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Anchorage House

Inspection report

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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 unannounced inspection was carried out on 26 and 27 May 2016. The last inspection took place on 23 January 2013 and found there were no breaches in the legal requirements at that time.

Anchorage House provides accommodation and personal care for up to six people who have learning disabilities or autistic spectrum disorder, some health conditions and some challenging behavioural needs.

Accommodation is arranged over three floors and each person had their own bedroom. Bath and shower facilities were shared.

Six people lived at the service and we met and spoke with each of them. People told us that they liked living at the service and received the care and support they needed. They were happy with their support arrangements; they liked the staff and told us staff were kind and caring. They thought the service was clean and tidy and provided a comfortable living environment.

The service did not require a registered manager as the provider manages this service and another owned by her locally. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was present during the inspection.

At this inspection we found improvement was required in some areas where some regulations were not being met.

Arrangements for the maintenance and repair for some parts of the service were not given sufficient priority; one person's bedroom was damp with mould visibly growing on a wall and shelves.

Quality assurance checks were not fully effective because they had not identified the maintenance shortfalls we found or ensured they were completed in an appropriate time scale.

Medicines were safely stored and correctly administered; established processes were in place to order medicines and safely dispose of any medicine that was no longer needed.

People were supported by engaging and enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Recruitment processes were robust, proper consideration was given to Disclosure Baring Service (DBS) checks to ensure suitable staff were employed by the service.

Where the service had a legal obligation to notify the Commission of certain decisions and events, correct

notification was made.

Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and applied these principles correctly.

People had personalised records detailing their care and support, including well developed support plans for their emotional and behavioural needs.

People were supported to access routine and specialist health care appointments. People told us staff showed concern when they were unwell and took appropriate action.

People enjoyed their meals, they were involved in deciding what they wanted to eat and went shopping to buy groceries.

Staff were caring and responsive to people's needs and interactions between staff and people were warm, friendly and respectful.

Staff spent time engaging people in communication and activities suitable for their current needs.

People felt comfortable in complaining, but did not have any concerns. People, relatives and visiting professionals had opportunities to provide feedback about the service provided both informally and formally. Feedback received had been reviewed and acted upon.

The provider had a set of values forming their philosophy of care. This included treating everyone as an individual, working together as an inclusive team and respecting each other. Staff were aware of these and they were followed through into practice.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Maintenance work had not kept pace with the need for repair and was not afforded sufficient priority.

Medicines were administered and stored safely; people received the right medicines when they were supposed to.

Appropriate recruitment checks were completed before employing staff.

There were sufficient staff on duty to meet the needs of people, support their activities and health care appointments.

Staff understood the processes for raising any concerns about people's safety.

Is the service effective?

Good

The service was effective.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

People consented to their care and treatment and staff were trained to support people's specific needs.

Communication was effective, staff understood people's needs. People told us they had choices about what they ate and how their meals were planned.

People were supported to maintain good health and had access to medical and social services as needed.

Is the service caring?

Good

The service was caring.

People told us they liked that staff who supported them and found this comforting and reassuring.

Staff spoke to people in a kind, patient and engaging way. Staff took the time to interact with people and engage them with them positively.

People were encouraged to make their own choices which were respected and supported. Staff supported people to be independent and helped them to maintain and develop life skills.

Staff demonstrated they wanted good outcomes for people and wanted to continue to improve the services people received.

People were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive.

Care plan reviews took place when needed. People's goals and ambitions were clearly recorded and actively pursued.

There was an accessible complaints procedure and people were confident that any concerns would be addressed and action taken where necessary.

The service actively involved people and their families or advocates in planning and reviewing care.

People had a choice about activities which helped them meet new people and maintain friendships.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes and maintenance arrangements were not always effective at identifying and addressing concerns.

Statutory notifications required by CQC were submitted.

Staff felt supported and there was an open culture which encouraged staff and people to share their views.

