Island Healthcare Limited

Northbrooke 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

Northbrooke House is registered to accommodate up to 62 people. The home provides services to a range of people in three distinct units. Services include rehabilitation and nursing care in Hazel Lodge, nursing care for older people in Mercury Suite and care for people living with dementia in Rylands Suite. At the time of the inspection the home accommodated a total of 59 people.

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

The inspection was unannounced and was carried out on the 17 March 2016.

The people, their families and health professionals told us they felt people were safe. People experienced care in a safe environment because the registered manager and staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety.

People were protected from individual risks in a way that supported them and respected their independence. 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 enough information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received the appropriate training, professional development and supervision to enable them to meet their 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.

People received their medicines safely. 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 their competency to administer medicines had been assessed. Healthcare professionals such as GPs, chiropodists, opticians and dentists were involved in people's care where necessary.

People and their families told us that staff asked for their consent when they were supporting them. 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, respecting their choices and privacy. People were encouraged to maintain their family relationships.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported

people 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 speaking with people and gave them time to respond to what was being said.

People and when necessary their families were involved in discussions about their care planning, which reflected their assessed needs. Each person had an allocated keyworker and a key nurse, who provided a focal point for that person and maintained contact with the important people in their circle of support.

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

People's families told us they felt the service 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 service.

There were systems in place to monitor quality and safety of the service 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.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people.

People were protected from individual risks in a way that supported them and respected their independence.

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

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 ongoing 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.

People were allocated a keyworker and a key nurse who provided a focal point for their care and support.

The registered manager sought feedback from people, their families and health professionals 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 registered 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.

Northbrooke 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 17 March 2016. The inspection team consisted of three inspectors and two specialist advisors. The specialist advisors had clinical experience and knowledge of frail older people and in particular those living with dementia.

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 11 people using the service and engaged with 10 others, who communicated with us verbally in a limited way. We spoke with 13 visitors and four health professionals. We observed care and support being delivered in communal areas of the home. We carried out pathway tracking of four people using the service, which meant we observed them and how staff interacted with them, looked at their care records and spoke with them and members of their family. 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 six members of the care staff, two nurses, three heads of care, two deputy managers, the activities coordinator, members of the administration, domestic and kitchen teams, a volunteer, the training manager, the registered manager and two directors.

We looked at care plans and associated records for 13 people using the service, staff duty records, eight staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in February 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said the home was a, "lovely place to live. This will be my home until I die". Another person told us, "Staff are very good". Visitors and health professionals told us they did not have any concerns regarding people's safety. One visitor said their relative was, "as safe as they can possibly be. The staff do their best to ensure [my relative] is safe". Another visitor told us, "the staff really care, I don't worry about [my relative] when I'm not here. They always call me if there is a problem".

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. They said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns.

Each person had a safeguarding care plan which described measures staff should take to keep people safe. For example, that a person could use a call bell and this should be in reach at all times. Within care plans there was an inventory of personal items including some photographs of more important/valuable items such as spectacles, which would help staff identify these if they were mislaid.

A member of the administration team had been given responsibility for oversight of safeguarding incidents within the home. They explained the action they would take when a safeguarding concern was raised. Each incident was discussed with the registered manager and the records confirmed the appropriate action had been taken when a safeguarding concern had been identified. The training manager told us they were made aware of all accidents and incidents so they were able to feedback any learning into the training programme. The registered manager ensured that any incidents were reported 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 was at high risk of falls. A falls risk assessment had been completed and detailed the action that staff should take to reduce the risk. This detailed the use of a pressure alert mat to inform staff when the person stood up. The assessment and guidelines also stated that 'bed rails should not be used unless unwell as [person's name] likes to sit on the edge of their bed'. This showed people's wishes were considered and risk management was the least restrictive as possible. A visitor told us staff, "always keep me up to date of that is happening with [my relative]. If they have a fall they tell me straight away".

Where risks were identified action was taken to reduce the risk. For example, people who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, according to the person's weight although there was no formal system to regularly check these were at the correct setting. Where people needed to be assisted to

change position to reduce the risk of pressure injury, their care records confirmed this was done regularly. One visitor said, "[My relative] has been cared for in bed for almost four years. Staff turn them every few hours and they have a special mattress as well. The staff must be doing the right things as [my relative] does not have any pressure sores". Moving and handling assessments clearly set out the way to move each person and correlated to descriptions given by care staff. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance.

