Ryde House Homes Ltd

Clifton Cottage

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

Clifton Cottage is a privately run care home, which provides accommodation for up to seven people who have a learning disability. At the time of our inspection there were seven people living in the home.

The inspection was unannounced and was carried out on 19 April 2016.

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

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

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

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

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

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

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

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

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

that they could understand. They were patient when engaging with people.

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

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 both informally, through 'residents' meetings' and through an annual questionnaire. They were also supported to raise complaints should they wish to.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

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

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

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

Is the service effective?

Good

The service was effective.

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

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

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

Is the service caring?

Good

The service was caring.

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

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

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

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

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

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

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The 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.

Clifton Cottage

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 by one inspector on 19 April 2016.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people living at the home and engaged with two others who communicated with us verbally in a limited way, we also spoke with a relative. Following our inspection, we received feedback from an advocate, a health professional and two care professionals. We observed care and support being delivered in communal areas. We spoke with two members of care staff, the deputy manager and the registered manager.

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

The home was registered with the Care Quality Commission in July 2015 and has not previously been inspected.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person told us, "I feel safe, especially now have a key to my room, so I can lock it when I go out". Another person said "Staff are good" and "I like it here". A third person told us "Yes I feel safe, they are nice". A family member told us their relative was "Quite safe. I never had any hesitation or concerns".

The advocate, the health professional and the two care professionals all told us they had no concerns about people's safety. The Advocate said, "In my experience the service is safe". They added that staff were, "very aware of what constitutes a safeguarding alert, and have in the past acted promptly and appropriately to ensure that the safety a resident was maintained when they have identified them to be at risk". The health profession said, "I have visited Clifton Cottage approximately 20 times in the past 12 months. In my experience, yes the service is very safe".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us if they had any concerns, "I wouldn't worry about intervening or saying something. I would report it to the manager". Another member of staff said they would report it and if nothing happened they would go above the person or report it to CQC". The registered manager explained the action they would take if a safeguarding concern was raised with her and the records they would complete to support this action, including reporting the concern 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 had a risk assessment in place in respect of their going out into the community independently. During the inspection we observed this person telling staff they were going out and staff checking the person had everything they needed, in line with their risk assessment. The health professional told us "All staff I have been involved with, have demonstrated risk awareness, and the need to monitor and review care based on this". They added "We discussed issue of client going out unsupervised. It was agreed staff would monitor his ability to manage safely going out into the community without getting lost, we agreed a plan for [the person] having his name and address to keep in wallet in case of rare incident of becoming disorientated". 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 recorded on the provider's electronic system. This enabled analysis to take place, both from the home's perspective and provided the opportunity for learning and risk identification across all of the services owned by the provider. Each person's care plan contained a 'Vulnerable Adult Form' which provided the information necessary for

health professionals to support that person should they be taken to hospital in an emergency.

People and a family member told us there were sufficient staff to meet people's needs. One person said staff, "help me, if I want them". A family member told us, "Yes, there is enough staff. They do extra hours so [my relative] can go out for a walk and go to the library". 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 employed by the provider at other homes. The registered manager was also available to provide extra support when appropriate.

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

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

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary. There was an easy read fire procedure in each of the rooms, suitable for the needs of people living at the home. A fire drill was completed each week, which include a practice evacuation of people present in the home at the time of the drill.

Good

Is the service effective?

Our findings

People and a family member 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, "I tidy my room but staff help me". Another person told us, "Staff are nice they look after me". A family member said there relative had been at the home a long time and "Staff know just how to help him when he is having a difficult time". An advocate, a health professional and two care 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. The advocate said, "I have developed a clear view that the provision of support and care, and the approaches adopted by the management and team are effective and supportive to promote quality of life for its residents as a priority.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. People were also supported by an independent advocate or an independent mental capacity advocate (IMCA), when appropriate, for important decisions that affects their lives. For example, a best interest decision had been made in respect of one person who held their own bus pass but had started to become confused when out in the community. A best interest decision was made following discussions with the person, who was supported by an advocate, for staff to hold their bus pass. This restricted the use of the bus pass without staff knowledge allowing the person to maintain their independence in a safe and supported way. The advocate told us, "The management have a comprehensive understanding of the importance of 'best interests' meetings to ensure that decisions about safety are made in a multi-disciplinary setting".

