Ashfield Care Homes Limited

Ashfield House - New Milton

Inspection report

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Date of inspection visit:
28 September 2016

Date of publication:
18 October 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 the 28 September 2016. The inspection was unannounced.

Ashfield House is situated in a residential area of New Milton. The service provides care and support for up to nine people with a learning disability. At the time of the inspection the service was home to seven people. The home has a lounge, dining room; a large kitchen and a smaller kitchen where people could make themselves hot drinks for example. There is also a laundry and an activities room. There is a secure garden to the rear and parking at the front. People's rooms were arranged over two floors with the upper floor being accessed via stairs. Some of the rooms were ensuite.

The service had a registered manager. 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 and associated Regulations about how the service is run.

Mental capacity assessments and best interest's consultations had not always been undertaken in line with the requirements of the Mental Capacity Act (MCA) 2005.

Whilst the design and layout of the building was suitable to people's needs some of the décor looked tired and worn and some of the furniture needed to be replaced and fixtures and fittings updated.

Supervision had not always been taking place on a regular basis, but this was an improving picture. Staff felt supported and received an appropriate induction and training which helped them to perform their role effectively.

Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

People's medicines were managed safely. People had risk assessments and risk reduction measures were in place to help keep people safe.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for.

The people we spoke with were all happy living at Ashfield house. Staff showed people kindness, patience and respect, were cheerful and motivating and the atmosphere was positive.

Staff had a good knowledge and understanding of the people they were supporting. Care records were person centred and helped staff provide care which was in keeping with people's needs and wishes. People were supported to take part in a range of activities.

People, relatives and staff spoke positively about the registered manager. There was a positive and person centred culture within the home. There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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.

People had risk assessments and risk reduction measures were in place to help keep people safe. Medicines were managed safely.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Staffing levels were adequate and recruitment practices were safe with relevant checks being completed before staff worked unsupervised.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments had not always been undertaken in line with the requirements of the Mental Capacity Act (MCA) 2005. Best interest's decisions were not always recorded.

Whilst the design and layout of the building was suitable to people's needs some of the décor looked tired and worn and some of the furniture needed to be replaced and some of the fixtures and fittings updated.

Supervision had not always been taking place on a regular basis, but this was an improving picture. Staff felt supported and received an appropriate induction and training which helped them to perform their role effectively.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met.

Is the service caring?

Good

The service was caring.

The people we spoke with were all happy living at Ashfield house. Staff showed people kindness, patience and respect, were cheerful and motivating and the atmosphere was positive.

Information given to people was in 'easy read' format which helped them to understand it and enhanced their ability to make informed choices and decisions.

Staff respected people's private space and their privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People's care and support plans were person centred. This supported staff to deliver responsive care.

People were supported to take part in a range of activities in line with their personal preferences.

Complaints policies and procedures were in place.

Is the service well-led?

Good

The service was well led.

The registered manager had fostered a positive and person centred culture with in the home which focused upon supporting people to receive the care and support they required to have a happy and comfortable life.

People and staff were provided with opportunities to give feedback about the service.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support.

Ashfield House - New Milton

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.

The inspection took place on the 28 September 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

We spoke with three of the people living at the home and spent time observing interactions between people and the staff supporting them. We also spoke to four people's relatives, the registered manager, four support workers and one health care professional who visited the service on a regular basis. We reviewed the care records of three people in detail. We viewed the medicine administration records for all seven people. Other records relating the management of the service such as staff files, rotas, audits and policies and procedures were also viewed.

The last full inspection of this service was in December 2013 when no concerns were found in the areas inspected.

Good

Is the service safe?

Our findings

The people told us they felt safe and happy living Ashfield House. Relatives were also confident that their family members were safe. One relative said, "We know they are safe, if I had any qualms at all, they would not be there". Another relative said, "There was an issue, but they rectified it straight away, safety is very important".

Assessments were undertaken to identify risks to people's wellbeing. For example, people had risk assessments in relation to accessing the community, absconding or suffering sunburn. Where risks had been identified, staff were provided with guidance which helped to ensure that the risk was minimised. For example, one person could at times display behaviour which might challenge others. To manage this risk, staff were provided with guidance about the actions they should take to de-escalate the behaviours or prevent them from occurring. Another person was at risk of choking when eating. Staff told us how they ensured the person did not eat too fast, only took small spoonfuls and ate in a quiet environment. This was in keeping with the dietary advice provided by a speech and language therapist and the person's care plan. Staff did not support people in an overly risk adverse manner. Whilst the kitchen and other cupboards were locked in order to safeguard one of the people using the service, other people had their own key to the cupboards and were able and encouraged to make their own hot drinks for example. A staff member told us, "Risk assessments are in place, but they are still able to take little risks if this is important to them, they still need a life". Incidents and accidents were investigated and remedial actions taken to prevent a reoccurrence of the incident. For example, a medicines error had been fully investigated, reported to the relevant authorities and the staff member involved provided with retraining.

