Marran Ltd

Arran House

Inspection report

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Ratings

Overall rating for this service	Good
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?	Good

Overall summary

We carried out our inspection on 23 February 2015. The inspection was unannounced which meant the staff and provider did not know we would be visiting.

Arran House is a mid-terraced house situated within walking distance of the local amenities available in the centre of Guisborough. It provides residential care and accommodation for up to four people who have learning disabilities and mental health difficulties. At the time of our inspection visit the service had four people living there. Accommodation is provided over three floors, with each person having a private bedroom with washing facilities and toilet facilities being available on each floor. The service provider is the long standing Miltoun House Group, which became a limited company and re-registered as Marran Ltd on 31 December 2014.

The service has a registered manager, who has been registered with us in respect of the service's new registration since 08 January 2015. Previous to this they were registered as manager for the service's previous registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected by the services approach to safeguarding and whistle blowing, with people who used the service telling us that they were safe, could raise concerns if they needed to and were listened to by staff. People who used the service told us that staff treated them well and they had not experienced any 'nastiness'. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and said that management acted appropriately to any concerns brought to their attention.

Safe arrangements were in place for staff recruitment and staffing levels were appropriate to the needs of the people living in the home. Safe systems were in place for storing and managing medicines, which were appropriate to the home and the needs of the people living there.

We had some concerns about risk assessment processes at the service. For example, some risk assessments had not been reviewed as often as we would expect and we did not see any formal risk assessments documented in the individual care files we looked at. Although the provider assured us that people were safe at the service, there was still a potential risk of people not being kept safe, because the provider had not identified, assessed and managed risks relating to the health, welfare and safety of service users.

People were supported by staff that were appropriately trained and supported to carry out their role. For example, training and supervision records showed that staff received relevant training and formal support and staff told us they were well supported by their management.

People's nutritional needs were well met, with people being involved in shopping and decisions about meals. People who used the service told us that they got enough to eat and drink and that staff asked what people wanted. We also saw that people lived in a comfortable home that was suitable for their needs.

The care records we looked at showed that people who used the service had regular access with other health and social care professionals. Other professionals who had recently been involved in people's care included chiropodists, opticians, nurses, GPs and dentists. One healthcare professional told us that they had no major concerns about people's care and that the service had a strong staff team, who create a supportive and homely environment for the people that live there.

Staff were receiving training and demonstrated a basic understanding of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). Where there were questions around a person's capacity and concerns that they might be deprived of their liberty the relevant professionals had been involved. At the time of our visit one person was subject to a DoLS authorisation and another was being assessed to see if a DoLS authorisation was needed. Staff were applying MCA principles in the care they provided, but we found that some issues around capacity and best interest decision making were not always adequately recorded in people's assessments and care plans.

People who used the service told us that staff were caring and treated them well, respected their privacy and encouraged their independence. Some people told us that they personally got on with some staff better than others, but that this wasn't anything to worry about. Our observations showed staff and people who used the service appearing comfortable together and interacting in a friendly and caring way. For example, staff explaining things carefully and encouraging people to be independent where possible.

People's needs were assessed and their care needs planned in a person centred way, although we saw two examples where relevant information had not been included in people's care plans. People who used the service told us that they were involved in reviews of their care plans and had signed their records and reviews to show this. People had access to the local community, and could take part in activities or do the things that interested them. For example, people using the service told us about their recent holidays, cinema trips and outings into the local town for shopping or coffee.

People who used the service had various opportunities to raise concerns or complaints. For example, regular residents meetings and reviews included asking people for feedback or concerns about their care and an 'honest feedback box' was available if people wished to use it. People who used the service and staff told us that they felt listened to.

Summary of findings

The service had a registered manager and supportive senior management structure. People who used the service knew who the registered manager was and had various opportunities to give feedback or raise issues. There was evidence of feedback being listened to and changes being made. For example, changes to meeting arrangements to make it easier for people to raise issues and changes to meal times as a result of feedback from people who used the service. Staff told us that the manager and providers were approachable and supportive. We saw evidence of audits and checks taking place to monitor the quality of the service.