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

People and their families told us that staff asked for their consent when they were supporting them. One

person told us, "I will tell them [staff] if I am not happy; I definitely let them know". Another person said, "Don't like cooking, so I don't". A family member told us their relative would "tell staff he does not want to do something". Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. One member of staff told us that seeking consent, "comes quite naturally, you just do it. If someone refuses something, it is their choice". Daily records of care showed that where people declined care or support this was respected.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS were the standards employees working in adult social care should meet before they could 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 the new set of standards that health and social care workers adhere to in their daily working life.

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 medicine administration, safeguarding adults, mental capacity act and first aid. Staff had access to other training focused on the specific needs of people using the service. For example, dementia awareness, autism awareness and proact scrip, which is training to help staff support people that display behaviour that challenges staff or other people. 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 were supported to undertake a vocational qualification in care.

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 registered manager 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. One person said "the food is perfect. My favourite is fish and chips which we have on Thursday". Another person told us, "I like the food. I can have what I want. I had eggs today [for breakfast]". Family members were complimentary about the food and told us their relatives were supported to eat the food they liked. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. Meals were appropriately spaced and flexible to meet people's needs.

During the morning one person asked staff if they could have celery at lunchtime. During lunch a member of staff checked with the person "Do you still want celery with your cheese. I know you like celery"? Another person, who was diabetic, told us "I like the food here. I am eating fruit because the doctor said". We saw this person helping themselves to fruit from the fruit bowl. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. People were offered a choice of drinks with their meal and staff encouraged people to drink throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. One person who was going out told us "[Named member of staff] is taking me; having a blood test and then fish and chips for lunch".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People's comments included "Staff are nice", "Staff are good", "Very happy" and "Staff check I am happy". A family member told us they did not have any concerns over the level of care provided or how it was delivered. They said the home was a "nice and homely place. [My relative] is always happy there. Staff are very nice and [my relative] relies on them quite a lot". They added "I can't speak about the home and staff more highly. I definitely would recommend the home to people".

An advocate, a health profession and two care professionals told us that staff at the home were very caring. The advocate said "It is refreshing to enter a residence where the service users are clearly the priority for the staff, when I have spoken with residents and staff they are often spending time together in the communal areas". A health professional told us "I have been so impressed by the care, support, and warmth that I have seen the staff demonstrate toward [person living at the home]. It is very clear that the client considers staff like a kind of family". They added "They [staff] really care".

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. During lunchtime one of the people started to become anxious about our inspection. A member of staff quietly reassured the person we were there "checking like the nurses do; checking we are alright". Staff were attentive to people and checked whether they required any support. For example one person was preparing to go out for the morning and staff checked they had everything they needed and whether they wanted any support getting ready. A health professional told us, "I have also witnessed interactions between staff and the clients, very very positive and caring, supportive".

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. An advocate told us, "It is also clear from speaking to the staff that their approach to the provision of support is person centred, ensuring that the residents are each given choice and opportunities to change their daytime activities". They added "The residents which I support love their activities and feel they are able to say if they do not wish to attend, without concern.

We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. One person said, "Yes, staff knock on my door and respect my privacy". A family member told us "Yes, staff knock on the doors before entering. I hear them when I phone. They knock on the door and say your sister is on the phone". A member of staff said that when supporting people, "I get them to do as much as they can and cover them with a towel". They added "I always knock on the door and wait before going in". An advocate, a health profession and two care professionals told us they did not have any concerns over how staff respected people's privacy and dignity.