Staff had a good understanding of the values and goals of the service.

Anchorage 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.

We undertook an unannounced inspection of this service on 26 and 27 May 2016. We spent some time talking with people in the service and staff; we looked at records as well as operational processes. The inspection was undertaken by one inspector, this was because the service was small and it was considered that additional inspection staff would be intrusive to people's daily routine.

We reviewed a range of records. This included four care plans and associated risk information and environmental risk information. We looked at recruitment information for three staff, their training and supervision records in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the provider. We spoke with each person, three staff and provider. After the inspection we spoke with a social care professional who had visited the service.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and healthcare professionals. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the service is required to tell us about by law. The provider had completed a Provider Information Return (PIR) before the inspection which we used to help us inform our Key Lines of Enquiry (KLOE) for inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy and felt safe living at the service; they had confidence in the staff and felt they received the right support. People were comfortable and at ease within their home environment. Comments included, "I feel like I've landed on my feet coming to live here, it's much better that any other place I've lived at", "I don't have any concerns or cause to worry about living here, I'm happy here and feel settled" and "The staff are good, I do feel safe and I know that I could talk to any one of them if I had any problems".

Although people told us they felt safe, the condition of one person's bedroom presented a risk which meant the service was not always safe.

We looked around the service including each person's bedroom, the communal lounge and dining areas, the kitchen and the laundry room. Most areas were recently decorated and provided clean and suitable living accommodation. However, one person's bedroom looked and smelt damp; there was a small area of black mould on a wall at a high level where it adjoined the ceiling, the rest of the wall, although not visibly mouldy, felt damp in places when touched. The undersides of the shelves in a built-in storage unit on the same wall were visibly mouldy with a brown mould growing. Some clean clothes were kept on the shelving unit stacked up against the wall, we pointed out to the staff and provider tiny black insects present on the wall and storage unit. These insects were also present on the person's stack of clothes.

The provider was aware of the damp problem in the bedroom, believing it to be caused by lack of ventilation and the maintenance plan for the service reflected the need for remedial action. However, sufficient priority had not been given to undertaking any remedial works; this had resulted in the growth of mould and an insect infestation in the person's bedroom.

The provider had not ensured the service was clean and properly maintained. This failure was in breach of Regulation 15 (1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The outside of the property required redecoration because paint was weathered and flaking from the building. Discussion with the provider and reference to the maintenance schedule confirmed this work was due to be completed during better weather later in the year.

We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. Medicines held by the service were securely stored and people were supported to take the medicines they had been prescribed when they needed them. People's Medicine Administration Records (MAR) showed that all medicines had been signed to indicate they had been given. Staff who administered medicines to people had attended appropriate training and were regularly assessed to ensure they were competent to manage medicines. People we spoke with told us they always received the right medicine at the right time. People were given their medicines privately and told us they knew what they were for. Where people occasionally took medicine, for example, for pain, staff asked if people wanted it and recorded how much was given and when. Staff had information and were knowledgeable about the possible side effects of

some medicines and signs to look out for.

Staffing levels were based upon people's dependency assessments and were flexible to accommodate outings, activities and accompanying people to appointments. Staffing comprised of four staff on the day shift and one wake night member of staff. There was an established on call system should additional support be required. Agency staff were not used, any shortfall was met by staff employed by the provider. This ensured familiarity of people's needs and enabled them to be addressed consistently and safely. People and staff felt there were enough staff on duty to support people, their activities and safety.

Recruitment practices were robust. Required checks were completed before new staff started work to safeguard people. Proof of identity was obtained and files contained evidence that disclosure and barring service (DBS) checks had been carried out. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Where needed, appropriate consideration was given to any risk that may result through the employment of staff where a DBS caution or conviction was shown. Application forms had been completed and two references had been received in each case. This helped to ensure people were protected by safe recruitment procedures because required processes had taken place.