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

Summary of findings

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.

People were protected by the service's approach to safeguarding, whistle blowing, and arrangements for staff recruitment and staffing. There were safe systems for managing medicines.

We had some concerns about risk assessment processes at the service. For example, some risk assessments had not been reviewed as often as we would expect and we did not see any formal risk assessments documented in the individual care files we looked at. Although the provider assured us that people were safe at the service, there was still a potential risk of people not being kept safe, because the provider had not identified, assessed and managed risks relating to the health, welfare and safety of service users.

Is the service effective?

Good

The service was effective.

Staff were appropriately supported and trained to carry out their role. People's nutritional needs were well met, and people lived in a comfortable home that met their needs. People who used the service had access to other health and social care professionals on a regular basis.

People were involved in decision making and staff had a basic understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were applying MCA principles in the care they provided, but we found that some issues around capacity and best interest decision making were not always adequately recorded in people's assessments and care plans.

Is the service caring?

Good

The service was caring.

People who used the service told us that staff were caring and treated them well, respecting their privacy and encouraging their independence. Our observations showed this to be the case.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and their care needs planned in a person centred way, although we saw two examples where relevant information had not been included in people's care plans.

People who used the service had access to the local community, and could take part in activities or do the things that interested them.

Summary of findings

People had opportunities to raise concerns or complaints and felt able to do so if needed. People who used the service and staff told us that they were listened to.

Is the service well-led?

Good

The service was well led.

The service had a registered manager and supportive management structure. People who used the service knew who the manager was and had various opportunities to give feedback or raise issues. There was evidence of feedback being listened to and changes being made.

Staff said that the manager and providers were approachable and supportive.

Audits and checks were in place to monitor the quality of the service.

Arran 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 checked 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 23 February 2015 and was unannounced. The inspection team consisted of one social care inspector.

Before the inspection we reviewed all of the information we held about the service. This included looking at the information we held relating to the service's recent registration process. We spoke with the responsible commissioning officer from the local authority commissioning team about the service. We also looked for any notifications we had received from the service.

The provider was not asked to complete 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. However, they had recently completed and returned a PIR relating to the service's previous registration. The registered manager confirmed to us during our visit that this information was still relevant and valid, as the service continued to be carried on and managed as before.

The inspector spent time talking to all four of the people who used the service. We spent time in and viewed all communal areas of the home, and with the permission of individuals we looked in two people's bedrooms.

During the visit, we also spoke with four staff members, including two care assistants, the house manager and registered manager.

We did not use the Short Observational Framework for Inspection (SOFI) during this inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We felt that it was not appropriate in such a small service where people could talk with us and such observations would be intrusive. Instead we used general observations of people's care and support throughout our visit.

During the inspection we reviewed a range of records. This included three people's care records (75%), including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Following our visit we contacted the local authority commissioners and three health and social care professionals for feedback.

Requires improvement

Is the service safe?

Our findings

Three of the people who used the service told us that they felt safe and comfortable in their home. One person told us that they sometimes felt uncomfortable, but that this was because they'd rather live on their own. This person was currently working with other health and social professionals to see if this would be possible. People who used the service told us that staff treated them well and they had not experienced any 'nastiness' from staff. One person told us, "Got a good home here."

We looked at the arrangements that were in place to protect people from bullying, harassment, avoidable harm and abuse. Information about safeguarding procedures was clearly displayed on a notice board in the kitchen. The staff we spoke with felt that the people living at the service were safe. One staff member told us, "I believe they (people using the service) are safe". Staff were able to describe local safeguarding procedures and demonstrate an awareness of the types and signs of abuse. They told us that safeguarding procedures were in place at the home, were regularly updated and that staff had access to them. The staff were also able to explain how the service's procedures on accepting gifts protected people. For example, how staff did not accept their drinks or meals being paid for by people who used the service while they were supporting them out in the community. We also looked at the arrangements that were in place for managing whistleblowing and concerns raised by staff. Staff we spoke with told us that their suggestions were listened too and that they felt able to raise issues or concerns with the manager and owners. One staff member commented, "If anything comes to our attention we report it and the owners are very, very good at putting things right. No problems at all."

