Aitch Care Homes (London) Limited

Sheringham House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Sheringham House provides accommodation and support with personal care for men with learning disabilities. The home is registered for 10 people. There were nine people living in the service at the time of our inspection. All the people who lived in the service had varied communication needs. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff while some people were more independent.

This inspection took place on 24 March 2017 and was announced. We told the provider 48 hours before our visit that we would be coming to allow time for the staff to prepare people who may experience anxiety about unfamiliar visitors. At the last inspection on 7 and 9 November 2014 the service was rated as Good.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The experiences of people who lived at the service were positive. People and their relatives told us they felt the service was safe, staff were kind and the care they received was good. We found staff had a good understanding of their responsibility with regard to safeguarding adults.

People's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. Medicines were stored and administered safely. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. We saw people were able to choose what they ate and drank.

People's needs were met in a personalised manner. We found that care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and

where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager and deputy manager was approachable and open. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and resident meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Sheringham 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 took place on 24 March 2017 and was announced. We told the provider 48 hours before our visit that we would be coming to allow time for the staff to prepare people who may experience anxiety about unfamiliar visitors.

The inspection team consisted of one inspector. Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning team that had placements at the home, the local Healthwatch, social care professionals and the local borough safeguarding team. 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, what the service does well and improvements they plan to make.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We spoke with two people who used the service and one relative at the time of the inspection. Not all the people that lived at Sheringham House were able to communicate verbally with us. After the inspection we spoke with three relatives. During the inspection we spoke with the registered manger, the deputy manager, the locality manager, one senior support worker and two support workers. We also spoke with a visiting professional who offered activities and reflexology for people who used the service. We looked at three care files, staff duty rosters, four staff files, a range of audits, minutes for various meetings, medicines records, finance records, accidents and incidents, training information, safeguarding information, health and safety folder, quality assurance records and policies and procedures for the service.

Good

Is the service safe?

Our findings

People who used the service and relatives we spoke with told us that they felt the service was safe. One person told us, "Yes, safe." A relative said, "I believe [relative] is [safe]. No reason to think otherwise." Another relative told us, "I wouldn't leave [relative] there if it wasn't safe." A third relative said, "[Relative] is safe and contented."

The provider took appropriate steps to protect people from abuse, neglect or harm. Training records showed staff had received training in safeguarding adults. Staff were aware of the different types of abuse and could tell us the procedure they would follow to report suspected abuse. One staff member told us, "We have to report." Another staff member told us, "Report to senior on duty and management." Staff were aware of their responsibilities in reporting any safeguarding matters and could confidently tell us the service policy on whistleblowing. Staff were confident in how to raise concerns with their manager and other health and social care professionals if required. One staff member said, "We have a whistleblowing policy."

The registered manager was able to describe the actions they would take when reporting an incident which included reporting to the Care Quality Commission (CQC) and the local safeguarding team. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Staff understood people's risks when they were in and outside of the home. There were risk assessments in place which had a clear emphasis on supporting people to have as much freedom as possible whilst remaining safe. Staff were provided with information as to how to manage these risks and ensure people were protected. Risks that were considered included personal care, falls, daily living skills, activities, accessing the local and wider community, diabetes, epilepsy, choking, night care, medicines, sexual health, finances, and managing aggression. For example, one person had been assessed at risk of skin burns whilst cooking. The risk assessment stated, "[Person who used the service] has little knowledge around the use of the cooker in the kitchen. Staff are to continually remind [person] that the cooker maybe very hot and this could cause injury." The registered manager told us the service completed risk assessments when people went on holiday. Records confirmed this. For example, one person had been diagnosed with epilepsy. The risk assessment for this person detailed the risks when swimming. The risk assessment stated, "Staff are to make the lifeguard aware that in the past [person] has suffered a seizure. Basic first aid trained staff are to accompany [person] in the pool and this must be at least on a one to one basis."

The provider had processes in place to ensure people's finances were kept safe. Records showed that for people who were not able to manage their own finances on returning from an outing or shopping, two staff members would check receipts and these were checked daily. This minimised the chances of financial abuse occurring.

