Newport Residential Care Limited

Newport Residential Care Limited

Inspection report

3 Watergate Road
Newport
Isle of Wight
PO30 1XN

Date of inspection visit:
25 April 2017
26 April 2017

Date of publication:
23 June 2017

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**

Summary of findings

Overall summary

This inspection took place on 25 and 26 April 2017 and was unannounced. The home provides accommodation for up to 31 people, most of whom had mental health care needs. There were 31 people living at the home when we visited.

There was a registered manager in place. 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 home was split into two inter-connecting units. Previously, support staff in the main part of the home supported younger adults with mental health care needs and care staff in the lower part of the home supported older adults, some of whom were living with dementia. The provider had recently taken the decision to focus entirely on accommodating younger adults with mental health needs. As vacancies arose, these were gradually being filled by people with mental health needs. At the time of our inspection, only three older people living with dementia were still being accommodated.

At our last inspection, in October 2015, we identified breaches of two regulations. Risks to people were not always managed appropriately; medicines were not always managed safely; and legislation designed to protect people's rights was not always followed.

At this inspection we found action had been taken and there were no longer any breaches of regulation; however, some further improvement was still needed to help ensure people's safety. The service had created new systems to gather additional information from external agencies about potential risks to people before they moved to the home. However, the information was not always accurate and staff had not made further enquiries to clarify inconsistencies. This meant the risk assessments were not always effective.

Other aspects of risk management were effective. Staff understood the factors that put people at risk of harm and people were involved in discussions about risk. A new fire alarm system had been installed to make it easier for staff to identify the source of a fire and this had reduced evacuation times during fire drills.

Medicines were managed safely and systems were in place to help ensure people received their medicines as prescribed. Staff knew how to protect people from the risk of abuse. There were enough staff to meet people's needs and safe recruitment processes were followed.

People's needs were met by staff who were trained and appropriately supported in their role. They were particularly skilled at supporting people with complex mental health needs and followed legislation designed to protect people's rights.

People praised the standard of care and the level of support their received. They enjoyed the meals and said

their dietary needs were met. When people needed support to eat, they received this in a dignified and supportive way. People were supported to access healthcare services when needed and to attend hospital appointments.

People were cared for with kindness and compassion. Staff created a calm atmosphere and interacted with people in a positive, supportive way. They spoke about people warmly and demonstrated a detailed knowledge of them as individuals.

Staff encouraged people to remain as independent as possible. They respected their privacy and dignity. They involved then in decisions about the care and support they received.

People were encouraged to make choices about every aspect of their daily lives. They received personalised care and support that met their needs. Staff understood the signs that could indicate a person's mental health was deteriorating and responded promptly by providing additional support.

Care plans provided staff with detailed information about how they should support people in an individualised way and were reviewed regularly. For people with mental health needs, they included goals and objectives that staff were supporting people to achieve. All people, including those living with dementia, had access to a range of meaningful activities suited to their individual interests.

People were happy living at the home and had confidence in the way it was run. There was an open and transparent culture. People knew how to make a complaint. The provider sought and acted on feedback from people to improve the service.

Staff were happy and felt valued and listened to by management. They demonstrated a shared commitment to the provider's vision of keeping people safe and supporting them in a compassionate way to achieve their full potential.

There was an effective quality assurance process in place, together with a development plan to further enhance the service.

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.

Inconsistencies in risk management information provided by external professionals were not always clarified to enable staff to conduct effective risk assessments. However, improvements had been made to the management of risk and staff took action to keep people safe.

Medicines were managed safely and people received their medicines when needed. People felt safe at the home. Staff knew how to identify, prevent and report incidents of abuse.

There were enough staff to keep people safe and appropriate recruitment procedures were followed.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and liberty.

People received effective care from staff who were suitably trained and supported in their roles.

People praised the quality of the food and their nutritional needs were met.

People were supported to access health care services, including mental health services, when needed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion.

Staff created a relaxed atmosphere and interacted with people in a positive and supportive way.

People were treated with respect and their dignity was

protected. Staff did not enter people's rooms without their express permission.

