed staff explaining to people what they were proposing to do and checking people were happy for this to happen. They watched for signs that indicated whether people were happy with this before assisting them. Where there was concern about people's ability to give consent to particular aspects of their care, their mental capacity to consent to this had been assessed. Where people were assessed as lacking mental capacity, staff made best interests decisions regarding the care that should be provided. They consulted as necessary with people's relatives and healthcare professionals in order to reach these decisions. Mental capacity assessments and best interests decisions for the people whose care we reviewed covered areas including providing care, administering medicines, the use of wheelchair straps and bedrails, the use of seizure monitors, managing finances and taking photographs.

People can only be deprived of their liberty so that they can 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). The registered manager had identified a number of people who they believed were being deprived of their liberty. They had applied to the relevant supervisory body to authorise these deprivations of liberty, and were awaiting these to be assessed. They were aware of the requirement to notify CQC of the outcome of the assessment once it had taken place.

Staff were aware of people's dietary needs and preferences. The person we spoke with told us they liked the food and were able to make choices about what they had to eat. People's needs and preferences were clearly recorded in their care plans and this information was readily available for staff when they were preparing food. Since the last inspection, the service had introduced a large pictorial menu board in the kitchen, with photographs of different meals and sorts of food to help people make choices about what they have to eat and drink. We saw staff supporting people to make food choices.

The service monitored people's weight regularly, in order to take action if there were unplanned weight changes, such as seeking a referral to a dietician. Staff had very recently been trained to use a recognised malnutrition screening tool, which took into account people's body mass index and gave a clearer indication of the appropriate action to take if people's weight changed.

People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their nutrition or their ability to eat and drink. Some people were unable to swallow food and were fed through a PEG tube directly into their abdomen. There were nutrition plans on file from specialist health professionals explaining what the person should have and when. Staff supported people with PEG feeding and care only after receiving training and having their competence assessed.

People living at the service had complex health needs and were supported to manage and maintain their health. Their health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals who were involved with their care. For example, between the first and second day of the inspection a person experienced several seizures and staff had requested the health professionals who oversaw their epilepsy to review the person. Care plans, including health action plans, were in place to address people's health needs and these were regularly reviewed. Records confirmed people had access to dental and optical care and could attend appointments when required.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff confirmed they had access to the training they needed. Staff had the training they needed when they started working at the home, and were supported to refresh this at intervals. Most staff training was up to date and where it was not, arrangements had been made to provide it. Training included basic life support, moving and handling people, health and safety, infection control, food safety, fire safety, the Mental Capacity Act 2005, DoLS, and safeguarding adults and children. Staff also had regular training in epilepsy awareness and rescue medication for epilepsy.

Staff were well supported to perform their roles. They had annual appraisals and regular supervisions (one to one meetings) with their line manager to discuss their work. Staff confirmed supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had.

Good

Is the service caring?

Our findings

The home had a welcoming and relaxed atmosphere, even though staff were very busy at times. One person told us that they liked living at Anchor House and that the staff were "cool". We observed that staff had a good rapport with the person and spent time chatting with them informally.

People were treated with kindness and compassion. The relationships between staff and people receiving support demonstrated dignity and respect throughout the inspection. Staff respected and treated people as adults, also speaking about them in respectful manner. They supported people in an unhurried way, working at each person's pace rather than rushing them. People's privacy was respected and any intimate care was attended to discreetly, behind closed doors. People all had individual bedrooms and could spend time there on their own if they wished; staff recognised that some people enjoyed others' company whereas others often preferred to be quieter. Where people needed monitoring for safety, for example, if they were prone to having seizures, there were monitoring systems in place in their best interest so the person remained safe whilst having some privacy.

People received care and support from staff who had got to know them well and responded to their needs quickly. People's records included information about their personal circumstances and what was known about their preferences regarding their care and support. We saw a communication passport for one of the people whose care we reviewed. This person used their own non-verbal system of communication and the passport was there to help staff and other people outside the service understand how they communicated. Staff understood people's individual communication styles. They were able to explain to us how people communicated and were aware of what people's gestures and facial expressions might mean. For example, they recognised the signs that someone was tired following a seizure and suggested to the person that they might want to rest for a while on their bed. The person accepted this and staff assisted them to go to their room.