Any concerns about people's safety or wellbeing were taken seriously. Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them about what to do. The service also held a copy of the locally agreed safeguarding protocols. Staff said in the first instance they would alert any concerns they might have to senior staff or the provider, but understood about and could name the relevant agencies that could be contacted if their concerns were not acted upon. Staff were aware of 'whistle blowing' procedures and told us they would not hesitate to report poor practice or abusive behaviour.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. Staff knew the different risks associated with each person and how to minimise any occurrence. Risk assessments were in place to help keep people safe in the service and when outside or attending activities and day centres. They clearly set out the type and level of risk as well as measures taken to reduce risk. These enabled people to be as independent as possible. For example, they included safety in public places, smoking and consumption of alcohol. This helped to ensure that people were encouraged to live their lives whilst supported safely, consistently and not presenting a risk to others. Risk assessments were reviewed when needed and linked to accident and incident reporting processes. Where incidents had occurred, particularly with one person when in public places, staff had discussed ways of reducing risk with the person and introduced measures to reduce the risk of them happening again. Our discussion with the person found they understood why the measures were in place; they had agreed to them, recognised they helped to keep them safe and thought they still had enough independence. Records showed and staff confirmed there was a low number of incidents and accidents.

Strategies were in place to support people with behaviour that could challenge. Staff were aware of potential behavioural triggers and indicators of people's anxiety or agitation. Discussion with staff and our observation found there was an emphasis on managing people's expectations about their plans or what was happening that day together with clear, reasoned communication. For example, staff were specific with some people about what was happening and when because this helped to manage their anxiety brought about by uncertainty. There was clear guidance about how staff should speak to people and what to do if people were unreceptive or showed behaviours which my challenge staff or other people. During the inspection staff reminded some people about speaking to each other respectfully and not invading other

people's personal space. Staff spoke calmly to people, their explanations and reasoning reflected guidance provided in people's support plans.

Records showed the provider ensured safety checks and servicing were completed as required. These included checks of the building electrical wiring, gas safety, portable electrical appliances, fire alarm and fire fighting equipment. An emergency plan provided staff with information about what to do in the event of a fire. People told us fire alarm checks and fire drills were held regularly, they knew what to do and where to go if there was a fire and thought the staff were familiar with actions to take.

Personal emergency evacuation plans (PEEPS) explained what support a person needed in the event of an emergency. They included important contact details and a current list of medication people took and what it was for. The plans were up to date and easily accessible in a grab bag; the grab bag also contained spare keys for the service to ensure people could get out as a locked door policy was in place. Duplicate PEEPS were kept in the service's mini bus in case people should need support outside of the service, for example, an unplanned admission to hospital.

Good

Is the service effective?

Our findings

People commented positively about the service and staff; our observation of the interaction between staff and people was also positive. People were confident in the staff supporting them; staff understood people's individual needs and how to effectively support them. One person told us, "The staff are excellent, they're always friendly and up for a joke and a chat. It's not all business, which makes a big difference to me; they are pleasant, it's a good home". Staff told us they felt supported by the provider and received the right amount and quality of training to effectively support people at the service.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS), which form part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for each person. One DoLS authorisation was in place and the remaining five applications were receiving consideration. Receipt of the applications had been acknowledged and the service maintained contact with the local authorities pending their decision making processes.

Staff clearly understood the about the MCA and how to support people with varying degrees of capacity. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Where some people were more independent and able to form more complex decisions, staff worked with them to tailor the support they needed. Staff gained people's consent to give them care and support and carried this out in line with their wishes. People told us they were involved in their day to day choices about accessing activities, spending time outside of the service, the food and drinks they had and their daily routines.

Policies reflected if people lacked capacity where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate of Relevant Person Representative was required. These are workers who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service and best interest processes had been used in relation to dental work and the prospect an operation.