People were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. Staff responded promptly when people's needs changed.

People had access to a range of meaningful activities. The provider sought and acted on feedback from people.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home and felt it was run well.

Staff were happy in their work and felt supported by management. They demonstrated a shared commitment to achieving the best possible outcomes for people

There was a caring and open culture in which people were valued.

Quality assurance processes were effective and there was a development plan in place to further enhance the service.

Newport Residential Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 April 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor in the care of people with mental health care needs 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 the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people living at the home and two family members. We also spoke with the provider, the registered manager, an administrative assistant, a cleaner, a cook, a maintenance person and seven care support workers. We observed how care and support were delivered in communal areas. We looked at care support plans and associated records for nine people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in October 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people were not always managed appropriately and medicines were not always managed safely. At this inspection, we found action had been taken and there was no longer a breach of this regulation. However, some further improvement was needed to help ensure people's safety.

Since the last inspection, the service had made significant progress in creating systems to gather essential information from external agencies prior to people moving to the home. These included links with the police and mental health services and had been used appropriately to help staff assess risks posed by and to people living and working at the home. However, we found the information gathered was not always used or analysed effectively, as staff said they were reluctant to challenge external agencies about inconsistencies in their data. For example, for one person, the information supplied by the police about risk was different to that supplied by another external agency, but no attempt had been made to clarify this. For another person, additional information had not been sought about an incident where they had assaulted a staff member at a previous placement. Therefore, staff did not have all the relevant information to enable them to complete effective risk assessments for these people.

The lack of accurate information about risk meant staff were not able to keep one person safe. The person had moved to the home at short notice after discharge from hospital. They had a history of self-harm, but their risk assessment contained conflicting information about this. The person made a further attempt at self-harm shortly after moving to the home which resulted in a serious injury and admission to hospital. Although staff had reflected on the incident and the person had since become settled at the home, they had not analysed the circumstances, the triggers or any behavioural indicators that could help reduce the likelihood of further incidents.

We discussed these issues with the registered manager, who accepted this was an area for further development. They acknowledged that they were in a strong position to challenge external agencies to provide more complete information about people prior to them moving to the home. They undertook to continue building positive relationships with other professionals to help facilitate this. They also reviewed the risk assessments for the person who had self-harmed.

The management of risks had improved in other ways since the last inspection. The registered manager involved the whole staff team in decisions about admitting new people to the home. They considered the person's needs, their known vulnerabilities and the group dynamics of the people currently living at the home to consider any potential conflicts. Recently, a room had remained vacant for two months as staff were not satisfied they could manage the level of risk posed by people wanting to move to the home.

When we spoke with staff, they demonstrated a clear understanding of the risks relating to each person living at the home and how to manage them in a supportive way. For example, some people were supported to clean and remove hazards from their rooms on a regular basis; other people informed staff when they

were going out and when they would be back, so staff could take action if they failed to return.

People were supported to manage risks in a way that respected their independence. For example, some people wished to be make hot drinks but were not safe using a kettle. To overcome this, a flask of hot water had been made available and we saw people taking pleasure in making drinks for themselves and others.

People and their family members, where appropriate, were involved in discussions about risk. For example, an older person with fragile skin was experiencing repeated bruising caused by equipment used to support them to move. After discussion with the person, their family and health professionals, a decision had been made to care for the person in bed. This had reduced the incidence of bruising significantly.

The risk of people developing pressure injuries had been assessed using a nationally recognised tool and appropriate action was taken when people were identified as at high risk. For example, two people were provided with special pressure-relieving cushions and mattresses; the mattresses were set correctly, according to the person's weight, and a clear process was in place to help ensure they remained at the right setting. Another person was at risk of falling out of bed, so bed rails had been put in place to prevent this, following an assessment of the associated risks.