Staff rotas confirmed that the numbers of staff on duty ensured that people received safe and effective care. One staff member said, "We have seven to eight staff on shift." Another staff member told us, "Enough [staff] to look after residents." A third member of staff said, "Days out [registered manager] will say bring in more

staff. If someone calls in sick will usually be covered." We observed that staff responded promptly to people's needs and spent time encouraging them to take part in things they enjoyed. Staffing levels were reviewed regularly and adjusted when people's needs changed. The registered manager and deputy manager were not included within the numbers of staff on duty, but were available so that they remained aware of people's needs and could monitor for any changes, whilst providing on-going support for staff. The registered manager told us, "We have bank staff if sickness or hours to cover. We don't use agency [staff]." A relative said, "Recently they have upped the numbers of staff. Plenty of staff on." Another relative told us, "Always someone is shadowed. Always someone there."

The service had a robust staff recruitment system. Records confirmed that appropriate checks were carried out before staff began work, references were obtained and criminal records checks were carried out to check that staff did not have any criminal convictions. This assured the provider that employees were of good character and had the qualifications, skills and experience to support people who used the service.

People had their medicines managed safely and as prescribed. The policy on medicines was well written, easy to follow and covered safety and security widely. People had their medicines recorded on medicine administration records (MAR). Records showed people's MARs were complete and accurate. Each person had a medicine care plan, which detailed their specific needs. Medicines administered followed the provider's procedure for the person as outlined in their care plan and the prescriber's instructions. We saw when people had PRN (as and when required) medicines there were clear protocols in place to tell staff what the medicine was for and when it was likely to be needed. Medicines were audited regularly to ensure any errors were identified and appropriate action taken to mitigate the errors.

The premises, décor and furnishings were maintained to a good standard. The service had completed a range of safety checks and audits. Health and safety checks included room and fridge temperature checks, first aid, fire system and equipment tests, gas safety, portable appliance testing, electrical checks, water regulations and emergency lighting. One relative told us, "[Relative] room smells nice. His bathroom is clean." Another relative said, "The rooms and en-suites are clean."

People had individual emergency evacuation plans and the service had an appropriate business contingency plan in case of emergencies. Each person had a 'missing person' file ready to be given to emergency services if needed and a 'communication passport'. Each bedroom had a call bell alarm system, which enabled people to call a member of staff when they needed assistance. All staff were trained in first aid and fire awareness. Senior managers were scheduled in an on-call rota during out of office hours.

Good

Is the service effective?

Our findings

People were supported by staff who were well trained and supported and had the skills necessary to meet their needs. One person told us, "I like the staff." A relative said, "The staff are friendly. Very accommodating and answer questions." Another relative told us, "I was impressed and still impressed with the staff."

New staff were supported with a four week induction programme. One staff member said about induction, "Two weeks in the office and two weeks shadowing." Newly employed staff had embarked upon the Care certificate, a nationally recognised qualification for the induction of health care support workers and adult social care workers. The induction included meeting all staff and people who used the service, shadowing more experienced staff, reading care plans and risk assessments, and a range of training sessions. Records confirmed this.

Staff we spoke with told us they were well supported by the management team. They said they received training that equipped them to carry out their work effectively. Staff training records showed staff had completed a range of training sessions, both e-learning and practical. Training completed included emergency first aid, autism, medicines, safeguarding adults, manual handling, mental health, communication, diet and nutrition, equality and diversity, fire awareness, food safety, health and safety, infection control, documentation, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One staff member said, "I asked to go on a [specific training course]. Two weeks later I got it." Another staff member told us, "I like the training we get. We got autism training and the [trainer] was autistic."

Staff received regular formal supervision and we saw records to confirm this. One staff member said about supervision, "Every six weeks. Any concerns we've got. You can have a moan and discuss anything." Another staff member told us, "Anything we need help with or training you want." A third member of staff said, "Get supervision every six to eight weeks. If we are happy and any concerns we have. For me I get a lot off my chest." Annual appraisals with staff to discuss and provide feedback on their performance and set goals for the forthcoming year were carried out.

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.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity. The registered

manager told us and records confirmed they had applied for DoLS authorisations for eight people living at the service. Where people had been assessed as not having mental capacity to make decisions, the registered manager and staff were able to explain the process followed in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications in a timely manner. One relative told us, "We have had best interest meetings with an independent person." This meant that the CQC were able to monitor that appropriate action had been taken. This meant the home was meeting the requirements relating to consent, MCA and DoLS.

