Island Healthcare Limited

Tile 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

Tile House is a care home registered to provide accommodation for up to 19 people, including people living with a cognitive impairment. At the time of our inspection there were 18 people living in the home.

The inspection was unannounced and was carried out on 23 May 2016.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

Staff were responsive to people's communication styles and gave people information and choices in ways

that they could understand. They were patient when engaging with people who could not communicate verbally and who used a variety of signs, noises and body language to express themselves. Staff were able to understand people and respond to what was being said.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Tile 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.

The inspection was unannounced and was carried out on 23 May 2016 by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send to us by law.

We spoke with the three people using the service and engaged with eight others, who communicated with us verbally in a limited way. We spoke with five visitors and a health professional. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three members of the care staff, the chef's assistant, the deputy manager, the registered manager, the estates manager, the financial director and one of the providers.

We looked at care plans and associated records for four people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in December 2013 when no issues were identified.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person described how the staff helped them they said the staff, "are lovely and I feel safe getting in and out [of the bath] I can't do it myself anymore". Another person told us they would rather be at home but liked it at the home because, "Staff look after me". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "[my relative] has visual problems associated with dementia. Staff keep the floor uncluttered, which is important because [my relative] spends a lot of time walking from room to room". Another family member, whose relative was in the home for a period of respite told us their relative was "not safe at home in the bath, they help him bathe here". A health professional told us they did not have any concerns regarding people's safety. They said "This home is very good; the staff are on the ball". They added "People are safe".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us if they had any concerns, "I know I can go to [the deputy manager], [the registered manager], [the provider] or you [CQC]". They added the registered manager "listens" and was also "Very understanding".

Each person had a safeguarding care plan which described measures staff should take to keep people safe. For example, how staff should support a person who occasionally displayed behaviour that staff or other people using the service may find distressing. The registered manager explained the action they would take when a safeguarding concern was raised with them and the records confirmed this action had been taken when a safeguarding concern had been identified. The registered manager had reported these to the appropriate authority in a timely manner.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person, who was at risk of falling, had a risk assessment in place in respect of the support staff should offer to help them mobilise. During the inspection we observed staff monitoring this person and offering support in line with their risk assessment.

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. Each person's care plan contained a 'My Life, a Full Life' care passport, which provided the information, in an easy read format, necessary for health professionals to support that person should they be taken to hospital in an emergency.

People and their families told us there were sufficient staff to meet people's needs. Comments included

"Nothing is too much trouble", "We are lucky to have [my relative] here" and "[my relative's] room is immaculate". A health professional told us there was enough staff to look after people safely.

The registered manager told us that staffing levels were based on the needs of the people using the service. They said, "Staffing levels have evolved with people's needs. For example we now have two waking night staff instead of one and one [one waking night and one sleeping night]. We have also created a twilight shift, which is a vital role supporting people in the evening". The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff employed by the provider at other homes and agency staff. The registered manager was also available to provide extra support when appropriate.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager had a process in place to review the DBS checks annually to identify whether staff circumstances had changed.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed by the registered manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "Staff are good they look after me". A family member told us, "Staff here are very good at recognising when [my relative, who was not able to verbally communicate] is feeling unwell". They added "The managers always let me know if they are concerned". Another family member said, "The staff notice if anything is wrong with [my relative] and let me know, she has a cough and the Dr is coming in to-day". A health professional told us the staff were knowledgeable about the people they supported and they did not have any concerns about the staff's ability to look after people effectively. They said staff provided "very very good care".

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, a best interest decision had been made in respect of one person who lacked capacity to enable a health professional to administer a 'flu jab'. A best interest decisions were also made in respect of the use of restrictive equipment such as bed rails and pressure mats.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

People and their families told us that staff asked for their consent when they were supporting them. One family member said their relative "will let everybody know if he does not want to do something. He is not slow in coming forward". A visiting health professional told us the staff always sought consent before providing care.

People and their families told us that staff asked for their consent when they were supporting them. Where people could consent and agree to care this was sought prior to care or support being provided, such as

offering to provide support to help them mobilise. Before providing care, we observed staff seeking consent from people using simple questions and gave them time to respond. Daily records of care showed that where people declined care this was respected. One member of staff told us, "I always check with people first. I explain what I am doing and it's their choice". They added, "If they don't want to do something I leave it and go back later which seems to work but it is always their choice".