We looked at the arrangements that were in place to manage risk, so that people were protected and their freedom supported and respected. We looked at the care records relating to three people who used the service. There were no formal risk assessments in the care files we looked at, even where staff had worked with people positively to take risks and gain increased independence. Some of the care plans included comments about relevant risks and measures that had been put in place to manage these, but this was not consistent or part of a robust risk assessment process that fed into the development of people's care plans and supported them in positive risk taking. For example, one person's care plan stated that they were now considered safe to go alone to the shops, but there were no details recorded about the assessment of the associated risks or the measures that had been put in place to manage them. We discussed this with the registered manager at the time of our visit.

The service had a Health and Safety policy that had been reviewed and updated in October 2014. This gave a brief overview of the service's approach to health and safety and the procedures they had in place to address health and safety related issues.

We asked to see the health and safety risk assessments that were in place for the service. The provider was in the process of reviewing the service's general health and safety risk assessment, which had previously not been formally renewed since 2010. We were shown the new draft risk assessment dated 30 January 2015, which was currently out for consultation and comments from the registered manager. The draft risk assessment covered all four of the provider's services, but with service specific comments included. On viewing the draft we had some concerns that this overall approach to risk assessment may not adequately recognise and address key differences in the provider's four services. For example, the very different premises and types of service, such as the small domestic type environment of Arran House compared to the larger, more traditional residential set up of another of the provider's services. We discussed this with the registered manager. They confirmed that the new risk assessment was being developed with input from a specialist health and safety consultant and that, where necessary, the final risk assessment would include service specific control measures. In addition they planned to develop detailed documentation in the form of specific policies and procedures where appropriate.

The service's fire risk assessment was dated January 2011. The risk assessment stated that a review was due in January 2013, but there was no evidence that a review had taken place. We discussed this with the registered manager at the time of our visit, who indicated that in reality not much had changed since the risk assessment was completed, but agreed that a review was overdue.

Overall we found that improvements were needed to ensure that robust systems were in place to identify, assess and manage risks relating to the health, welfare and safety

of service users. This was in breach of regulation 10 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that personal emergency evacuation plans (PEEPS) were not in place for each of the people who used the service. PEEPS provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. We asked the manager about this and they explained that the people living at the service were all able to evacuate using the service's standard evacuation procedure, so individual PEEPS had not been judged to be necessary. Records showed that regular evacuation practices had been undertaken, including the people who used the service and staff. The most recent practice had taken place in January 2015. This meant that people knew what to do in the event of a fire and individual PEEPS were not necessary at this time.

We looked at the arrangements that were in place to ensure the safety of the premises. During our visit we looked around the service and found that it was in a good state of repair. We saw that monthly health and safety 'walk around' checks were completed and recorded. A full health and safety audit had been completed in April 2014. The gas boiler and thermostatic valves (valves which automatically maintain hot water outlets within safe temperature parameters) had been serviced and checked in June 2014. The service's fire equipment had been checked and serviced by a specialist company in October 2014. Weekly fire alarm tests and monthly emergency lighting tests had been completed and recorded. Portable appliance testing (PAT) had last taken place in September 2014.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the risk of reoccurrence. The registered manager told us that they had recently implemented an improved system for monitoring and responding to incidents and accidents. This was following an accident not being brought to their attention or recorded in the accident book in the past. Staff were now required to notify the manager of accidents or incidents by telephone and in a monthly management report for the service. The registered manager then carried out a monthly check of accident and incident forms to ensure that all accidents and incidents had been reported and that appropriate actions had been taken. We were shown two recent accident reports, which showed that appropriate actions had been taken. The registered manager also told us that accidents and incidents were considered and discussed during senior management team (SMT) meetings, to look for trends and any further actions that may be needed. We looked at the most recent SMT meeting minutes, but could not see any formal discussion about trends in accidents and incidents recorded. Due to the current client group and scale of the home accidents and incidents were not common occurrences.