People had individual communication plans together with Disability Distress Assessment Tools (DisDat) cues to help identify distress signs in people who, because of cognitive impairment or physical illness, have severely limited communication. This included information about facial expressions, body language and gestures as well as other indicators such as people's general demeanour and what any changes may indicate. For example, how people may appear and react if they experienced pain, anxiety or were becoming frustrated. These helped to ensure effective understanding between people and staff and helped staff to

recognise if people were unable to communicate their needs. Communication aids such as pictorial prompts were available if needed. Staff understood individual communication needs and interacted with people effectively.

Staff were aware of people's food preferences and any specific dietary needs. People told us they often went food shopping with staff and this helped them to decide what they wanted to eat. People were aware of the benefits of healthy eating and where some people had needed support to lose weight, they had achieved this. People thought there was a good choice of food; meals were varied and enjoyed. People said they always had enough to eat and drink. One person had a tendency to drink too much to the extent it could present a risk to them, all staff were aware of this and supported the person to drink moderately.

People were supported to maintain good health and received ongoing healthcare. They were registered with the local GP and had access to other health care services and professionals as required. Where specialist advice was needed, for example about people's mental health, we found that referrals had taken place and the advice received was followed. Health action plans were based upon individual needs and included dates for medical appointments, medicine reviews and annual health checks; these had taken place when needed. Where one person required an operation, the provider and staff made sure they were seen by the consultant. Where people presented challenging behaviour, staff worked with health professionals to look at ways of managing the behaviour. Interventions and restraint were not used to manage behaviours; other techniques and strategies, such as positive behaviour support and distraction or diffusion strategies were used.

A training planner identified when training was due and when it should be refreshed. Staff received regular training in areas essential to the effective running of the service such as fire safety, first aid, infection control and food hygiene. Additional training had been delivered which helped staff support people, including epilepsy, autism, depression awareness as well as continence promotion. All staff had received training to support people with behaviour that challenged. Training provided was a mixture of computer based learning and face to face training. Staff told us the training was good quality and they felt confident to do their job properly. One member of staff told us, "I feel confident about supporting the people living here". Another member of staff commented, "There is always something new to learn, but even if it's refresher training, it still helps to validate what you know".

Supervision of staff took place every three months and appraisals annually, these are formal meetings between staff and the provider or senior management. Supervisions covered achievements, training and individual actions or targets for staff. They gave staff the opportunity to raise any concerns about working practices and focussed on ideas to progress individual development of staff. Staff told us supervisions were useful for their personal development as well as ensuring they were up to date with current working practices. Supervision processes linked to staff performance and attendance and, where needed, led to disciplinary action. A comprehensive induction programme and ongoing training ensured staff had the skills and knowledge to effectively meet people's needs. The provider subscribed to and used the Skills For Care Certificate, an identified set of standards that social care workers adhere to in their daily working life for the induction of new staff. All staff had achieved or worked towards NVQ or Care Diplomas levels two and three.

Staff communication was effective. A handover book ensured key information was passed between staff, such as GP appointments and key comments about care and support delivered. Staff told us this system worked well.

Good

Is the service caring?

Our findings

People told us they liked the staff who supported them and found them considerate and reassuring. Everyone thought they were well cared for. One person told us, "This is by far the best place I've lived at, I can't fault it". Other comments included, "On nice days we have a BBQ or go out for lunch or dinner, they don't need to do that, but they do" and "They have our best interests at heart and it shows". People were settled and happy. People told us and we observed they were treated respectfully and with dignity; their individuality was recognised and their independence actively promoted to suit their needs. Staff enjoyed working at the service and felt this was reflected in their approach to work and the quality of care delivered.

Staff were intuitive in their interaction with people, giving reasoned explanations. Interactions between people and staff were positive, respectful and often made with shared humour. The atmosphere was light, calm and friendly. When staff supported people, they responded promptly to any requests for assistance. Staff spoke with people in appropriate tones and were friendly and unhurried, giving people time to process information and form their responses. Staff were knew which people responded to different styles of verbal communication and were consistent in the way they spoke with them. Short sentences helped some people understand what to do, where as other people benefitted from a more conversational approach. This helped people know what was happening, avoiding unnecessary worry or anxiety. Staff helped people budget if they were saving towards more expensive items such as a watch, certain clothing and holidays. This helped to manage people's expectations and anxieties about when such things could be purchased.