Risks posed by the environment were also managed effectively. A new fire alarm system had been installed to allow staff to identify the location of any fire more accurately; fire drills showed this had reduced evacuation times. People told us they were only permitted to smoke in designated areas outside; they said the new system was more sensitive and discouraged them from smoking indoors. One person said, "You can't risk it [smoking indoors] as the alarms are more sensitive now." A new CCTV system had also been installed to monitor people's safety in communal areas of the home. People told us they had been consulted about this and understood the reason for it.

Each person had a personal emergency evacuation plan (PEEP) which showed the support they would need if they needed to leave the building in the event of an emergency, such as a fire. These were kept in accessible 'grab bags' together with emergency equipment and information about the home that staff may need in an emergency. Staff had been trained in first aid and fire safety. They knew what action to take if the fire alarm activated, took part in regular fire drills and checked the fire safety systems weekly.

People told us they felt safe and secure at the home. One person said, "I'm very happy; I've got no worries." A family member told us, "[My relative] is perfectly safe and we don't have any concerns." Staff had the necessary knowledge to enable them to respond appropriately to concerns about people who were at risk of abuse. All staff had received safeguarding training; they knew how to raise concerns and were confident that managers would take appropriate action. One person had made themselves vulnerable to financial abuse by lending their bank card to another person. Staff had taken action by alerting the person's care manager and this had led to alternative arrangements being put in place to safeguard the person's money. Another person was potentially at risk from a visitor. Measures had been put in place to protect the person and staff were clear about the need to monitor the visits closely.

New procedures had been introduced since our last inspection to help ensure medicines were managed safely. There were now appropriate arrangements in place for obtaining, storing, administering and disposing of all medicines. We saw medicines were administered in a safe way, by staff who were suitably trained and competent. Medicines administration records (MAR) were completed fully. On viewing the MAR charts, no gaps were identified; this indicated that people had received their oral medicines when needed. The MAR charts used to record the application of topical creams were also completed fully.

Information was available to guide staff when administering 'as required' (PRN) medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way. We heard people asking for and being given these during the inspection. One person looked after their own medicines; they had been given secure storage facilities and regular audits were conducted to check the medicines were properly accounted for. Other checks of the medicine stock and the MAR charts were made twice daily so any errors would be identified quickly. Where occasional errors were made, we saw these were investigated and resolved promptly.

There were enough staff to meet people's needs and provide a supportive presence in communal areas. We saw staff had time to sit and engage with people, including those living with dementia, in a relaxed and unhurried way. One person told us, "The staff are always their when you need them." Some people chose to remain in their rooms and staff visited them often to check if they needed support. The registered manager told us they used a staffing level calculator to determine the number of staff required. The calculator showed there were more staff employed than were needed to meet people's essential needs. The registered manager said this enabled them to support people more effectively with activities in the home and out in the community. Absence and sickness were covered by permanent staff working additional hours, which meant people were supported by staff who knew them.

Safe recruitment procedures were in place. These included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these procedures were followed before they started working with people.

Good

Is the service effective?

Our findings

At our last inspection, in October 2015, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff were not following the Mental Capacity Act 2005 (MCA). At this inspection, we found action had been taken. There was no longer a breach of this regulation and people's rights were protected.

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. Most people living at the home had capacity to make their own decisions and they had signed their care plan to indicate their agreement to the care and support they received. Where people lacked capacity to make decisions, staff had completed MCA assessments using the recommended two-stage test. They had consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines, the provision of personal care and the use of bed rails. When we spoke with staff, they demonstrated a sound understanding of the MCA. They could recite the key principles and gave examples of how they sought valid consent from people before providing care and support. We repeatedly heard staff seeking people's consent before administering their medicines and providing support.

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 staff were following the necessary requirements. DoLS authorisations had been approved for three people and a process was in place for renewal applications to be submitted in good time. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. For example, a staff member told us, "[One person] can't go out on their own as they would get lost. They can still go out, but we go with them; for example, we took them round [a local attraction] in their wheelchair." Staff also understood that people not subject to DoLS authorisations were free to leave. This was reinforced in people's care plans, one of which stated: "[The person] has capacity to make his own decisions. He may decide to go out without telling staff. This has been discussed with [the person] and the risks have been acknowledged by staff and with [the person] signing to show this."