Medicines were managed safely. Staff who administered medicines had completed training and underwent annual competency assessments. Medicines were kept safely in a locked cabinet in the office. The temperature of the fridge and room used for storing medicines was monitored daily. Storing medicines within recommended temperatures is important as this ensures they are safe to use and remain effective. There were basic protocols in place for the use of 'as required' or PRN medicines. These included information about the strength of the drug and the maximum dose to be given in 24 hours. PRN protocols were in place for the use of medicines which managed people's agitation or anxiety. Staff told us the circumstances in which they would administer these medicines; this was in line with the guidance contained within the protocols. We reviewed seven people's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines and did not contain any gaps or omissions. This provided reassurances that people were receiving their medicines as prescribed. Each person had a list of homely remedies approved for their use by their GP. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. At each supervision staff were asked if they had any concerns about people using the service. The organisation had appropriate policies and procedures and information was available on the local multi-agency procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking

action to ensure people's safety. Staff told us they were aware of how to report concerns about poor practice which is often known as whistleblowing. They were also aware of other organisations with which they could share such concerns. One staff member said, "If I saw something not good, I would tell the manager or deputy, I feel free to raise concerns".

Staffing levels were adequate. During the day the usual staffing levels were four support workers to support the seven people using the service. At night there were one waking night staff and one sleeping in. The registered manager told us the staffing levels were determined by the commissioners of people's care. Shifts were planned to ensure that there was the correct skill and experience mix to meet people's needs. For example, each shift had a member of staff trained in caring for people with epilepsy, someone to drive the car, staff trained to administer medicines and in the use of physical interventions. There was currently one full time staff vacancy within the service, but the registered manager tried to ensure this was covered by regular agency staff or bank staff. All of the staff we spoke with told us the staffing levels were adequate and enabled people's needs to be met in a safe manner.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks which were repeated every three years. Staff underwent a competency based interview which tested their skills and knowledge in relation to areas such as protecting people from harm. These measures helped to ensure that only suitable staff were employed to support people at the service.

Requires Improvement

Is the service effective?

Our findings

Relatives were confident that their family members received effective care. One relative told us, "We know they are giving [the person] a better life that we could". Another relative when asked if the service could do anything better said, "No nothing……they have brought [the person] on no end, he is a different person". A third relative said the home was "100% the best place for [their relative]". People were supported by staff that had a good knowledge of their needs and during our inspection we observed that staff delivered care effectively and to an appropriate standard. A health care professional told us, "I have worked with the home for many years and I am always impressed by the standard of care….they do look after the physical and mental wellbeing of individuals, they work with families and individuals to provide the best possible quality of life".

Whilst people and their relatives told us the service provided effective care, some areas required improvement. The design and layout of the building was suitable to people's needs and each person had their own room which they had personalised according to their own taste. However, some of the décor looked tired and worn and some of the furniture needed to be replaced. Some of the fixtures and fittings needed to be updated, for example, the carpet in several areas needed to be replaced. One of the sofas in the lounge was very worn. The worktops in the kitchenette used by people needed to be replaced. The service employed a maintenance person to undertake repairs and a maintenance plan was in place which had identified many of the issues above. However there was no clear timescale in place for these improvements to be made. We were concerned that this could impact on people's enjoyment of their home. This is an area that requires improvement.

Support for staff was achieved through individual supervision sessions and an annual appraisal. All of the staff we spoke with felt adequately supported in their role. One staff member said, "The manager is very supportive". Another said, "Their door is always open… you can go to them". The supervision schedule showed that earlier in 2016 some of the planned supervision sessions had not always taken place. The registered manager told us they had recognised that this was an area where they needed more support and so the deputy manager was now taking the lead for staff supervision. We were able to see that the frequency of supervision was now improving. We noted that the registered manager had not been receiving regular supervision. The registered manager had last received supervision in December 2014. They told us they worked very closely with their line manager and had regular contact with them about any matter affecting the service or staff team. However supervision is an important tool and helps ensure that staff and managers develop their skills and understand their role and responsibilities. This is therefore an area that requires improvement. The annual appraisals that had taken place were detailed and recorded information such as the staff member's achievements, strengths and goals.