There were many examples of positive interactions between staff and people. Staff held affection toward the people they supported, always showing respect and kindness. Staff spoke respectfully about people and this was also reflected in terminology used in written records.

People were encouraged to make decisions about their care. Care plans contained a lot of pictorial information to make them more meaningful and engaging for people. People told us they had plenty of opportunity to talk to staff about their care, they felt they were listened to and thought the care they received reflected their needs. People told us they could keep their own daily routines and chose where they spent their time. People moved around the house and garden as they wanted to, attended varied activities and spent time away from the service supervised by staff when needed. Each person had a key to their bedroom. Bedrooms were decorated how people wanted them, reflecting their interests and tastes.

People's independence was maintained and some activities linked to daily living skills, such as reading, computers and managing money. People chose the meals they liked to have, planning menus, helping to prepare food and going food shopping. People were involved in household chores if they wanted to; there was pictorial information to help remind people what they were doing. People felt staff encouraged them to improve their independence and daily living skills.

Each person had a detailed pen picture. This included the most important things about them, the most important things to them and the most important areas where they required support. This provided detailed

information for staff and helped to ensure staff were aware of these needs. Staff were knowledgeable about people's life experiences and spoke with us about people's different personalities. They knew what people liked and didn't like. Staff told us they had got to know people well by spending time with them and, where possible their relatives, as well as by reading people's care records. There was information about people's lives and who was important to them so that staff were able to support them with their interests and keeping in touch with friends and family. Staff had offered counselling and helped to support a person who had experienced a recent bereavement.

People said staff knocked on doors before coming in and respected people's privacy and wishes if they preferred staff not to come in. People told us they felt clean and well cared for. When clothes were washed people told us they got their own clothes back with very few mix ups. Staff and the provider all recognised the importance of dignity and respect for people and this was conveyed in the way they supported them.

Care records were stored in a locked room when not in use. Information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this.

Good

Is the service responsive?

Our findings

People felt staff knew what they liked and which activities, interests and subjects of discussion were important to them. They had regular activities and outings, some people felt they especially benefitted from going to social clubs, day centres and events held locally. They told us this gave them an opportunity to see friends, learn new skills and practice day to day life skills. This helped to ensure that people did not feel socially isolated. The service had a mini bus available help with transport for activities.

Pre-admission assessments were completed to ensure that the service was able to meet people's individual needs and wishes. Care plans were then developed from the assessments as well as discussions with people, their relatives where possible and the observations of staff. Where one person had joined the service more recently, a comprehensive care plan was in place.

Care plans contained information about people's wishes and preferences. These were in an easy to read format and some people had completed parts of them themselves or with the support of staff and signed them to show they were happy with the content. Care plans contained details of people's preferred routines, such as a step by step guide to supporting the person with their personal care. This included what they could do for themselves, however small and what support they required from staff. For example, the elements of personal care that people could do independently. There were behaviour support plans and risk assessments about the support people needed when they became distressed or challenging towards staff or others. This included information for staff to help them understand why some behaviour may occur, primary and secondary behaviour prevention strategies and any reactive action that should be taken or avoided. Evaluation of behavioural events and the support provided helped to inform reviews by staff and health care professionals. Care plans gave staff an in-depth understanding of each person and staff used this knowledge when supporting people. Care plans reflected the care provided to people during the inspection. Daily notes reflected what each person had done, their mood and any events of importance.