We looked at the arrangements that were in place to ensure safe staffing levels. During our visit we saw the staff rota. This showed that the service had a small and stable staff team of five main female staff. The numbers of staff on the rota were appropriate to the needs of the people living at Arran House at that time. Staff told us that only female staff worked at the service, because of the needs of the people living there. The registered manager told us that staffing levels were flexible, and could be altered according to need. For example, when staff had accompanied one person on holiday additional staff had been provided to maintain the usual staffing levels at the home for the remaining people who used the service. During our visit we observed that there were enough staff available to respond to people's needs and enable people to do things they wanted during the day. For example, staff were available to support two people on separate trips out of the home during our visit. The care staff we spoke with told us that there was a long standing and stable staff team working at the home. One staff member said this was "Because they are very well treated." Staff felt that staffing levels were appropriate to the needs of the people using the service and the setup of the home. Staff told us that the small staff team worked well and that there were appropriate arrangements for cover if needed; using staff from the owner's other local services. One staff member told us, "We have plenty of people willing to come in." Another said, "It's not often we have a problem."

We looked at the arrangements that were in place to ensure that staff were recruited safely and people were protected from unsuitable staff. The service had a very stable staff team with the permanent staff having been in post for a long time. However, a new member of bank staff had recently been recruited, so we looked at their recruitment records. The staff file included check lists to

Requires improvement

Is the service safe?

help the provider ensure that the appropriate recruitment processes and checks had been completed. We saw that the staff member had completed an application form, which included information about their qualifications, experience and employment history. There was also an interview record, medical questionnaire, two written references, copies of personal identification and evidence of a Disclosure and Barring Service check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. The recruitment records showed that safe recruitment procedures had been followed.

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. The provider had reviewed their medication policy in October 2014 and provided us with a copy during the inspection. At the time of our inspection none of the four people who used the service looked after or administered their own medicines. Staff had taken over the storage and administration of medicines on people's behalf. When we asked staff about this they told us that the people at the home were either unable, or had shown no interest in self-administering their medicines. We saw that people's care plans contained information about the help they needed with their medicines and the medicines they were prescribed. The care plans we looked at didn't include information about the reasons why people did not self-medicate, evidence that this had been a positive decision made with the person's involvement or information about possible ways to develop increased independence if possible.

We saw that medicines were stored in a locked cupboard in the kitchen and the storage area temperature was monitored daily. We also observed a staff member administer one person's medicines at lunch time. This was done in a pleasant and safe way. We looked at three people's medication administration records (MARs) and saw that medicines had been given in accordance with people's prescriptions. Two people were prescribed medicines on an 'as required' basis (PRN). We saw that PRN guidelines had been written for these medicines, providing staff with information on when they were needed and how they should be given, to maintain the person's safety. Staff told us that all staff had completed training on administering medicines and that this training had recently been updated. Training records we looked at confirmed this. The staff we spoke to were able to describe the medicines used by the people living in the home, including those with specialist requirements and the arrangements for homely remedies. This showed that staff had the knowledge and skills they needed to help people manage their medicines safely.

Good

Is the service effective?