When appropriate, people's 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. The registered manager told us, "People in the home can access their care plans. Some like to be involved in their care and take their care plans into their care review. They are really proud of them".

People were encouraged to be as independent as possible. One person told us "I am able to go out on my own. I get the number two bus to Shanklin". Another person described how they had been out that morning on their own to the pier to photograph the boats. We observed a member of staff supporting a person to make their own sandwich. Other examples of people being encouraged to be independent included domestic tasks such as taking their crockery to the sink after lunch or doing their own washing. Staff praised people's efforts and we saw their faces which reflected a sense of achievement.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. One person told us they were "going to visit my brother this afternoon". Another person, were going out to meet their friend at bowling and a third person told us about a friend who used to come and visit them in their room before they moved away.

People's bedrooms were individualised and reflected people's interests and preferences. They were personalised with photographs, pictures and other possessions of the person's choosing. One person proudly showed us the medals they had won playing table tennis, which were displayed in their bedroom. They also showed us caricature picture of themselves, which were done when they visited Disney World, displayed in his room. Another person show us their room and told us it was "how I like it". There was an electric organ and a guitar is the room and the person said "I like playing music in my room".

Good

Is the service responsive?

Our findings

People and a family member told us they felt the staff were responsive to their needs. One person said, "Staff are okay and they know how I like things". A family member told us "Staff know [my relative well] and can see is unwell straight away". An advocate, a health professional and two care professionals told us that staff at the home were responsive to people's needs. The advocate said, "In my experience, the service and staff are responsive to their duties, and their responsibility to support and care for their residents". They added "One of my residents has a deteriorating visual condition, as such the staff are always facilitating the provision of supportive visually-impaired equipment such as large button phones, easy use radios and alarm clocks". A health professional told us "staff demonstrate that their goal is to provide high quality care, which is based upon needs of clients, is flexible according to their needs and presentation". They gave an example where the registered manager and the deputy manager had responded to the changing needs of a person living with dementia. They added "I was involved in suggestions that they implemented in terms of ideas to help with orientation for the client".

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

When appropriate, people's families were involved in discussions about their care planning, which reflected their assessed needs. One family member told us, "I always come when [my relative] has their assessment. They talk to [my relative] so they are included in the decisions".

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 support plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. The advocate told us, "Care plans are always made available to me and any reported incidents are always well documented and explained to me when I attend". Each person had an 'easy read' health action plan supported by pictorial representations suitable for the needs of the person they related to. Where possible, this was used to encourage people to become involved in developing their care plan.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift and supported by a communication book, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Each person had an allocated keyworker. The registered manager told us this was "So the person knows they have a special staff member to talk to, be the focus for the family regarding birthdays and Christmas etc; The first line advocate to support the person and keep an eye on any health issues". One person told us "[Name of a member of staff] is my keyworker. He is top notch". Each of the key workers carried out a monthly review with the person of the activities they had engaged with and the activities they might like to

try in the future. They discussed their health needs and asked for the person's views about their support.

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People were supported to go out independently, carry out jobs in the community and had access to activities that were important to them. These included gardening, photography, going to a football match to watch a team they supported, attendance at day centres, going to the pub, the theatre, film club and shopping. People were also support to go on trips and holidays away from the home. One person enthusiastically told us they had been working at John's club that morning and had "managed to save £4 for my trip". They explained they were going to Poulton's Park with John's club. John's club is a venue run by volunteers providing leisure and recreational activities for people with learning and physical disabilities. Care plans contained numerous photographs of various trips and holidays as well as a narrative, which told the story of different holidays such as a visit to Butlin's. These allow staff to engage with people about their holiday and their experiences. There were activities available for people in the home, such as helping with domestic duties, watching TV and DVDs, listening to music or playing an instrument. The advocate told us that "The residents at Clifton Cottage appear to have a comprehensive timetable of activities which they can opt-in and out of as they wish". The health profession said, that one person at the home "has a camera that he carries everywhere, and has many pictures spanning several years - having looked through these, as a means of engaging with him, the photos demonstrate many trips out/ adventures which include staff. The photos are happy mementos of these occasions".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People were supported by advocates and independent mental capacity advocates (IMCAs) who were available to support them if they were unhappy about the service provided. The IMCAs had been involved in supporting people with the decision to apply for authorisations under the deprivation of liberties safeguards (DoLS). The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. A family member told us "Whenever we speak [the registered manager] asks me if I am happy". They added "I wouldn't be afraid to say something if I wasn't happy. As I say [the registered manager] is so approachable".