People's needs were met by staff who were skilled and suitably trained. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, some staff had received training in de-escalation techniques to support people with heightened emotions. One person told us, "This home has saved my live and is supporting me to get my life back." A family member of a person living with dementia said, "I'm quite satisfied with the way they [staff] look after [my relative]. He's always clean and shaved and they even cut his hair. The personal care is really good." Another family member told us, "All the staff are very good and know what they're doing. [My relative] is

always washed, fed, clean and happy."

New staff completed a comprehensive induction programme before they were permitted to work alone. Arrangements were also in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Following their initial training, staff then worked alongside more experienced staff until they felt confident to work alone. They also benefitted from a staff mentor, who oversaw the completion of their Care Certificate and provided additional support and guidance when needed. Having completed the Care Certificate, staff were then encouraged to obtain vocational qualifications in health and social care and most staff members had gained these or were working towards them

Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, a care support worker who had completed diabetes and MCA training told us, "I used to tell [people with diabetes] they can't have things like cakes, but now I understand they can, in moderation, if they choose. I would advise, but it's their decision." A staff member who supported a person living with dementia told us, "I've learnt a lot about dementia and it's helped me understand what [a person] wants. For example, if he says 'I want to go home', or constantly asks for the toilet, it means he wants to go back to his room."

From discussions with people and a review of their care plans, it was clear that staff were providing effective support to people with complex mental health needs, many of whom had not experienced such a long period of stability in their condition before. Records showed that one person was recently assessed by a managers' panel of an external agency that clearly recognised the progress the person had made at the home.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision which were organised consistently. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the supervisors and staff mentors on a day to day basis. One staff member told us they had received additional support after they had witnessed a traumatic incident. They said, "[The registered manager] was really good. She was really supportive and broke me back into work slowly [after the event], doing a few hours at a time. She still thinks of me now and reassures me."

People praised the quality of the food and said their dietary needs were met. One person said, "The food is very good. If you get a chance, you must have a homemade cake." A choice of meals was available and special diets were catered for where needed. For example, one person needed a pureed diet and another needed a soft diet, both of which were provided. People said they could ask for alternative meals if they did not like what was on the menu. One person told us, "I'm a vegetarian and they make this lasagne especially for me with [a meat substitute]. It's lovely." People were encouraged to make healthy food choices; for example, one person was on a low carbohydrate diet. The cook told us, "We can only try and advise; it's [the person's] choice whether they follow it or not. But we limit the amount of chips [on the menu] and tempt them with homemade soup and homemade bread." People had access to a range of hot and cold drinks and were encouraged to drink throughout the day. Some people also had access to a small kitchen to prepare their own drinks.

Staff created a relaxed, social atmosphere at lunchtime. This helped provide a positive mealtime experience

for people that encouraged them to eat and drink well. One person needed full support to eat and drink and received this in a dignified and supportive way. The staff member interacted positively with the person, put them at their ease and made sure their spoon was not overloaded. Staff had identified that the person was at risk of choking; they had sought medical advice and were following a recommendation to add thickening fluid to the person's drinks. Where people were at risk of malnutrition or dehydration, staff monitored their weight and recorded the amount they ate and drank. They then took action if people experienced unplanned weight loss. For example, one person staff referred to their GP was provided with high calorie meals and given regular snacks. This had helped stabilise their weight.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, dentists and specialist nurses. In particular, staff worked effectively with mental health practitioners and the drug and alcohol service to help maintain people's mental health and well-being. Staff also accompanied people to appointments to provide support and aid communication with health professionals.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. They described staff as "lovely", "nice" and "kind". One person said of the staff, "They always have time for me, even though they are always busy." Another person told us, "My kids said that it is nice to see me happy; and this is because I live here." Written feedback from another person echoed this comment and said, "Since I've been here, I have never been happier. Thank you so much." A family member said of the staff, "They're good at communicating. They are a caring bunch and are all very helpful. [My relative] has always been happy here."