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 of this, which was reviewed and action taken to prevent any reoccurrence. We observed monitoring of a person over a period of time following an accident to support them and ensure their well-being. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, use of bed rails, nutrition, moving and handling, and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm.

People, their families and health professionals told us there were sufficient staff to meet people's needs. A visitor said their relative was "definitely safe" at the home and added "There is always four staff on [in the unit]. There is never a time when you can't find a member of staff when you need one".

The registered manager told us that staffing levels were based on the needs of the people using the service. 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 from one of the other units within the home and agency staff. A head of care told us that because of the complex needs of the people in the Rylands suite, which supported people living with a cognitive impairment, agency staff would be placed in one of the other units and staff from that unit would support the people in the Rylands suite.

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.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed. Each of the three units within the home managed their medicines in a way that best meet the needs of the people they were supporting. In the Mercury and Hazel Lodge units the medicines were administered by qualified nurses, while in the remaining Rylands unit other staff were trained and assessed to administer medicines. 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. A document contained staff members names and their initials provided a clear guide as to who had administered the medicine and initialled the MAR chart.

Care plans contained information to assist staff to support people who declined to take their medicines. When necessary GP advice was sought to ensure people received their medicine safely. For example, care records showed that a GP had been consulted when a person refused to take their antibiotics. On another occasion the GP was consulted about changing a medicine which was making the person feel nauseous. 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.

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, in each unit, 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.

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. Evacuation Ski sheets had been provided, which are an aid to assist staff to evacuate people with limited mobility in an emergency.

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 so helpful they assist me to eat". A family member told us, "My overall impression of the home is it is amazing. I am here in the morning and afternoons. The staff are lovely; the level of care is perfect. They know how to deal with [my relative] on a bad day". Another family member said "[My relative] always looks well cared for, personal needs met". A third family member told us, "Staff understand [my relative's] needs and how to look after her. [My relative] is very happy with her interactions with staff". Health professionals 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.

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, such as the delivery of personal care, the administration of medicines, the use of bedrails any decisions made on their behalf must be in their best interests and as least restrictive as possible. We saw staff consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests.

The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. Best interest risk assessments were seen in care files in respect of some aspects of care people required such as bed rails and pressure relieving mattresses. We saw MCA and best interest decisions were specific to the decision that had to be made. In one person's records the MCA assessment identified they had the capacity to decide on whether or not to have a flu immunisation but concluded they did not have the capacity to decide where they should live, which was subject to a best interest decision. People were also supported by an independent advocate or an independent mental capacity advocate (IMCA), when appropriate, for important decisions that affects their lives.

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 when appropriate.

The registered manager carried out a review of the applications on a regular basis to ensure they were still required. An IMCA was also a regular visitor to the home to review the DoLS authorisations. 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 person said, "Staff will always do what I ask them to do". A family member told us staff, "always seek consent". 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. One member of staff asked a person whose foot had come off of their wheelchair foot plate "Is it okay if I move your foot so it doesn't get hurt". Another staff member told us, "If a person says that they don't want care I will ask again and then leave them. I will then go back later or get another staff member to ask them". Daily records of care showed that where people declined care this was respected.

There were arrangements in place to ensure staff received an effective induction into their role to enable them 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. New staff 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. The training manager explained that 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.

People were supported to have enough to eat and drink. People told us they enjoyed their meals. People's comments included "The food is lovely", "The food is always nice", "The food is absolutely delicious" and "I am a vegetarian and they cater for me". Family members were complimentary about the food and told us their relatives were supported to eat the food they liked. One family member said, "If [my relative] isn't eating they offer something else. I saw a carer make someone a sandwich because they didn't want what was offered". 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. During lunch a member of staff asked one person "Do you want potatoes or chips" with their lunchtime meal. Another member of staff who was serving vegetables asked a person "is that enough for you".

Mealtimes were a social event with lots of laughter and staff engaged with people in a supportive, patient and friendly manner. People were supported to be as independent as possible and were provided with special cutlery when needed. One person wanted to remain in their lounge chair and eat their meal without assistance. Staff arranged for the person to have a tray with a tea towel on their lap and allowed them the time and space to eat their meal at their own pace. Staff were aware of people's needs and offered support when appropriate. One person said, "Staff are so helpful, they assist me to eat". A family member told us their relative was "able to feed themselves. [My Relative] sometimes needs help and staff are there supporting her while encouraging her to be independent". A choice of snacks and drinks were available throughout the day. Snacks included a choice of biscuits, fruit, crème caramels, fromage frais and yogurts. Drinks offered included tea, coffee, milkshakes or fruit juice.