There was a range of ways used to make sure people and their relatives were involved in decisions about their care and support and people's preferences were respected. For example, people's and their relatives' preferences had been sought in relation to the renewed décor in communal areas and the renovation of the garden. Through consultation with their families, people's bedrooms had been decorated in a way that reflected their interests and preferences. We observed a staff member talking with a person about their plans for the weekend, when that staff member was rostered to support them on a trip out, encouraging person to think about what they would like to do.

People and their relatives were given the information and explanations they needed, at the time they needed them. A relative commented that they would be informed if their family member was unwell but that they would value more regular communication from the service. We observed staff explaining to people what they were doing and where necessary providing reassurance, for example, during moving and handling transfers or when people were having seizures. Easy read and pictorial information was available around the house. For example, there was a staff and visitors board in the hall, which had photographs of the staff and of who was present at a particular time. This was usually updated by one of the people who lived at the

service. In addition, there was a Your Voice board, with photographic rather than written minutes of the last meeting, so that people could see what had been discussed and what had been done about this.

Good

Is the service responsive?

Our findings

The person we spoke with said they got the support they needed and that their choices were respected, for example, about when they got up and went to bed. The relatives we spoke with were all complimentary about the way their family members' needs were met.

At our last inspection in October 2015, we found that care and treatment was not being assessed, delivered and monitored in a safe way. Care plans and records were not up to date and some care that people needed had not been delivered. We issued a warning notice in relation to person-centred care, which required the provider to meet the relevant regulation by 29 January 2016.

At this inspection we found that measures had been taken so that the service met the fundamental standards and people received the individualised care they needed.

Care plans were personalised and the examples seen contained information about the person's likes, dislikes and people important to them. Care plans were thorough, with clear instructions for staff, with details of people's daily routines. They covered areas including communication, pain and discomfort, eating and drinking, personal hygiene, moving and handling, and managing health conditions. There were hospital passport summaries on people's files, giving information about people's care needs and communication styles for hospital staff in the event that people were admitted to hospital. The service had liaised with health professionals where their advice and input was needed, such as requesting moving and handling guidelines for people with complicated moving and handling needs, and when sourcing specialist equipment, for example, a sleep positioning system for a person who needed to sleep in a particular position. Staff were able to tell us about the care and support people needed.

People had the care and support they needed. One of the people whose care we reviewed had a daily exercise regime designed by their physiotherapist, and needed staff to support them with this. At the time of the last inspection these exercises were sometimes being missed. The registered manager had since emphasised to staff the importance of the exercises and had arranged for the physiotherapist to show staff what to do. There were clear instructions for the exercises in the person's care records and the person's daily records showed the exercises were happening regularly. People with epilepsy had detailed care plans based on seizure management plans from health professionals. During the inspection, we observed that staff followed the instructions in two people's epilepsy plans to ensure the people remained safe during their seizures. Seizures were timed and recorded, and seizure records showed that paramedics had been called if seizures lasted longer than the time specified in the care plan. We reviewed the records of a person who had their food and drink through a special tube that had been inserted into their abdomen ('PEG feeding'). The care for the PEG site, such as water flushes and syringe changes, had been recorded at the intervals specified in the care plan, which was based on guidance from health professionals.

People's needs were reviewed regularly and as required and their care plans were updated accordingly. All of the care plans we saw had been updated to reflect people's current needs and outdated information had been removed. Following the last inspection, staff had liaised with people's families and health

professionals to establish the care people needed currently. As a result, out of date information had been taken out of their records. For example, a person had been reviewed by their hospital consultant who advised that their body brace was no longer necessary; this part of their care plan had been removed. Similarly, a person's GP had confirmed the person no longer needed their oxygen saturation monitored and the person's care plan had been updated accordingly.

Each person had a keyworker who involved them and their families in reviewing and updating their care plans, including exploring ideas for new activities. A keyworker is a named member of staff responsible for ensuring people's care needs are met, including spending time with them and supporting them with activities. People had their care reviewed each month by their key worker. This was part of the Your Voice process to involve people in decisions about their care. It looked at what people had achieved and the support they had needed during the past month, such as the arrival of new furniture and equipment and their involvement in cleaning their room. The review also considered plans for the coming month. For example, one person's review discussed plans for redecorating their bedroom, going to see their family and a forthcoming appointment to review their wheelchair. A photographic record of activities and events was included, to show what people had done and how they had been involved.