All interactions we observed between people and staff were positive, supportive and friendly. Staff were relaxed, respectful, and knew people and their backgrounds well. They took time to listen to people and responded with empathy when needed. While supporting a person to take their medicines, a staff member adopted a relaxed approach, dancing to some background music to help put the person at their ease.

Staff created a calm atmosphere by supporting people in a patient and unhurried way. They also spoke fondly about the people they supported and demonstrated a commitment to treating them well. Comments included: "You've got to look past the mental health and see the person, not the label" and "[A person] has been here for two years now when all their other placements had failed and he says he is happy now. I love it when we do that." When describing another person to us, the staff member said, "He is lovely; he seems to fit in so well here." Other comments from staff included: "We try to treat people like family and deliver the care you would want a loved one to receive" and "I like just being there for [people]. They get a lot of comfort just knowing I'm there for them".

Written feedback from an ancillary staff member who only worked at the home occasionally stated: "This is the best place I have ever had the pleasure to work. All the staff and residents are absolutely lovely and the whole atmosphere of the home is very calming and relaxed and peaceful. When I leave after my shift, I always feel happy and find myself smiling more throughout the day. They really care about the residents. It is a wonderful place to be."

People's privacy and dignity were protected. For example, staff used a dignity screen while taking a blood sample from a person in the lounge. Staff were also discreet when talking about people and made sure their conversations could not be overheard. One staff member described the practical steps they took to preserve people's dignity when receiving personal care; these included keeping curtains and doors closed, explaining what they were doing and keeping them covered as much as possible with towels. A family member told us, "Staff always give [my relative] privacy when I visit. They're very friendly and helpful." Written feedback by a doctor who had regular contact with the home stated: "They [staff] are always professional and treat residents with dignity and respect."

When people were present, staff knocked and sought permission before entering people's rooms. However, staff had a policy of not entering a person's room if they were out; they waited until the person returned and their permission could be sought. This included cleaning staff, who did not enter a room to clean it without the express permission of the person. A staff member told us, "We wouldn't go in someone's room without

permission. We just wouldn't do that."

People were encouraged to follow a set of 'house rules' for the safety of themselves and others. One of the rules required them to agree, as a condition of residence, to regular room checks by staff, to identify any hazards in their rooms. We saw these were conducted in cooperation with the person on a risk-assessed basis. One person who had a tendency to hide out of date food in their room received daily room checks, while another person, whose room rarely contained any items of concern, only received occasional checks. A staff member told us, "If a person doesn't want a check, I leave and come back later."

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, at lunchtime staff gave people space to eat and encouraged them to clear away their plates away when they had finished. Two people were also supported to make their own packed lunches for the day. A staff member told us, "Any way we can promote independence we do, whenever possible. If they [people] are capable [of doing something] we encourage them to; like making their own drinks. If they can still do that we should encourage them to."

People were involved in planning and making decisions about the care and support they received. They often did this before they moved to the home, on arrival at the home and at regular intervals thereafter. Records confirmed that people were consulted whenever their care plan was reviewed and we saw their comments and views were recorded.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their individual needs. People told us staff supported them in a way they "like things done". A family member said, "I wouldn't want [my relative] to go anywhere else. They [staff] do whatever is needed for them." A doctor who had regular contact with the home said, in a survey conducted by the provider, "I have always been impressed with the care provided by all the staff I have had contact with."

Staff were clear that they were led by people's individual wishes and accommodated them wherever possible. A staff member told us, "It's about providing the right care at the right time, rather than following a routine." All staff demonstrated an in-depth understanding of the individual support needs of people living in the home. For example, staff supporting older people, in the lower part of the home, knew which people needed to be encouraged to drink well and the subjects each person liked to reminisce about; they recognised that one person's mobility varied from day to day and were able to assess and accommodate the level of support they needed at a particular time. A staff member told us, "We judge when to use the hoist with [the person] as it varies from day to day. Sometimes he can't weight bear, but other days he can."