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. One family member told us their relative "has their own hairdresser and chiropodist visit her as she didn't like the one in the home".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People, Family members and health professionals told us they did not have any concerns over the level of care provided or how it was delivered. One person Said, "This is a lovely place to live. It will be my home until I die". They added "Staff are always so helpful, they take me down into the lounge to join in with activities and take me out regularly". Other comments from people included "I have nothing but praise for the staff who work so hard", "Staff are really good" and "Lovely staff". One family member said "I can't praise the home enough; the level of care is perfect. The staff are lovely and they love my mum". Another family member told us "The home is good and the level of care provided is good". They added "I have even moved house so [my relative] can stay here". A third family member said the care was so good "I'm booking myself in".

People were cared for with dignity and respect. Staff spoke to people with kindness and warmth and were observed laughing and joking with them. A member of staff asked a person sitting in a wheelchair "Can I just turn you around [name of the person]". Then waited for their agreement before moving them. A family member of a person with a cognitive impairment told us "Staff always make sure [my relative] is smart and well turned out. They always make sure she is co-ordinated. She would like that". Staff responded promptly to people who required assistance. A person sneeze and a member of staff said "bless you" and provided a tissue and reassurance as the person had a cold. Another person was looking uncomfortable while sitting in their chair. Staff quickly became aware of this and spoke with the person before helping them to reposition themselves. On a different occasion staff supported another person to move to a chair in the lounge area. Staff took the time to ensure the person's jumper was pulled down straight and provided a cushion for their comfort. A member of staff told us ""None of us ever lose sight that we work in their home. They do not live in our workplace". They added "We treat our people like family. I would not hesitate for one of my family members to live here". A volunteer said "Everyone here seems so happy and nothing is too much trouble" They said they had "nothing but praise for the place".

Staff understood the importance of building up relationships with people and respecting their choices and privacy. Staff explained how they engaged with people and developed relationships with the people they supported and their families. One member of staff was heard to say to a person "I expect your [relative] will be in shortly to see you". They then moved a chair next to the person so their relative would have somewhere to sit. Their relative arrived a short while later.

Staff 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. A family member told us their relative was often up in the night and said "staff are happy to sit with [my relative] in the lounge and if she is hungry they make her something to eat". Another family member told us they like to sit in their relative's bedroom with them when they visit and added staff, "respect our privacy at all times"

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. One person was sat outside enjoying the sunshine and when lunchtime arrived staff came to take him back inside to the dining area. The

person said they wanted to eat their lunch outside so staff arranged a table and brought their food and a drink out to them. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering.

People and when 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. A member of staff was giving a person a drink and said "I managed to find you some jammie dogers [biscuits]; I know they are your favourite". The family member of a person living with a cognitive impairment told us "I am included in [my relative's] care. Any discussions around changes, like her medication, they tell me and ask my views. If I suggest something they take it on board". Another family member said "I do get involved in [my relatives] care. It is my choice".

People were encouraged to be as independent as possible. One family member said staff, "encourage [my relative] to do things for themselves. Staff know when she is having a bad day and needs more support. They are always trying to encourage her to be independent".

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. We saw photographs in the 'memories book' demonstrating people's participation with activities. One person told us "My family can visit me whenever they want". A family member said, "[The provider] told me I can come [to visit my relative] whenever I wanted." Another family member told us "I can visit anytime. I just turn up".

People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing, which supported them to feel more relaxed with familiar items around them.

Good

Is the service responsive?

Our findings

People and visitors told us they received personalised care from staff who understood and met their needs. One visitor said "Staff understand [my relative] so if she is unwell they react straight away". They added "They always let me know what is happening, if [my relative] has had a fall or is unwell". Another visitor told us that when she phones the home staff can instantly tell her about her relative and don't have to look it up". A different visitor said their relative "was getting unsettled, staff thought this was because of the footpath which went past their bedroom window and they could see something moving when people walked along it. So the staff got some special film to go on the window so that the light still comes in but you can't see what's happening outside. [My relative] is so much more settled now". Health professionals were very positive about the responsiveness of staff to people's needs and reinforced the treatment programmes they recommended.