Our findings

We looked at the arrangements that were in place to ensure that staff had the training and skills they needed to do their jobs and care for people effectively. Staff told us that they were up to date with their mandatory training and had completed training that was relevant to the service. They also told us that they were asked in supervision if they had any training needs and could request training they felt was needed. The registered manager showed us the training records for the service's five main staff members and the training that was planned for 2015. The training record showed that staff had undertaken training on food hygiene, fire awareness, infection control, manual handling, medication administration, safeguarding and first aid. The registered manager explained how training in these subjects was considered 'mandatory' and was renewed on a three yearly basis. The training plan for 2015 showed that the training updates that would be due during 2015 were planned. Three of the five staff had achieved formal care qualifications called National Vocational Qualifications (NVQs) and training on the Mental Capacity Act was taking place at the time of our visit. We noticed that only one of the staff members had currently received formal training on mental health awareness. We asked the registered manager about this, because of the specialist nature of the service. They told us that they were looking at providing relevant specialist training and support sessions through group supervision in 2015.

We looked at the arrangements that were in place to ensure that staff were adequately supported, through effective support, supervision and appraisal systems. Staff told us that they received regular formal supervisions, which were completed by the registered manager. Staff also told us that they received appraisals, which were usually completed by the home's owners. When asked if staff felt well supported by their management one staff member said "Yes, yes we do" and another said "They are normally very, very good." The registered manager showed us the support and supervision plan for the service's staff during 2015. This included a programme of six group and one-to-one supervision topics that were to be completed during the year. The topics included general sessions, equality and diversity, feedback and complaints, mental health recovery principles and individual goal planning. Records showed that staff had received a group supervision session during January 2015 and that individual supervision sessions had also taken place.

We looked to see if appropriate arrangements were in place to ensure that people's legal rights were protected by proper implementation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA protects people who lack capacity to make a decision for themselves, because of permanent or temporary problems such as mental illness, impairment of the brain or a learning disability. If a person lacks the capacity to make a decision for themselves, best interest's guidelines should be followed. The DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. These safeguards are designed to protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed and is lawful.

At the time of our visit one person living at the home was being deprived of their liberty and subject to the DoLS. Another person was in the process of being assessed to see if they were being deprived of their liberty and DoLS appropriate in their circumstances. Feedback from a social care professional involved in the DoLS process told us that, in their opinion, staff had a "Basic understanding of the MCA and DoLS." Staff told us that they were in the process of completing additional training on the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). During our visit the manager showed us the workbook that was being used by staff for this training and confirmed that they themselves had signed up for additional training provided by the Local Authority. The staff we spoke with were able to describe the basic principles of the MCA and understood that the people currently living at the home had capacity to make most of their own decisions regarding their care and welfare.

When we looked at people's care records we did not see evidence that the principles of the MCA had been incorporated into the service's care planning arrangements, as recommended by the Social Care Institute of Excellence's report into The Mental Capacity Act (MCA) and care planning. For example, there was no information in

Good

Is the service effective?

one person's care plans about their capacity, being subject to a DoLS authorisation or how their care was to be managed in the least restrictive way possible. This person's care plans also described that they were unable to safely manage their own money and were only given a limited amount of money each week to look after themselves with staff support, but the records contained no information or assessment around the person's mental capacity to make financial decisions or if the restrictions had been decided in accordance with best interest decision making guidelines. Discussions with staff and the manager about this person and their care arrangements evidenced that capacity assessments had been considered during their care programme approach reviews and that best interest decision making had taken place, with the involvement of the individual concerned. The manager has since informed us that this person's care plan has been updated.

We looked at the arrangements that were in place to ensure that people received a balanced diet and received the help they needed with eating and drinking. People who used the service told us they had plenty to eat and drink. One person said "They are nice like that, always doing drinks for you" and "We get loads to eat." Another said "Staff ask us what we want" and "They do very well with the food." Staff were able to tell us about the individual likes and dislikes of the people living at the service. There was no formal menu in place, with people choosing what they wanted to eat on a daily basis. A record of all meals was kept so that staff could monitor people's diet and ensure that a balanced and varied diet was being provided over time. We looked at this record and saw that a variety of meals and snacks were provided.