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS are the standards employees working in adult social care should meet before they can safely work unsupervised. Staff, new to care, who were recruited after April 2015, received an induction and training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Each new member of staff was allocated a mentor as part of their induction who was an experienced member of staff. New staff spent time shadowing their mentor, working alongside them until they are competent and confident to work independently.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, epilepsy awareness, dementia awareness, mental capacity act and deprivation of liberties safeguards. Staff were supported to undertake a vocational qualification in care. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us they had regular supervisions and had an appraisal yearly but to be honest I am always coming up to see [the registered manager] if I have a concern about anything".

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person told us, "The food is lovely". A family member said, "[my relative] is a vegetarian, [they] have good food here and on Christmas Day I came for lunch and we both had a very special meal". Another family member told us, "There was a high tea recently here when relatives were invited, lovely food and on Friday's there's always fish and chips which [my relative] likes, its high quality". A third family member said their relative had a small appetite and was offered small portions at regular intervals. The cook and kitchen staff were aware of people's likes and dislikes, allergies and preferences. People were provided with a choice of food and an alternative was offered if they did not want what was offered.

Meals were appropriately spaced and flexible to meet people's needs. Meal times were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. For example one person needed extra support with their meal. A member of staff saw this and intervened sitting next to her and encouraging them to eat. On a different occasion the registered manager identified that one person was not eating. They spoke with the person, offering them an alternative which they agreed. The register manager then sat with the person and engaged with them while they ate their replacement meal. One person, who had just woken up, from dozing in their chair, was offer the opportunity to eat their meal where they were, which they agreed. Staff then supported

the person allowing them the time and space to eat their meal at their own pace. Drinks, snacks and fresh fruit were offered to people throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A professional told us staff "always know where people are and I trust them to do what we have asked". They added "This is one home I would recommend".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People's comments included "Staff are nice" and "It's lovely". A family member told us "We looked at [a number of home's] before this one. We immediately felt this was the right one for [my relative]. This is his forever home". Another family member told us their relative was living with dementia and had starting attending the home as a day visitor, as their dementia worsened their the relative moved to become a permanent resident. They said that the transition was made easier because "this is a caring environment. The staff are friendly and understanding. They care about the well-being of the residents". A third family member said, "Everyone is always so welcoming, everyone says hello to you, I feel supported". A health professional told us staff we caring and supportive of people living in the home.

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One member of staff supported a person to sit down at a table. Gently informed them that the chair was behind them and it was safe to sit down. They patiently supported them to move their chair until they were comfortable and the sat next to them and engaged with them looking at a magazine. Staff were attentive to people and checked whether they required any support. For example one person, had fallen asleep in the chair and slumped over to one side. The deputy manager gently woke the person and supported them to reposition themselves so they were more comfortable. She then offered to get the person a pillow to "prop herself up on to, which was accepted.

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected.

We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. A member of staff told us that when supporting people, "I always close the door, make sure the curtains are drawn and cover people up when helping them. I explain what I am doing and stay in their vision so they are not surprised".

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. One member of staff told us they "always read the care plans so they know their [people's] needs".

People were encouraged to be as independent as possible. One person told us staff, "We try and help people to maintain their independence and encourage them to get involved in activities. We join in and are available to help people if needed". Staff praised people's efforts and we saw their faces which reflected a

sense of achievement.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. One person said they had "talked to the manager because I didn't like it when another resident had once walked into my room". They told us that as a result of their concern, the lock had been changed and they had been given their own key. One family member said, "I can leave my mum here; she is well cared for". Another family member told us, "I like it here mum can walk around, it's nice and light". A health professional told us that staff were, "really well organised, they respond to clients changing needs with a common sense approach".

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication care plan' which provided information about their communication style. For example, one person's communication care plan identified the need for staff to support them with a pictorial aid.

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which were individualised and detailed people's preferences, backgrounds and behaviours. They also included specific individual information to ensure medical needs were responded to in a timely way. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs.

People received care and treatment that was personalised and they or their relatives were involved in identifying their needs and how these would be met. One family member told us, "I was involved in the planning of [my relative's] care when admitted to the home. I've read it [care plan] and look at it regularly". They added "When the manager or deputy updates the care plan, they discuss any changes with me".

Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their meals and when mobilising. This corresponded to information within the person's care plan. Staff were kept up to date about people's changing needs through a formal handover meeting at the start of each shift. Relevant information about risks or concerns and care provided to people was handed over. All oncoming staff were present and the handover was of an appropriate duration to allow staff to ask questions or clarify information.