New staff received an induction which involved shadowing more experienced staff for a minimum of two weeks to learn about people's needs and routines. The registered manager told us, "New staff don't go on the floor until they have done all of the training and are confident". The induction records seen were basic but demonstrated that new staff learnt about the provider's policies and procedures and the values of the organisation and about safeguarding people from harm. The registered manager told us that new staff

would in the future be registered on the provider's skills academy and be supported to complete the Care Certificate as part of their induction. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff completed a range of essential training. The training completed included, moving and handling, first aid, safeguarding people, fire safety, food hygiene, Mental Capacity Act 2005 and infection control. Staff also completed training in how to use physical interventions to de-escalate behaviour which might challenge others. We did note that the provider of this training was no longer accredited with the British Institute of Learning Disabilities. We brought this to the attention of the deputy manager who advised that in light of this, action would be taken to source a new accredited provider for their training. Some staff had undertaken training relevant to the needs of people using the service, for example, training in caring for people living with epilepsy or diabetes. Some staff had also undertaken nationally recognised qualification in health and social care. Staff told us they completed sufficient training which helped them to perform their role effectively. One staff member said, "Yes there is loads of training".

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. The need to act in accordance with people's choices was clearly referenced throughout support plans. For example, it was noted whether people preferred a male or female care worker and which name they wished to be known by. Where people used specific communication techniques to indicate their choices, these were described. For example, one person touched their teeth when hungry. Picture cards were used by staff to help other people with limited verbal communication to indicate their choices.

Some of the people using the service were able to make a range of day to day decisions such as what to wear and what to eat or what activity they would like to take part in. However, some people's needs meant they were unable to make some decisions. Where this was the case, in some instances, a mental capacity assessment had been completed. For example staff had contributed to a mental capacity assessment and a best interest's decision with regards to one person having a surgical procedure. However, there was evidence that people also lacked capacity to consent to other key aspects of their care such as the administration of their medicines, or to having photos or taken. Where this was the case staff had not completed a mental capacity assessment or undertaken a best interest's consultation. Staff were instead seeking consent from people's next of kin. For example, one person's consent for the administration of their medicines was signed by a relative without there being evidence that they had legal authority to do so. This is not in keeping with the principles of the MCA 2005. Improvements are therefore needed to ensure that in each case, the provider has undertaken a decision specific mental capacity assessment and then, following best interest's consultation, has made a record of the actions staff are to take in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were awaiting assessment by the local authority.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. Staff demonstrated a good understanding of these specific needs and were able to clearly describe how these were catered for. People

were involved in decisions about what they ate and staff told us they all sat down together each week and planned the weekly menu. The service employed a cook, but people also got involved in preparing meals. One person said, "I cook on Fridays, I cook custard well". We ate our lunch in the dining room with people and the staff supporting them. The meal was a roast dinner which looked and smelt appetising. The atmosphere was lively with people and staff chatting about everyday matters or sharing a joke whilst they ate. When people finished their meal, they took their plates to the kitchen and one person made hot drinks for their fellow housemates like a family might. The mealtime experience was fully inclusive and people ate well.

Where necessary, staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met. This included GP's, speech and language therapists, dentists and opticians. One health care professional told us they were "Very confident in [the services] management of complex regimes in clients with multiple medical conditions". Each person had a health plan. This recorded information about their individual health needs, the professionals who were involved to support those needs and information about hospital and other relevant appointments. A health care professional told us, "I have been through the care plans for all the residents and we have worked on these together….they have never asked for my advice or attendance inappropriately, we try to work together". They felt staff were knowledgeable about people's health care needs. Hospital passports were in place which could be shared with hospital staff in case of admission to hospital. They contained key information about the person such as how they communicated and their abilities which would assist hospital staff in providing person centred care. People were supported to live a healthy lifestyle. For example, one person was being supported to lose weight through attending a gym. Another person had been supported to reduce how many cigarettes they smoked. A relative said, "They have done a sterling job….[the person's] chest is better".

Good

Is the service caring?

Our findings

The people we spoke with were all happy living at Ashfield house. One person said, "I'm happy, it's nice here". Relatives were also positive about how caring the service was. One relative told us, "It's a home from home". Another said, "The staff seem really friendly, when [the person] sees us, they tell us about them all and what they have done together…it's a happy home, they [the staff] are all cheerful….[the person] now has two families". A third relative said, "[the person] is not just a number, he's a person". Our observations indicated that staff showed people kindness, patience and respect. The staff team were cheerful and motivating. The atmosphere was positive and it was clear that staff had developed a meaningful relationship with each person and that they in turn had trust and confidence in the staff supporting them. Staff acted in a manner that helped to make sure that people, and the things that were important to them, mattered. For example, staff told us how one person loved Christmas and so they would soon be supporting them to redecorate their room as a winter wonderland in preparation for this celebration. The registered manager demonstrated that they too had a good relationship with people. One staff member described her as being "Like a mum" to the people living at the service. A health care professional told us, "All my contacts [with the service] have been positive and I do feel they [the staff] are kind, attentive and client focused".