We heard staff offering people choices and gaining consent from them throughout the day. We saw that people could access all shared areas of the home when they wanted to. We saw people going back and forth to their bedrooms, the lounge, kitchen, and dining room. People could go to the local shops, local swimming pool, college or cafés with support from the staff. One relative told us, "[Relative] is given choices. They [staff] don't push him if he doesn't want to go out." This meant that people could have the independence and freedom to choose what they did and where they went, in safety with as little restriction on their liberty as possible.

Some people were supported by staff to eat and drink. We observed staff offered a choice of drinks throughout the day and healthy snacks. People were able to access the kitchen with assistance of staff and prepare drinks safely. We observed one person being assisted during lunch ate at a pace that minimised the risks of choking. The choice of menus was based on guidelines obtained from an internet website that promoted 'changes for life' and that provided pictorial healthy recipes. People's dietary requirements were discussed at staff and resident meetings. One person told us, "Food is nice." A visiting professional said, "They [people who used the service] have nice food." A relative told us, "Every meal smells nice." Another relative said, "[Relative] always has access to enough food. They try to give him food he likes."

Food and fluid intake was recorded daily for each person. People's weights were monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted. One relative told us, "They keep [relative] weight under control." Food was prepared and people supported to eat at different times to accommodate their different needs and the challenges that meals times posed for some people. Staff knew about people's dietary preferences and restrictions. Specific dietary needs for people who had diabetes or for people who needed soft diet were respected.

Healthy living was promoted by the service and in practice. People had separate health files in which their medical, mental health needs and health care professional visits were recorded with clear objectives and recommendations for staff to follow. For example, a dentist's recommendations were noted following a review of a person's care and recorded in their health file. People were weighed monthly and encouraged to eat healthy snacks and people's diet was monitored to ensure that satisfactory weight was maintained. Equipment such as seizure monitors were provided at night for people who were at risk of seizures to ensure prompt staff response. People's state of health and general wellbeing checks were recorded by staff every morning, afternoon, evening and several times at night time. Records confirmed this. A reflexologist visited weekly and a chiropodist visited regularly. A relative told us, "They [staff] take him to the GP whenever he needs it. He has regular six monthly epilepsy checking."

Good

Is the service caring?

Our findings

People received care and support from staff who were caring and understood their needs. A relative told us, "Staff are lovely and approachable. It's a lovely place." Another relative said, "They [staff] are aware of each individual's needs." A third relative told us, "I take my hat off to them [staff]. They are considerate and patient."

Our observations showed that people were relaxed in the company of staff, and seemed genuinely happy when they saw them. Staff were aware from facial expressions and hand gestures what people wanted. Staff also used specific points of reference to communicate with people and find out their needs. We saw that staff responded swiftly to people's requests for assistance and took time to explain things so that people knew what was happening. People received good care and support from staff who were caring. One staff member told us, "You spend a lot of time with [people who used the service] watching facial expressions." Another staff member said, "It's like a little family. They [people who used the service] are like friends."

Staff knew the people they were caring for and supporting. Each person using the service had an assigned key worker. A keyworker is a staff member who is responsible for overseeing the care a person received and liaised with professionals or representatives involved in the person's life. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences and these details were reflected in care plans that we looked at. A relative told us, "[Staff member] has been [relative's] key worker for five years. We have a good relationship. If [relative] needs anything [staff member] will let me know. I value [staff member's] judgement as they see [relative] more than me." Another relative said, "The key worker is [staff member]. I do get information if he has a seizure. Let's me know his appointments. I do get information and encouraged to give feedback."

Throughout the course of our inspection we observed staff speaking with and treating people in a respectful and dignified manner. Staff appeared to know all of the people using the service well. Support was delivered by staff in a way which met people's needs, for example staff were observed engaging people in conversation and activities such as dancing with people who used the service and supporting a person to make a cake. We observed staff gave people time and space to do the things they wanted to do. For example, we saw one person go to their bedroom to use their computer.

Staff told us how they made sure people's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms. We observed staff knocked on doors and asked permission before entering people's rooms. Staff told us they tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could. One staff member told us, "We work in their house. We knock on the door. Keep them covered in personal care." A relative told us, "They [staff] will always knock before going in [relative's] room. They will tell him what they are going to do like change his pad." The same relative said, "They take care dressing [relative] and make him look nice. I value that." Another relative told us, "They [staff] always take [relative] to his room to get changed."