The registered manager also sought formal feedback through 'residents' meetings and the use of quality assurance survey questionnaires sent to people and staff. We looked at the minutes of the residents' meetings held in March and April 2016. The meetings covered a range of topics including issues that affected people at the home, such as new staff, Easter activities and voting in a forthcoming election. Other topics included discussions about suggestions for inclusion on the menu; possible holiday locations; and feedback from a recent table top sale people had been involved in which raised £34. People agreed that the money raised should be used to support a local venue, which was they all used. The feedback from the latest quality assurance survey, which had just been completed, was all positive in respect of the care and support they received.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided; this information was also available in an easy read format, which was suitable for the needs of people living at the home. The registered manager told us that people's keyworkers would support them to raise any complaints initially and people also had access to independent advocacy services if they needed them. During the March residents' meeting the registered manager reminded people of the complaints procedure and where the easy read poster was displayed on the notice board. The family member told us they knew how to complain but had never needed to. The registered manager told us they had not received any complaints and was able to explain the action that would be taken to investigate a complaint if one was

received.

Good

Is the service well-led?

Our findings

People and a family member told us they felt the service was well-led. The family member also said they would recommend the home to their families and friends. They added, "Everyone is relaxed and approachable". An advocate, a health professional and two care professionals told us they had no concerns regarding the management of the home. The advocate said, "The manager is, from my experience, a very knowledgeable and effective manager". They added, "Clifton Cottage and its management team are very efficient. I have been impressed with the management and the quality of the support that they provide to the residents whom I support/ represent. I have never had any issues or difficulties working with the staff at Clifton Cottage, and the service users have never indicated to me that they are unhappy with the provision of support or care". The health professional told us, "During discussions with [the registered manager and the deputy manager], it is clear that their goal is to promote independence, encourage use of meaningful activities that are person centred to meet the needs and interests/ hobbies of clients, to promote self-esteem and confidence whist engaging socially". They added, "I believe Clifton Cottage is a really good example of excellent person centred care".

There was a clear management structure, which consisted of a registered manager, deputy manager and the provider. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us the registered manager was, "very approachable. I can speak with her when I want". Another member of staff said they thought the registered manager "was supportive. I can raises concerns if I have any".

Care staff were aware of the provider's vision and values and how they related to their work. The deputy manager told us, "our philosophy is to give people the best life they can have in a homely environment and to help them to achieve their potential". Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. One staff member said "The meetings have an agenda but they are really interactive". Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. The family member told us they were given the opportunity to provide feedback about the culture and development of the home and said they were happy with the service provided.

The provider had suitable arrangements in place to support the registered manager. The registered manager told us they attended regular manager's meetings with the managers from other homes owned by the provider. They said the meeting was "a good opportunity to keep in the loop with up to date information and raise concerns if needed". They told us they saw the provider each month and felt very supported in their role. There were systems in place to monitor the quality and safety of the service provided and the maintenance of the buildings and equipment. The registered manager carried out regular checks of infection control, the cleanliness of the home, people's bedrooms, medicines management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water

temperatures, the medicine cupboard temperatures and fire safety. The registered manager told us that if a concern was identified remedial action would be taken. All of feedback from people, the results of the surveys and the audits were logged onto the provider's electronic management system, which provided an overview of the home and the opportunity to identify any trends and concerns developing at the home or across the other homes owned by the provider.

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 (CQC) if they felt it was necessary.

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