People were encouraged to maintain relationships with their family. Relatives were welcomed at the home or people were supported to visit them in their own home or to speak with them on the phone. People were encouraged to maintain their independence and achieve their potential with specific tasks. Activity plans showed that as well as leisure activities people were encouraged to undertake household chores and develop their domestic skills. For example, people were involved in cleaning their rooms, changing their beds and helping to cook meals. One person told us, "I do cooking at college and cook pasta for the whole house…I have to clean my room too". A staff member told us, "It's important that they are as independent as possible, that we don't do things for them unless they ask for help. If they ask for help, I try and show them a way of doing it themselves, for example, showing [the person] how to tie their shoelaces….we encourage every individual".

Information given to people was in an 'easy read' format which helped them to understand it and enhanced their ability to make informed choices and decisions. People had access to a 'service user guide'. This was in an easy read format and included information about the service, the people living there, how many staff would be available to support them and how their cultural or religious beliefs would be met. The service user guide also explained that people could have the support of an independent advocate if they wished. This all helped to ensure that people were supported to be involved in making decisions about their care and support.

Staff respected people's private space. The registered manager introduced us to each person using the service and sought their permission before showing us their rooms. People were able to lock their rooms using their own key. During a recent survey, one person had said that staff were not always knocking on their door before entering. In response a notice had been placed on their door reminding staff of the importance of doing this. People's care plans included information about how staff should support them should they display behaviours in the community that could compromise their dignity. Staff told us how they ensured

people's doors were shut when personal care was taking place or stepped outside the bathroom whilst people were drying themselves to give them some privacy.

Good

Is the service responsive?

Our findings

Our observations indicated that staff knew people well. They were able to give us examples of people's likes and dislikes and needs which demonstrated this. We were given examples of the types of activities people enjoyed most as well as their preferred daily routines. A staff member told us, "There has been the same core staff for a long time….the key worker system works well too, you get to know them which means we can cater better to what they want". The relatives we spoke with felt involved in their family members care. They felt that the staff kept them informed and updated them quickly about any changes in people's needs. One relative said, "The staff are quite approachable, any problems, they let you know straight away, we are always aware of what's going on". People and their relatives were also positive about the activities provided. One relative said, "[staff member] takes him out for long walks, he loves walks".

People's needs were assessed before they moved into the home. The information provided helped to ensure that staff would be able to support and care for the person appropriately and served as the basis for developing the fuller person centred plan. We viewed three people's support plans which were detailed and contained information about them as a person. For example, the support plans noted 'What those who know me like about me' which for one person was their ability to 'sing songs' and to be 'mischievous'. The plans also provided information about people's daily routines, their needs, how they communicated and what aspects of their behaviour might mean. One person's support plan contained detailed information about the potential triggers for self-injurious behaviours and the strategies staff could use to de-escalate these. A specific tool had been used to help identify the signs that might indicate one person, who was unable to communicate verbally, was content or distressed. Strategies were in place to support staff to manage other behaviours which might challenge others such as screaming in public or declining to get out of the car. This supported staff to deliver responsive care.

Some of the people within the service could at times express themselves through displaying behaviours which could challenge others, which could at times include physical aggression towards others or objects. We reviewed one person's positive behavioural support (PBS) plan. The plan included a description of the antecedents to the behaviour, the non-physical strategies staff should try before resorting to physical interventions and the agreed techniques to be used. The support plan stressed the importance of using the minimum amount of force for the minimum amount of time and that the physical interventions were to be used as a last resort only after all other strategies had failed. Staff were well informed about the approved techniques but told us they had not had to use these for some time. One staff member said, "We know [the person] so well, we work out they are getting agitated and take them to their room which helps them to calm down". We did note that the person's PBS plan had not been reviewed for some years. We spoke with the registered manager about this. They told us a referral had already been made to the provider's behavioural support specialist who would work with staff to ensure that the person's plan was reviewed. This will help to ensure the plan continues to appropriately reflect their individual behaviours and how staff should respond to these.