People's independence was encouraged. Staff gave examples how they involved people with cooking,

housework and doing certain aspects of their personal care to help them become more independent. This was reflected in the support plans for people. For example one support plan stated, "Staff are to offer to carry the vacuum to my room. I am able to plug it in and hoover my room independently." Another support plan stated, "Once I am in the bath I would like staff to encourage me to wash myself, I may need support to wash my hair and back. I am able to wash my chest, body and face." A staff member told us, "We strive to do [encourage independence]. It's the aim of the service." Another staff member said, "Our aim is [people who used the service] get to go to independent housing."

People's cultural and religious needs were respected when planning and delivering care. Records showed people visited their place of worship. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "They would be treated as anyone else." One staff member said, "Each to their own. We cater to their needs. We have to respect them."

People had regular contact with people that mattered to them. People maintained relationships with people outside of the home and arrangements were made to support them to visit friends and relatives if they chose. Relatives were encouraged to visit people at the service. People developed relationships with people from services they attended and were encouraged to invite people to visit as they wished. A relative said, "Everyone pleased to see you when you are there. They [staff] are very nice."

We looked at people's bedrooms with their permission. The rooms were personalised with personal possessions and were decorated to their personal taste, for example hand painted murals on the bedroom walls, family photographs and stuffed toys.

Good

Is the service responsive?

Our findings

Before a person started to use the service the registered manager would carry out an assessment of their needs, before an agreement for placement was made. This was carried out to ensure that the service could meet the person's needs. We looked at the records of one person who had started to use the service since our last inspection. Records showed that an assessment of their needs had been carried out before they came to stay at the service. Information was obtained from the pre-admission assessment, and reports from health and social care professionals had been used to develop the person's care plan. This helped staff to ensure that people received individualised care and support which took account of their wishes and preferences.

Care records contained detailed guidance for staff about how to meet people's needs. There was a wide variety of guidelines regarding how people wished to receive care and support including their likes and dislikes, personal care, daily living skills, activities, travelling in the community, meals, sleep pattern, religious and spiritual needs, sexual health, and hopes and dreams. The care plans were written in a person centred way that reflected people's individual preferences. For example, one support plan stated "I like to eat my meals in the dining room. I prefer to take my plate back to the kitchen hatch after I have finished and to place my chair under the table. I like to sit back at the table and chat to staff after I have finished my meal." Another example, a support plan stated "When I am feeling sad I will show this through the expression on my face. I will not want to engage with you and will walk up and down the corridor." Pictorial aids were incorporated in care plans to assist peoples understanding. For example, where a person was being offered an activity, pictorial cards were shown to the person to assist communication. The person was encouraged to handle the cards and express whether they felt positive or not. Staff quickly understood the non-verbal communication and acted accordingly.

People and their relatives were encouraged by staff to be involved in the planning of their care and support as much as possible. Staff told us they read people's care plans and they demonstrated a good knowledge of the contents of these plans. One relative told us, "Staff have told me they have read [relative's] care plan. I know that for a fact they have." We were told that plans were written and reviewed with the input of the person, their relatives, their keyworker and the registered manager and records confirmed this. Staff told us care plans were reviewed regularly. One relative told us, "We have annual review meetings. Usually with the manager and key worker." Another relative said, "There is a meeting every six months with [registered manager] and [deputy manager]. The key worker will go and present any relevant information." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People had opportunities to be involved in hobbies and interests of their choice. Staff, people who used the service and relatives told us the home offered a range of social activities. People's care files contained an activities planner and records showed activities were recorded daily. On the day of our inspection one person went to college, and another person went swimming and out to lunch. People were supported to engage in activities outside the home to ensure they were part of the local community. Recorded activities included going to the cinema, attending college, visiting the local pub, walks in the park, meals and visit

family. We also saw people could engage with activities within the home which included arts and crafts, reflexology, music sessions, reading sessions and games. One person told us, "I go to the pub." Another person when asked about activities said, "Reflexology, arts and crafts." A visiting professional told us, "They [people who used the service] go out a lot and do things." One relative told us, "[Person who used the service] has aromatherapy and a woman massages his feet. They asked me what smells he likes." The same relative said, "They take him to the cinema, trampolining, the pub and for walks. They [staff] encourage him."

Resident meetings were held and we saw records of these meetings. Topics included meals, indoor and outdoor activities, holidays and any other concerns. The record of the minutes were in a pictorial format for people. One person told us, "We have a meeting about the home." A staff member told us, "We have resident meetings. Some people are verbal. We use symbols."