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 kept under regular review by the named nurse for the person.

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 visitor described how their relative's needs had changed and described how they had been involved in their relative's move to another part of the home. Where people's needs changed staff identified this and took the necessary action. For example, to request a GP visit when they identified a person had a sore area on their foot which may have been infected.

Nursing and 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 help a person required with mobilising, meals and personal care. This corresponded to information within the person's care plan. They were also able to describe how they repositioned people who were cared for in bed and what may need to be passed onto the nurses such as changes in the person's skin. It was evident that staff knew the people in their units and how their needs should be met. Staff were kept up to date about people's 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.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also had a named nurse to oversee their care plan and ensured they were up to date and reflected any changes in the person's needs. The key worker and the key nurse could also act as an advocate for the person, if they were living with a cognitive impairment, and needed support with a decision.

Staff were knowledgeable about the types of activities people liked to do. People had access to activities that were important to them. The home had an activities co-ordinator who organised group activities, such as craft events, quizzes and indoor bowls. They also supported people with individual activities, which included those people who stayed in their rooms. The activities co-ordinator spent time in the communal areas of the home engaging with people. They told us they supported people to focus on activities that supported their independence and reflected their historic life skills. For example, one person liked to clean shoes, another was helping with the cleaning and sweeping up and a third person helped with the gardening when the weather permitted. People were also encouraged to develop and maintain links with the local community. The people from the home have a close relationship with the local primary school and regularly attend a 'Tea pot Club' for tea and cakes. The provider had arranged a garden party at the home for the community to celebrate the Queen's birthday. Following feedback from people regarding a visit from the local donkey sanctuary, the provider had arranged for two donkeys to lodge in the grounds of the home. The activities co-ordinator hoped they would provide a distraction for people and an opportunity for people to be involved in looking after them. One visitor told us staff "encourage [my relative to do things". They added their relative was "always doing activities, yesterday when I came she was out walking around the garden".

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints, if they were dissatisfied with the service provided at the home. The registered manager arranged 'client forum' meetings' for each of the units within the home to provide an opportunity for people to express their views about the service. The areas discussed included the level of care provided, choice of food and activities they would like to do. We saw the minutes of the latest meetings for each unit and these included action points which were followed up and discussed at the next meeting. People's relatives were also invited to attend the meeting if they wished to. One visitor, whose relative was living with a cognitive impairment, told us "I am constantly being asked for feedback and if I need to raise any issues they respond straight away. For example [my relative] was having sandwiches [in the evening] but now has a meal at my request". Another visitor said "I can always ask or suggest things. If I suggest something they take it on board".

The registered manager asked people, their relatives and staff to complete a satisfaction survey. The registered manager had analysed the responses to each survey and told us that if issues were identified they would use the information to help develop an improvement plan for the home. We looked at the result for the September 2015 survey and saw they were positive.

There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. 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 person said "I have no concerns but if I did I would happily raise them with anyone of the staff". A visitor told us "there is a notice on the wall if you wanted to complain but I have never had to".

Good

Is the service well-led?

Our findings

People, their relatives and health professionals told us they felt the service was well-led. One visitor said "I have and do recommend this home to my friends and family. The [registered manager] is very approachable, they work tirelessly and their professional commitment is high". They added "[The providers] work unstintingly, they really put themselves out for the clients". Another visitor pointed out one of the providers and said "She is one of the owners, we often see her here".

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 with a registered manager, heads of care for each unit, nursing staff, care staff and administration 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. Positive feedback was also recorded through a compliments file.

Staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the management team on a one to one basis through supervisions and informal conversations. 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 said that they enjoyed their jobs and described management as supportive. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one to one or staff meetings and these were taken seriously and discussed. One member of staff told us "I will be here until I retire. It is the best job I have ever had". They added "The management team are so approachable. I can ask them anything without feeling that I am wrong". Another member of staff said "The home is a home in the true sense of the word. The standard of care is second to none". A third member of staff told us "We have excellent management support and there is a real understanding of our needs and welfare". Other comments about the culture of the home included "It is a home, not just a place to live", "Lovely place to work", "I wouldn't work anywhere else" and "If I had to go into a home in the future, I would want this one".

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.