Care plans were reviewed continually to ensure they remained up to date. Annual reviews were current and provided an oversight of the care provided. These were open to people's social worker, their family or an advocate and staff. People told us they thought they received the support they needed. Care plans included what people wanted to change in their lives and what they wanted to remain the same. Activities and goal setting enabled people to create changes they may want and introduced structure and a way of helping people manage and meet their expectations. We looked at how people's goals and aspirations were recorded and reviewed and saw how this linked to activity planning, development of learning and exploring new activities and challenges. People told us about a car mechanics and woodwork course and the sense of fulfilment and enjoyment it gave them. Other people enjoyed their own company and liked helping around the service with household chores.

People had monthly key worker reviews about their care and support. A key worker is a specific member of staff who works closely with people to help ensure their needs are met. This included discussions about health issues and appointments, activities and any contact with family and friends. In addition people told us they had an annual review meeting with their care manager, their family or an advocate and staff. Some

people told us that staff supported them to travel to see their family and they had regular telephone contact.

The service's complaints procedure was accessible to people and visitors and available in pictorial form. People told us they did not have any complaints and did not wish to make any. They told us they knew the staff and provider by name and were confident that, if given cause to complain, it would be resolved quickly. There were no complaints at the time of our inspection. Staff clearly explained how they would support people to make a complaint if the need arose and gave us examples of when they had done this.

Requires Improvement

Is the service well-led?

Our findings

Staff enjoyed their work; they were proud of the service and the support the provided. Everyone spoke positively about the provider, commenting she was determined and worked hard to ensure the best for the people supported and that she was always approachable, supportive and fair. People were involved in developing the service and staff encouraged people's suggestions and ideas. Examples included taking part in meetings where things like decoration, improvements to the home, holidays, activities and food choices were decided. However, we found some areas in how the service was managed which required improvement.

Established auditing and checking procedures were in place. The provider and key staff undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, medicine management and care plan quality. However, the quality of checks was variable and systems did not always attach sufficient urgency to tasks requiring action. For example, a bedroom cleanliness check list completed earlier in the month did not identify the presence of mould or damp in one person's bedroom, yet this had been noted as requiring attention in the service's maintenance plan. Although noted in the maintenance plan, no further action had been taken; maintenance and checking procedures were not sufficiently robust to ensure required work was completed when needed.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a clear commitment to the people they supported and philosophy of care. The values and commitment of the home were embedded in the expected behaviours of staff and were discussed during staff meetings and linked into supervisions and annual appraisals. Staff told us the values and behaviours included treating people as individuals, being respectful, teamwork and supporting people to live a fulfilled life. Staff recognised and understood the values of the service and could see how their behaviour and engagement with people affected their experiences living at the home. We saw examples of staff displaying these values during our inspection, particularly in their commitment to care and support and the respectful ways in which it was delivered.

People had completed quality assurance questionnaires to give feedback about the services provided, which were positive. Other feedback included responses to surveys from people's relatives and care professionals. Again the responses received were positive.

There was an open culture within the service that encouraged people and staff to express their views through service user or staff meetings. People were given opportunities to comment about the service and their personal experiences through these meetings, and people confirmed they used these to raise issues or comment about aspects of the service such as menu planning.

Staff told us that and records confirmed that they attended regular staff meetings and felt the culture within

the service was supportive and enabled them to feel able to raise issues and comment about the service or work practices. They said they felt confident about raising any issues of concern around practices within the home and felt their confidentiality would be maintained and protected by provider.

Although we did not see any visitors during our inspection, people told us and recent surveys confirmed friends and family were welcomed and could visit at any time. Staff and the provider welcomed people's views about the service and surveys of people, relatives and visiting professionals took place annually to facilitate this. The provider was in the process of redesigning a number of surveys to make them more user friendly.

Policy and procedure information was available within the home; staff knew where to access this information and told us they were kept informed if changes were made. When policies were amended, staff signed acknowledgement sheets indicating that they had read and understood them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the service was clean and properly maintained. Regulation 15 (1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes effectively assessed, monitored and improved the quality and safety of the service. Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.