The registered manager and staff told us that the people who used the service were involved in planning their care and support as much as possible. Meetings were held with people on a weekly basis and were an

opportunity for them to make choices, as much as they were able, about their meals for the week and the activities they wanted to take part in. They were also asked if they had any ideas about the running of the home or any concerns or complaints. People had key workers who worked closely with them so that they became very familiar with their needs and wishes. The key workers produced monthly reports. These contained information about the activities the person had been involved in, any updates to their support plans and the outcome of any medical visits they might have attended. Key workers also monitored the progress people were making toward their goals. For example, it was one person's goal to be involved in cleaning their room. They were making good progress with this. Relatives felt the key worker system worked well. One said, "[the key worker] is very, very good, they are knowledgeable and kind, very good at communicating with me, I trust them". Annual reviews were held and were used as an opportunity for the person, their family and professionals to come together and discuss the ongoing relevance of the person's support plan and any dreams they might wish to achieve.

People regularly took part in a range of activities. Within the home, people were involved in activities such as nail painting or sensory time. Staff led relaxation sessions. We observed one of these which involved people using drums. They appeared to be enjoying this. Some people had their own computers which they spent time on, whilst others enjoyed using their games consoles. Outside the home, people were supported to go for walks in the New Forest or locally. We were told people enjoyed visiting car boot sales, local fetes and markets. One person was doing a cookery course at a local college and another attending a choir. Staff supported another person to go swimming and attend spinning classes which had resulted in a positive impact upon the person's overall fitness and health. In the evening people could if they wished attend local clubs providing activities for people with learning disabilities. A relative told us how their family member talked to them about working in the kitchen with the cook enjoying the opportunity to be helpful. Another relative said, "[the person] goes swimming, church, college, they make sure they are kept busy".

Complaints policies and procedures were in place and were available in an easy read format for people using the service. People told us they would speak with the registered manager if they were worried about something. One person said, "If I was worried I would talk to her [the registered manager], she's the boss". Relatives told us they were confident they could raise concerns or complaints and these would be dealt with. One relative said, "Any problems, I phone up, they always deal with it". The service had not received any formal complaints within the last 12 months.

Good

Is the service well-led?

Our findings

The registered manager was also responsible for managing another of the provider's nearby services and so split her time between the two locations. In both locations she was also supported by a deputy manager. People were positive about the leadership of the home. One person told us the registered manager was, "A good boss, she's alright, good fun". Relatives told us the home was well led. One relative told us the registered manager was "Very approachable….things are dealt with efficiently". Another relative said, "She always keep me informed, she really cares about them [people]". A third said, "They are excellent, they have everything at their fingertips, they have very good knowledge about the residents". Staff were positive about the leadership of the service. Their comments included, "They are very good, they always make sure everything is done" and "They are more than happy to get involved, they are personable".

The registered manager had fostered a positive and person centred culture within the home which focused upon supporting people to receive the care and support they required to have a happy and comfortable life. All of the staff we spoke with were committed to providing a high standard of person centred care and support and were proud of the job they did. When asked what they enjoyed most about their job, each of the staff we spoke with said it was working alongside the people using the service and seeing them enjoy their life. One staff member said, "They are well looked after, have a good quality of life".

People and staff were provided with opportunities to give feedback about the service. Annual surveys were completed, the responses were analysed and an action plan drafted to address any areas for improvement. People's feedback from the last survey in October 2015 was all positive with those responding being either very satisfied or satisfied in all of the areas surveyed which included questions such as 'How satisfied are you that you have become more independent since being supported by the home'. Feedback from staff was also positive and related to issues such as job satisfaction and the effectiveness of management support. Staff meetings were held on a regular basis and were an opportunity to discuss issues with the manager. One staff member told us, "Staff meetings are always an opportunity to make suggestions". Staff clearly enjoyed their work and told us that they received regular support from their manager and that morale amongst the staff team was good. They felt confident going to the manager with any concerns or ideas and they felt that the manager would listen and take action if they could.

There were systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support. The registered manager completed an annual management review of the service which summarised how the service was performing against national standards and internal targets. The provider's quality assurance auditors visited the service approximately four times a year. The most recent visit was in August 2016 and reviewed a number of areas including the accurateness and completeness of care plans and medicines management. Reports were produced as a result of these visits and if any areas for improvement were identified, an action plan was produced which detailed the actions needed to address the shortfall. Staff undertook medicines audits quarterly and daily checks were made of the records relating to people's finances.

Monthly health and safety walk throughs were completed as were checks of the fire and water safety within

the service. We did note that the monthly fire drills had not taken place since May 2016. We discussed this with the registered manager who told us they would take action to address this. A drill was held the week following our inspection.

The registered manager demonstrated a good understanding of all aspects of the home and the needs of people living there. They told us about the challenges facing the service but also about the things they were proud of. For example, they explained they were very proud of how people had developed since living at the service. They were proud that they had maintained a stable staff team and felt they had grown in confidence in the role of registered manager.