Staff supporting people with mental health needs understood people's 'relapse indicators' and knew how to respond to them. Relapse indicators are the early warning signs that a person's mental health may be deteriorating. A staff member told us, "Everyone's [relapse] indicators are different." They then described specific relapse indicators for certain people and added, "If they show any of these signs, that's when we need to take action and give extra support." Records of the daily care provided confirmed that people had been supported in accordance with their individual needs and wishes.

Staff responded promptly when people's needs changed. They were alert to changes in the way people presented and took account of the known relapse indicators. When these were observed, staff liaised closely with mental health services, including the crisis resolution and home treatment team, to obtain the necessary support for the person. One person had gone missing for a period of time and their care records showed that staff had liaised closely with the police, mental health services and the person's family until they were found.

Some people had diabetes and staff monitored their blood sugar levels in accordance with instructions given by doctors. Information in people's care plans provided clear guidance to staff about actions to take if blood sugar levels were particularly high or low. One person confirmed that staff did this "properly" and records showed they had taken appropriate action when the person's readings were unusually high.

People's care plans were well organised and provided comprehensive information to enable staff to deliver care and support in a personalised way. They were centred on the needs of each person and took account of their medical history, their preferred daily routine and how people wished to receive care and support. They included information about people's physical and mental health; medicines; continence; skin integrity; nutrition; and mobility. For people with mental health needs, staff also used a 'Core Mental Health Assessment' tool to assess the person's mental health needs. Where needed, they also included a

contingency plan detailing the action staff should take when people's mental health deteriorated.

Care plans were reviewed regularly by nominated key workers in conjunction with the person. A key worker is a staff member who takes a particular interest in a named person and acts as a point of contact for them and their family members. We found all care plans were up to date and reflected people's current needs.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, and how and where they spent their day. Most people were free to come and go as they pleased, although some people chose to inform staff when they were going out as a pre-planned safety measure. People could choose how often they took a bath or a shower. One person, who needed support to bathe, had recently asked to increase the number of baths they had each week and we saw this had been accommodated.

People had access to a range of meaningful activities, including arts and crafts, relaxation sessions and yoga. Everyone we spoke with said they could get involved as much or as little as they wished. Five people told us they particularly enjoyed the exercise classes that were run and we saw two people had volunteered to paint a fence at the home.

People with mental health needs had each developed a set of goals and objectives they were working towards. Many of these involved accessing the community and becoming involved in activities outside the home. For example, one person wanted to get involved in rural activities and staff supported this by providing a later meal for them when they had been out all day. Three other people undertook voluntary work which staff encouraged. Staff had also developed links with a national charity aimed at supporting people to recover from mental health illness. This had given people access to a wide range of rehabilitative therapies and activities, including cooking, gardening and creative writing. People told us these had improved their self-esteem.

Staff adopted a different approach for people living with dementia to ensure their activity needs were recognised and met. For these people, activities were arranged that staff knew were popular. For example, a musician attended weekly to play songs they enjoyed; they also played skittles, board games and organised trips to local attractions.

The provider sought feedback from people, including through the use of 'residents meetings' and survey questionnaires. Comments from people were then used to improve the service. For example, some people had commented that some rooms were too cold, so the boiler had been adjusted to make the home warmer. Other people had expressed an interest in keeping chickens, so the registered manager had ordered a chicken coup, which was due to be delivered shortly after the inspection. People had also been asked for their views about the menu and we saw this had been tailored to meet their individual requests. For example, one person had requested pies and we saw beef and ale pie had been added to the menu.

People and relatives told us the registered manager was "always available" to discuss any concerns. They knew how to complain and felt able to raise concerns. Everyone we spoke with expressed confidence that their concerns would be listened to, taken seriously and acted on. We observed one person approach the registered manager about a piece of furniture that was too large for their room. The registered manager responded sympathetically and invited the person to choose another item of furniture from a catalogue. From the person's body language and comments, it was clear they were highly satisfied with the response. A family member told us, "If I need to mention anything, I do and they sort it out." People were invited to record their complaints in the 'complaints book' and staff supported people to do this, if needed. The records showed that each complaint had been responded to and resolved within 24 hours.