During our visit we observed the lunch time meal. Staff and people who used the service all sat and ate together at the kitchen table. It was a relaxed and friendly meal, with people chatting sociably. Staff asked people what they wanted and agreed on bacon and sausage sandwiches. We also saw people helping themselves to drinks and the desserts of their choice, either from the fridge or fruit bowl.

Staff described how they has a weekly budget for food shopping, with a weekly big shop completed by staff and daily smaller shops undertaken with the people who used the service. We observed the shopping being unpacked and saw that it contained a variety of fresh foods from the local supermarket, including treats like cakes, biscuits and pies. Staff confirmed that the budget was sufficient and that they didn't just shop "for the basics."

We looked at the arrangements that were in place to ensure that people were able to maintain their health, including access to specialist health and social care practitioners when needed. The care records we looked at showed that people who used the service had regular appointments with health and social care professionals. For example, each record we looked at included regular reviews with the person's consultant psychiatrist. Other professionals who had recently been involved in people's care included chiropodists, opticians, nurses, GPs and dentists. We obtained feedback from one healthcare professional as part of the inspection. They told us, "I don't have any major concerns. They are a strong staff team who create a supportive and homely environment for the people that live there." We also obtained feedback from a social care professional as part of the inspection. One told us that the service worked well for the person they supported and that they were involved in regular reviews with the person and service, to ensure that it continued to meet their needs.

We looked at the arrangements that were in place to ensure that the design and adaptation of the service's premises met the needs of the people receiving care. Arran House is a terraced property that looks like an ordinary house on the street, rather than a residential care home. The premises are intended to provide the four people living there with as much of an 'ordinary' home as possible, while still meeting their individual care and support needs. The home was arranged over three floors, with the main communal living space of dining kitchen, living room and toilet being located on the ground floor. A downstairs bedroom was also available and had been allocated according to the physical needs of the person who occupied it. The other bedrooms and bathrooms were located on the first floor and accessed via stairs. At the time of our inspection the people who occupied these bedrooms were able to manage the stairs and access their bedrooms independently. Staff office space was located on the second floor. Two people who used the service offered to show us their private bedrooms. We saw that their rooms were personalised and comfortable. During our visit we observed that the home was clean and well maintained, providing people with a pleasant and homely place to live.

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. People who used the service told us that they were treated well and that staff were pleasant and caring. Some people told us that they personally got on with some staff better than others, but that this wasn't anything to worry about. One person told us "The staff are really nice and treat us well. Some I get on with better than others, but no problems." The staff and people who used the service told us how each person who lived at the home had a keyworker. The keyworker was a named member of staff who worked closely with the person, to develop a close relationship and make sure the person had the support they needed and in the way they wanted it. During our visit we observed the interactions between staff and the people using the service. Staff were pleasant and caring in their approach, spending time in friendly chatter and explaining things to people where needed. A social care professional told us that "(name of person) thrives in that more caring environment and has developed strong relationships with some of the staff."

We looked at the arrangements in place to ensure equality and diversity and support people in maintaining relationships. People who used the service told us they had been supported to maintain relationships that were important to them. For example, one person told us about their boyfriend and how they visited them. People also told us how they had regular visitors to the home, such as family and friends. Another person told us how they had continued to attend their church on Sundays after moving into the service, because this was important to them.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives and provided with appropriate information, explanations and advocacy to enable their involvement. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, such as their personal care choices. During our visit we observed people being involved in decisions about their day to day lives. For example, decisions about where they spent time, what they ate and drank and where they wanted to go during the day. We also saw that people were regularly asked their opinions and involved in wider decisions about the service during regular residents meetings. For example, we saw that people who used the service had requested an earlier evening meal during one meeting and that this had been implemented immediately.