People were involved in a range of activities at home and out. People regularly went out with support from staff, both locally in their wheelchairs and further afield. For example, one person attended a regular work placement and others went to day centres. During the inspection, some people went for wheelchair walks locally and some went for a trip to the beach. Ideas for activities were discussed at people's Your Voice meetings and we viewed photographs of things that people had tried, including being involved in household tasks such as vacuuming their room. Shortly after we arrived on the first day of the inspection an aromatherapist made one of their regular visits, working with certain individuals who enjoyed this. A person browsed the internet on their laptop computer, using the Wi-Fi provided. Someone was also supported to care for their pet rabbit, who lived at the service.

Complaints and concerns were viewed as an opportunity to improve the service. However, there had been no complaints since our last inspection. The service worked to the provider's complaints policy and easy read information was available for people and their relatives.

Good

Is the service well-led?

Our findings

At our inspection in October 2015 we found widespread shortfalls in the leadership and governance of the service. There were systems in place to promote high quality care but these were not being implemented. Regular audits were not happening. Accidents and incidents were not reviewed so that action could be taken to reduce the chance of them happening again. People and their relatives had limited opportunities to provide feedback about the service, and when they did there were no action plans in place to address concerns. We issued a warning notice in relation to governance and record keeping, requiring the provider to meet the regulation by 29 January 2016.

At this inspection, we found that action had been taken to meet the fundamental standards. Relatives spoke highly of the way the service was run. Comments included: "Now it is really brilliant", and "Since [registered manager] took over with the new team it's been absolutely amazing."

There was a registered manager, who had registered with CQC since the last inspection. It is a condition of the service's registration that it has a registered manager. A registered manager is a person who has registered with 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 registered manager had notified CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

The service now had a positive culture that was person-centred, open, inclusive and empowering. People and their relatives had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. The registered manager had recognised the challenges of addressing low staff morale and shortcomings in the quality of care provided. Compliments the service had received from relatives included positive feedback about changes at the service, one noting there was now "a lovely, calm, happy atmosphere" and another remarking on "happy staff working as a team". All the staff we spoke with came across as motivated and positive, and told us about how the service had changed for the better since the last inspection. A staff member commented that this had been achieved by the registered manager and staff team working together. They said, "[Registered manager] is absolutely inspirational… she has done such an amazing job" and that it was "really exciting to be a part of the changes". Another staff member commented, "The atmosphere is a lot better… It's a lovely place to be, a lovely place to work". Staff said they could go to the registered manager with ideas they had to improve the service and expressed confidence that the registered manager would deal appropriately with any concerns they raised. Staff felt able to raise items for the agenda of their monthly team meetings.

People's and their relatives' experience of care was monitored and used to improve the service. This happened informally through contact with the manager and keyworker updates to relatives, and in a more structured way through Your Voice meetings and individual reviews, and quality assurance questionnaires. The registered manager acted on their suggestions. For example, a person and their family had asked about

being able to connect to the service's Wi-Fi, and the staff had subsequently enabled them to do this. There had been a recent summer barbecue for people and their families, to give them an opportunity to meet the staff who had been recruited in recent months, to give feedback about the service and hear about how they would like the service to develop.

The registered manager had moved their office from a garden outbuilding into the house, which meant they were easily visible to people, staff and visitors, and were more readily able to spend time with them. This also helped the registered manager to have oversight of how staff were working with people. Plans had been discussed with people and their relatives, for converting the outbuilding into a sensory room and it was envisaged that this would happen in the forthcoming weeks.

Quality assurance systems operated to monitor and improve the quality of service being delivered and the running of the home. Following the last inspection, the provider had drawn up an action plan to bring the service into line with the fundamental standards. The registered manager's manager undertook regular audits that checked progress with the action plan and reviewed service quality generally. Any issues raised, such as a cluttered and untidy bathroom on one occasion, had been put right. The provider's head of quality had visited in May 2016 to check the necessary actions had been taken to meet the regulations. In addition, there were unannounced out of hours spot checks by the regional manager or managers from other services. Regular audits were also undertaken within the service, such as monthly safety checks, medicines audits, safeguarding audits and infection control audits. Any feedback and shortcomings identified were addressed, for example through staff meetings and supervision.