Good

Is the service well-led?

Our findings

Everyone we spoke with said they were happy living at Newport Residential Care and felt it was run well. One person told us, "It's the best home I have lived in. I like living here and do not want to leave." Another person said, "This is the best home on the island." A family member said of the home, "It seems well run. If there are ever any problems, I can always ask [the registered manager]. They keep me up to date with everything." Another family member said, "Everything is well organised and staff are on the ball."

The service had previously been split into two interconnecting parts. One part of the home provided care to older people, some of whom were living with dementia, and the other part provided support to younger adults with mental health needs. The provider had recently taken the decision to focus entirely on accommodating younger adults with mental health needs. As vacancies arose, these were gradually being filled by people with mental health needs and the two parts of the home were becoming more integrated. However, they also remained committed to continuing to meet the needs of three older people who had lived at the home for several years.

The staff team were fully aware of the changes. Those who had previously only worked with older people were being encouraged to develop the skills needed to support people with mental health needs. The registered manager told us "[Staff] are being nurtured into the new [arrangements]. We are supporting staff to move forward at their own pace, as they become comfortable."

Staff enjoyed working at the home and told us they felt valued and listened to by management. Comments from staff included: "I think [the registered manager] is doing a great job. A lot has changed, for the better"; "Since [the registered manager] has been here, things have been more proactive than reactive. People are doing more; morale is good; and it's a good place to work. She has modernised the service and brought it up to date"; "[The registered manager] is really supportive and has got the place up together"; and "The manager is very open. You can discuss any issues with her. She even phoned me at home once to check I was okay [after an incident]".

A range of methods was used to help ensure effective communication between staff. These included weekly meetings to discuss each person and their needs to help identify additional ways of supporting people to achieve their goals. A newsletter had also been introduced to inform people and staff of events and changes at the home.

The registered manager was in the process of developing the management team to share the supervisory workload. They had supported senior staff to obtain management qualifications and were seeking to appoint two 'deputies'. This would make the management arrangements more flexible and resilient. In order to keep up to date with best practice guidance, the registered manager was studying for a diploma in health and social care. They also attended seminars run by the local authority and were active members of the local care homes association. This enabled them to seek and share knowledge and best practice with their peers.

The provider had a clear vision for the service, based on keeping people safe and supporting people in a compassionate way to achieve their full potential. They monitored this through regular contact with the registered manager and staff and through monthly visits when they completed a review of each aspect of the service. There was clear evidence of a highly caring culture, promoted by the registered manager and adopted readily by the whole staff team. Every staff member we met demonstrated a shared commitment to treating people with understanding and compassion, valuing them as individuals and supporting them to achieve the best possible outcomes.

There was also an open and transparent culture. The provider's performance rating from their last inspection was displayed in the entrance lobby, together with a summary of the responses from a recent survey. Visitors were welcomed any time and were able to come and go as they pleased. There were good working relationships with external professionals and the provider notified CQC of all significant events. A duty of candour policy was in place and followed, to help ensure staff acted in an open and honest way when accidents occurred. The registered manager had also welcomed support from a social care professional working with the clinical commissioning group (CCG). In particular, this had helped them enhance the service provided to people living with dementia.

The quality assurance system had been further developed since our last inspection and was now more robust. This was based on a range of audits conducted by the provider, the registered manager or a senior staff member. It included audits of care planning, the environment, medicines and infection control. Where improvements were identified, specific actions were developed and implemented. For example, a recent care plan audit had identified some missing information in one care plan and when we checked it, we found it had been updated and the relevant information was present. The rooms audit had identified some furniture was no longer functional and this had been replaced. In addition, a full audit of the premises, completed by an external health and safety consultant, had been completed. This showed the service was fully compliant with the relevant legislation.

The registered manager had a rolling development plan in place for the service. We saw all of last year's objectives had been achieved; these included the installation of CCTV, the upgrading of the fire safety system and the redecoration of some communal rooms. The current year's plan included further enhancements to the environment, building additional rooms and developing staff skills to enable them to support more people with mental health needs.