We looked at the arrangements in place to protect and uphold people's confidentiality, privacy and dignity. People who used the service told us that they could spend time in their private rooms if they wished and that staff respected their privacy and treated them well. One person had chosen to have a private meeting with a visitor in their room during our visit, and staff respected their privacy during this. Staff were able to describe to us how they worked in a way that protected people's privacy and dignity. For example, they described knocking on people's bedroom doors and asking if they could come in before entering, asking permission before doing things and explained how they tried to offer reassurance and reduce or manage embarrassment where necessary. One staff member said "We know people well so can cater for them, try to get them to do as much as possible for themselves." During our visit we observed the interactions between staff and people who used the service and saw that people's privacy and dignity was maintained in the ways staff had described.

During our review of people's care records we saw two written comments which indicated that staff did not always recorded things in a way that treated people with respect or maintained their dignity. For example, staff had used the phrases "very stroppy" and "in a mood" to in records describe two people's behaviours when they were not willing to cooperate fully with staff interventions. The registered manager told us that this was the terminology that the people themselves used to describe their behaviours and that staff were encouraged to use people's preferred terminology where possible.

We looked at the arrangements in place to support people with positive risk taking and to maintain independence. During our visit we observed people being encouraged to help with normal household tasks where they were able. For example, helping to clear away the dishes and wash up after a meal and assisting staff to fold and put away their laundry. One person who used the service told us how they were able to go out on their own and stay with friends when they wanted, saying "I go out shopping by myself" and "Can come and go, as long as they know where you are

Good

Is the service caring?

its fine." Another person told us how they had been learning to be more independent and now felt able go out to the shops on their own. They also hoped to get a place of their own in the future.

Staff we spoke with were able to tell us how they had supported people living at the service to maintain and develop independence and take positive risks. For example, staff described how they had supported one person to use the bus, gradually gaining confidence and independence with the aim of them using the bus independently one day. One staff member told us "We try to promote independence more than anything else, it can take a long time but we get there eventually."

Good

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. People who used the service told us that they were involved in reviews of their care. For example, one person told us how they sat and talked with their key worker to update their care plan and attended their care programme approach (CPA) meetings, which included other relevant professionals. The care records we saw included records of reviews and CPA meetings which had included people who used the service. We also saw that people had signed their care plans to show their involvement.

Each person who used the service had their own care file, which included records and plans relating to their care. We looked at three people's care files (75%). Each file contained information about the individual and their life history. We also saw that each care file contained a selection of care plans that were relevant to the individual. For example, we saw care plans relating to communication, mobility and road skills, nutrition, finance, continence, leisure and hobbies, medication, living skills and holidays. The care plans we viewed contained person centred information about each individual's needs and preferences, and had been reviewed regularly to ensure that they remained up to date and relevant. However, we found two examples where relevant information relating to people's individual care needs had not been included in their care plans. For example, one person told us that they were eating healthily and trying to lose a bit of weight. Staff confirmed that this was the case, but there was no mention of this in the care plan relating to that person's nutritional needs.

We looked at the arrangements in place to help people take part in activities, maintain their interests, encourage participation in the local community and prevent social isolation. People who used the service told us about the activities and events they took part in. For example, one person told us about trips to the theatre they had experienced and their plans for future trips, saying "I've been to see Joseph and I'm going to see Calamity Jane." Another person told us about the holidays they had been on and the holidays they were planning. One person told us how they liked to attend church each Sunday, because this was something that they had done before they moved into the home and was important to them. During our visits we saw two people go out, one enjoying a coffee at a local café and one to look round the local shops. Each of the care records we looked at included a weekly activity plan, showing the activities and events that each person regularly took part in. These included formal college and work placements, trips to clubs, social events and amenities in the local community, and time for domestic and social activities at home.

We looked at the arrangements in place to manage complaints and concerns that were brought to the service's attention. People who used the service told us that they could raise issues with staff and were listened to. One person told us how when they had difficulties they had talked to staff and things had been put right. They described how staff were supportive, taking them out for a drink and chat if needed. Staff told us that the service had a complaints procedure and that a copy of this was available in each person's bedroom. We saw evidence that one person had recently raised an issue, which the manager had logged as a complaint and investigated.