The registered manager informed us that they were trialling of a new electronic diagnostic system. This system allows them to measure and monitor people's temperatures, blood pressure and other vital signs parameters for clinical review at a remote location using phone lines or wireless technology. They were able to give examples where this new system had been used to support people and had prevented the need for hospital admission. Staff had received training in the use on this new system, which was still under evaluation.

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. One family member told us that care staff had recognised that their relative preferred classical music and they always offer her the opportunity to listen to some in her own room and as part of the activity sessions. People were encouraged to engage in domestic activities that helped to maintain their life skills. For example, some people choose to take part in vegetable peeling in preparation for lunch. This was a social event and a member of staff was nearby to support people if required. The deputy manager asked one person, if they would like to join a group of people engaged in a singing activity in the lounge area or help with setting the tables for lunch. The person replied "let's do both" and went off happily with the deputy manager.

Staff encouraged people to interact with the homes cat, who had been chosen by some of the people from a rescue centre. Other people spent time stroking two large toy dogs; they appeared relaxed and liked this tactile opportunity. Other activities included craft and art work, chair exercise and reminiscence. Where people did not want to engage in group activities staff interacted with them on a one to one basis. One person told us, "I like to sit here and do my knitting" They added "They [staff] stop and say hello and am I alright".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People had access to advocates who were available to support them if they were unhappy about the service provided. The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. A family member told us "I haven't got any [concerns] but I wouldn't worry about going to [the deputy manager] or [the registered manager]. I'm lucky to have [my relative] here".

The registered manager also sought formal feedback through the use of quality assurance survey questionnaires sent to people, their families and staff. We looked at the feedback from the latest survey, from February 2016, which was all positive in respect of the care people received. Comments included 'kindness and helpfulness of staff', 'a good quality home', 'friendliness of staff and the atmosphere' and "the care and food excellent; and understanding staff'. The registered manager explained the action they would take if concerns were raised.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. This information was also available in an easy read format. The registered manager told us that people's keyworkers would support them to raise any complaints initially and people also had access to independent advocacy services if they needed them. All of the family members knew how to complain but told us they had never needed to. The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received. A visiting health professional told us "If I had a concern I would have raised it with the management here. I feel [the registered manager] would be responsive".

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us they had received one complaint from a family member during the previous year. They explained the action they had taken to investigate the complaint and respond to the concern raised.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One family member, whose relative had a cognitive impairment said they had talked to registered manager about taking their relative to their spouse's funeral. They told us, "[My relative] coming here has made a big difference to me. Even at [their relative's spouse's] funeral [the registered manager] and [the deputy manager] brought [my relative] to the funeral and sat with us". They added "Friends at the funeral commented on how well [my relative] was treated". Another family member said, "When we came here there was an immediate feeling of well-being". A health professional told us they did not have any concerns over the management of the home.

The providers were fully engaged in running the service and their vision and values were built around 'Valuing individuals; Inspiring them to keep; Treasured memories; Active; Lives' VITAL. The provider said their underlying philosophy was "built on compassion. Staff look after people, their families and each other. For good dementia care you have to understand the family". There were posters explaining the VITAL philosophy and reinforcing the provider's expectations with regard to people's experiences of the care displayed in the home. There was a clear management structure, which consisted of a registered manager, a deputy manager, a head of care, senior care staff and support staff. Staff understood the role each person played within this structure. There was the opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities, such as informal interactions with the registered manager, client forums and the feedback survey.

Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said the registered manager was "definitely approachable and [the deputy manager] was always on the end of the phone if you have any problems". Another staff member told us "I love working here; [the registered manager] listens to you. She is very understanding, confidential and I can always go to her with anything".

Family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided. The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager told us that support was available to them from the provider. They were also able to raise concerns and discuss issues with the registered managers of other locations owned by the provider.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The provider carried out their own quality assurance process and provided documentary feedback of their findings to the registered manager. These included observational checks in line with the fundamental standards of care. The registered manager carried out

regular audits which included medicines management, staff files, infection control, environmental health and safety, and fire safety. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The providers were responsive to new ideas and had developed links with external organisations and professionals to enhance the staff's and their own knowledge of best practice and drive forward improvements. They were a member of the Isle of Wight Safeguarding Adults Board, Chair of the Isle of Wight Registered Care Homes Association and had worked with other professionals in developing wider health care initiatives, such the Alzheimer's café.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.