There was a complaints process available and this was on display in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure.

Relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions resulting and response to complainant. Records showed the service had one formal complaint since the last inspection. We found the complaint was investigated appropriately and the service provided a resolution in a timely manner. One relative told us, "I would go to the manager. If not addressed I would speak to manager again or go higher." Another relative said, "I would speak to [registered manager] or [deputy manager] in the first instance. The details on how to make a complaint are in the lounge room."

There was a booklet entitled 'Welcome to Sheringham House' that included an introduction to the service and facilities and that provided recommendations about how to respond to people's behaviour when inside the premises. The recommendations took account of the risks involved for the safety of people and for the visitors and were illustrated with examples. The booklet also contained an introductory paragraph on each person to explain how best to communicate with them and individual photographs. This made visitors aware of how best to communicate with people and respected people's dignity as this promoted understanding.

Good

Is the service well-led?

Our findings

Relatives said they found the registered manager helpful and listened to them. A relative told us, "He's always been very open." Another relative said, "I think he is very human and sympathetic. He runs a good home." A third relative told us, "He is lovely. He enjoys the residents. I can have a laugh and a chat. Can be very sensitive when need be. He is really kind." Relative also told us they found the deputy manager supportive. One relative said, "She is lovely. She's nice and very approachable. Her door is always open with a smile." Another relative told us, "I've known her for a long time. She is excellent." A third relative said, "She provides stability in the home." A visiting professional told us, "I really like [registered manager]. He is approachable. He really cares, all the staff do."

There was a registered manager in post and a clear management structure. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff told us the registered manager was approachable. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any concerns raised. One staff member told us, "I love [registered manager] as a manager. He's down to earth and easy to talk to." Another staff member said, "I think he is a great manager." A third staff member told us, "He is really lovely. Really nice guy." Staff also told us the deputy manager was very supportive. One staff member said, "She is amazing. [Deputy manager] is someone who wouldn't hesitate to help you. I can always go to [registered manager] and [deputy manager]. They have a good dynamic that rubs off on the house."

The staff were clear of their role and spoke passionately about how the registered manager supported people to lead meaningful lives and to have a good quality of life. There were clear values that had been developed to enable people to receive the care and support they wanted and to innovatively develop the service to ensure people were actively involved within the home and community.

Staff told us the service had regular staff meetings. Staff said that team meetings were helpful and that all staff had input into discussions about the service. Records confirmed that staff meetings took place regularly. Agenda items at staff meetings included updates on people using the service, safeguarding, training, diet and menu planning, key working, activities, medicines, communication, complaints, infection control, and finances. One staff member told us, "Normally every one to two months. We have an agenda but can speak about anything." Another staff member said, "[Registered manager] will go around the room if you have anything to say." A third staff member told us, "[Registered manager] will discuss what he wants and how the house is going. Staff can say what they want to say."

The registered manager told us that various quality assurance and monitoring systems were in place. The registered manager told us and we saw records of a monthly audit. The audit included checking the staffing levels, recruitment, training, supervision, fire checks, medicines, care plans, maintenance finances, team meetings, complaints, and accidents and incidents. Areas of concern from audits were identified and acted

upon so that changes could be made to improve the quality of care. A locality manager inspected the service every month to check compliance with regulations and make recommendations. Records showed the locality manager checked the registered manager's monthly audits for accuracy. We looked at the last three locality manager's checks which included supervisions, training, maintenance, and care plan reviews. This meant people could be confident the quality of the service was being assessed and monitored so that improvements could be made where required.

The quality of the service was also monitored through the use of regular surveys for people who used the service, their family members and friends, and visiting professionals. Surveys for people who used the service included questions about the premises, garden, food and drink, feeling safe, choices and being involved with discussions about their care. We viewed completed surveys which contained positive results. Overall all the surveys for people who used the service, their family members and friends, and visiting professionals were positive. Comments from the family members and friends included, "I love coming here and I have a good rapport with the staff", and "[person who used the service] receives great care from the staff. I can always ring and speak to [registered manager] if any issues." One relative told us, "They [staff] have asked me a couple of times for feedback. They take things on board." Another relative said, "I have got surveys over the years."

There were policies and procedures to ensure staff had the appropriate guidance, staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current and appropriate.