Staff also told us that people who used the service were always asked if they had any problems and reminded what to do if they were unhappy during resident's meetings. The records of residents meetings we saw confirmed that people who used the service were asked their opinions and asked if they had any problems. The registered manager told us how they were making changes to the way residents meetings were organised, to make it easier for people to raise concerns if they needed to. Residents meetings would now be chaired by someone familiar to the people who used the service but who did not work in the home, rather than the home's own staff, so that people would hopefully feel more comfortable raising any issues they had. The registered manager also showed us how they had recently set up 'honest feedback boxes', so that people could bring comments or issues more easily to their attention.

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Is the service well-led?

Our findings

We looked at the arrangements in place for the management and leadership of the service. The registered provider of Arran House had recently changed and was now a limited company, called Marran Ltd. The provider informed us of these changes and made sure that the required changes were made to their registration. The business remained a family run organisation with the same people in charge and carrying on the service as before.

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered manager of Arran House was also the registered manager for three other services in the local area, sharing his time between them. People who used the service knew who the manager was and said that they saw them regularly at the home. Comments made about the registered manager by people using the service included "He's alright" and "He'll talk to you if you want."

Staff we spoke with were complementary about the home's owners, the manager and their approach, telling us that they listened to staff and people who used the service, and made positive changes when needed.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager was able to show us the formal quality audit programme for 2014 and 2015. There was a rolling programme of audits planned for 2015, including medication, health and safety, finances, housekeeping, catering, care plans, policy and procedures, annual development plans and staffing. We saw records of the medication audit and health and safety checks completed during January 2015. Records also showed that audits of catering, medication, housekeeping, staffing, finance and health and safety had been completed during 2014. Some of the completed audits we viewed identified areas for minor improvements, but not all had space to record action plans or the dates that the improvements had been made. This meant that it was not always clear from the audit records if the identified improvements had been implemented. However, the registered manager was able to tell us how they had improved documentation for the 2015 audits to improve this.

The provider held a monthly service user representative group, which people from each of the provider's four services were encouraged to attend. This provided people who used the service with a forum to raise and discuss issues, experiences and actions. Staff told us that a new system for regular meetings was being trialled, so that resident's meetings, staff meetings and management meetings took place within 3 weeks of each other, to allow better communication and handover of information. Records showed that regular residents, staff and management meetings took place and included asking people for their feedback and opinions. We saw examples in the meeting records where people had made suggestions or requests and these had been acted on. For example, arrangements for Christmas and times of evening meals. We also saw evidence of service user newsletters and staff memos that had been distributed to inform staff of particular issues.

Other quality and governance processes were also evident, such as arrangements for staff supervision and support, accident and incident systems, care plan reviews and service reviews, which included the people who used the service and other professionals involved in their care.

We looked at how the service worked with other agencies, such as the local authority, commissioning groups and other stakeholders. The main commissioning local authority had undertaken a quality review of all of the provider's services during April 2014. The provider had provided the local authority with an action plan, detailing how they were making the suggested improvements or explaining what they had in place and why they felt this was appropriate for the needs of the service.

The law requires that providers send notifications of certain changes, events or incidents to the Care Quality Commission (CQC). Due to the current client group and scale of the home notifiable incidents were not common occurrences. The only recent notifiable event that had occurred was a person who used the service becoming subject to the deprivation of liberty safeguards (DoLS). Although the registered manager was aware that certain notifications needed to be made to CQC they had not yet notified us of the DoLS. We discussed notification

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Is the service well-led?

requirements and the registered manager agreed to submit the required notification and refresh staff knowledge on the notification requirements, to ensure that appropriate notifications were always made in future.

We looked at the culture of the service, including if it was open, transparent and accountable. Throughout our inspection the registered manager was open and cooperative, answering questions and providing the information we asked for. They were open about areas for improvement they were working on and open to our feedback regarding areas for improvement. This included asking us to sign post them to relevant good practice guidance where they thought this might be helpful.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. This was in breach of regulation 10 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.